October 15, 2018

Veronica Longstreth RN, MSN

Program manager

Department of Health

899 North Capitol Street, NE, 2nd floor

Washington, DC 20002

Dear Ms.Longstreth,

Please find attached updated POC for the Federal tags, and State tags, and survey that were completed at our facility on August 15, 2018.

If there are questions, please contact me at 301-254-9250.

Sincerely,

Stephen Gbenle,RN,BSN,LNHA

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 ______	08/15/2018

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

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L 000	Initial Comments	L 000		

An unannounced Licensure Survey was conducted at Health Rehabilitation Center at Thomas Circle August 7, 2018, through August 15, 2018, and consisted of a review of 19 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 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)
G-tube Gastrostomy tube
HSC Health Service Center
HVAC - Heating ventilation/Air conditioning
ID - Intellectual disability

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L 000	Continued From page 1 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	L 000		
L 012	3203.2 Nursing Facilties A list of all employees, with the appropriate current license or certification numbers, shall be on file at the facility and available to the Director. This Statute is not met as evidenced by: Based on observations and records review, the facility failed to ensure that persons in charge, who are certified food protection managers, obtained or renewed a District of Columbia	L 012	1. No specific resident identified. The Dining leadership team: Director of Dining services, Dining Room Manager and Executive Chef currently do have their server certification along with the required DOH food safety manager's examination and certification.	

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L 012	Continued From page 2 issued Food Protection Manager Identification Card, as evidenced by two (2) of two (2) persons in charge who did not have a District of Columbia issued Certified Food Protection Manager Identification Card. Findings include: 25 DCMR Food and Food Operations Chapter 2 Supervision & Training of Food Employees 203- 'Certification and District-issued ID Requirements- Food Protection Manager, Person in Charge' dated November 30, 2012 stipulates: "203.1- Each person in charge shall be certified by a food protection manager certification program that is accredited by the Conference for Food Protection Standards for Accreditation of Food Protection Manager Certification Programs...203.3- A person in charge who is a certified food protection manager as required in §203.1 shall obtain a District-issued Food Protection Manager Identification Card (ID Card), issued by the Department, and shall renew the District-issued ID Card every three (3) years." Findings included ... Two (2) of two (2) Persons in Charge did not have a District of Columbia issued Food Protection Manager Identification Card. During a face-to-face interview on August 9, 2018, at approximately 10:25 AM, Employee #9 acknowledged the findings.	L 012	2. The new Director of Dining services hired on 8/1/18 is actively reviewing, developing, and implementing dining leadership support schedule that will ensure full coverage at all limes within the Dining Department. 3. The Food Services Director/designee will conduct monthly environmental rounds, record audits, monitor staff daily to ensure compliance and food delivery as ordered and required, and document findings. Performance will be reported to quarterly QAPI meeting for review and/or further recommendations. 4. Compliance date	10/15/18
L 051	3210.4 Nursing Facilities A charge nurse shall be responsible for the	L 051		

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L 051	Continued From page 3 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; (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: A. Based on record review and staff interview for one (1) of 19 sampled residents, the charge nurse failed to accurately code the Minimum Data Set (MDS) to reflect one (1) resident's diagnoses Depression, and oxygen therapy, and residents with Hallucinations and Insomnia. Resident #13. Findings included... A. Failed to accurately code the Minimum Data Set for Hallucinations and Insomnia. Resident #13 admitted on June 6, 2018, with a	L 051	1. Resident #13 was discharged on 8/15/18 and the record cannot be amended retrospectively. 2. The Facility will audit by all current residents' MDS for timeliness and accurate coding. Any omitted areas identified will be corrected. 3. An educational review with the new MDS Coordinator, NHA and DON was completed. Resident records will be reviewed by (NHA) for accurate MDS coding to include resident diagnosis within 48 hours of admission. 4. Monitoring for accuracy and completion will be added for review during the daily stand-up meeting X3 months. 5. Compliance date	10/15/18 10/15/1

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L 051	Continued From page 4	L 051		

diagnosis that included Chronic Obstructive Pulmonary Disease with Acute Exacerbation, Acute and Chronic Respiratory Failure with Hypoxia and Shortness of Breath.

A review of Resident #13's Admission MDS with a date of June 11, 2018, showed that in Section I Active Diagnosis, under Psychiatric /Mood Disorder the box next to the Disorder I5800 Depression, was blank indicating, "Not done."

A review of the medical admission record dated June 11, 2018, review of system Psychiatric: showed Anxiety, Depression, and Irritability, but no Hallucinations and no Insomnia."

A review of the Medication Review Report sheet showed that Resident has been receiving the following medications:

"June 4, 2018, Bupropion Hydrochloride 75 mg give 2 tablets by mouth every 12hrs [hours] for Depression."
"June 6, 2018, Zoloft 25 mg give 1 tablet by mouth in the morning for Depression

During an interview on August 15, 2018, at approximately 1:00 PM with Employee #2. She was made aware that there are concerns with coding resident diagnoses. Employee #2 acknowledged the finding.

B. Failed to accurately code Minimum Data Set for Resident #13 who receives oxygen therapy.

A review of Resident #13's admission MDS with a date of June 11, 2018, Section O Special Treatments, Procedures, and programs Section C Oxygen Therapy was blank indicating, "Not

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L 051	Continued From page 5 done." A review of the medical admission record dated June 11, 2018, review of system Respiratory: showed Dyspnea, Shortness of breath, but no cough." A review of the Medication Review Report sheet showed that Resident has been receiving the following: "Continuous O2 [oxygen] @ [at] 2 liters/min. Diagnosis for use SOB/COPD [shortness of breath/ Chronic Obstructive Pulmonary Disease]. Administer via NC [nasal cannula] every shift for monitoring." During an interview on August 15, 2018, at approximately 1:00 PM with Employee #2. She was made aware that there are concerns with coding resident diagnoses. Employee #2 acknowledged the finding. B. Based on observations, record reviews and resident and staff interviews for one (1) of 19 sampled Residents, the charge nurse failed to develop a care plan to address one (1) Resident problem with constipation. Resident # 15. Findings included... The charge nurse failed to develop a care plan to address Resident #15 problem with constipation. Resident #15.	L 051	1. Resident #15 was discharged on 8/28/18 and the record cannot be amended retrospectively. 2. Medical records of all current residents with the potential problem concerning constipation were audited by (ADON/DON) to ensure a corresponding care plan with appropriate goals and approaches ~~is~~ was completed. 3. The Interdisciplinary team will be re-educated DON regarding care plan updates as they relate to resident problems concerning constipation. 4. Audits of care plan updates for residents with problem with constipation will be completed by the DON and/or designee weekly to ensure compliance until three consecutive months of greater than or equal to 95% compliance is achieved. Results of these audits will be reported at the quarterly Quality Assurance Committee meeting, for review and/or further recommendations. 5. Compliance date	10/15/18

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L 051	Continued From page 6 During tour interviewed with Resident #15 on August 07, 2018 at 3:41 PM he stated, "I am constipated need something better." He pointed to the bedside table and continued to say, "I went and got some prune juice and hope it goes away." At the time of the interview, a bottle labeled Prune juice half-full was located on the resident bedside table. A review of the Physician's order showed the following orders for Bowel Management: June 4, 2018, directed, "Senna S Tablet 8.6 - 50 mg [Sennosides - Docusate Sodium] 1 tab by mouth every 12 hrs (hours) for Bowel management." June 4, 2018, directed "Bisacodyl Suppository 10 mg Insert 10 mg rectally every 24 hours as needed for Bowel management." June 6, 2018, directed, "Add 1 cup of Prune juice to every meal" A review of Resident #15's care plans showed that a care plan was not developed with goals and approaches to address the resident's problem with constipation. A face-to-face interview conducted with Employee#2 on August 15, 2018, at 3:15 PM. She reviewed the care plan and acknowledged the findings. C. Based on observations, record reviews and staff interview for one (1) of 19 sampled residents, the charge nurse failed to update the	L 051	1.Medical records of all current residents with the potential problem concerning constipation were audited by ADON/DON to ensure a corresponding care plan with appropriate goals and approaches was completed. 2.The Interdisciplinary team was re-educated by the ADON/D.O.N. regarding care plan updates as they relate to resident problems concerning constipation. 3. Audits of care plan updates for residents with problem with constipation will be completed by the DON and/or designee weekly to ensure compliance until three consecutive months of greater than or equal to 95% compliance is achieved. Results of these audits will be reported at the quarterly Quality Assurance Committee meeting, for review and/or further recommendations. 4.Completion date	10/1/18 10/1/18 10/15/18

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L 051	Continued From page 7 care plan to include goals and approaches to address one (1) resident change in diet. (Resident # 15). Findings included... Resident #15 was admitted on December 22, 2017 with diagnoses to include Hypertension, Hyperlipidemia, Aphasia, and Cerebrovascular Accident. On August 13, 2018, at approximately 12:30 PM, Resident #15 was observed feeding himself. He ate 100% of his diet "Regular diet Puree Texture, honey fluid consistency". According to the clinical record, on June 6, 2018, Resident #15 had a Modified Barium swallow test. The Resident on July 28, 2018, had a diet change to "Regular diet Puree Texture, honey fluid consistency" A review of Care plan showed May 23, 2018, speech therapy change diet to "Pureed with nectar consistency" The evidence shows that facility staff did not update the Resident #15 care plan with goals and approaches goals and approaches to address "Regular diet Puree Texture, honey fluid consistency". A face-to-face interview conducted with Employee #2 on August 15, 2018, at 3:15 PM. She reviewed the care plan and acknowledged the findings.	L 051	1. Resident #15 was discharged on 8/28/18-and the record cannot be amended retrospectively. 2. Medical records for current residents with diet change was completed by the Dietician to ensure a corresponding care plan concerning goals and approaches is included. 3. The IDT team will be re-educated by DON on care plan updates as they relate to resident with diet changes, all new diet orders will be reviewed by the IDT team on daily basis and Dietician will make sure the care plans are updated with the new changes. 4. Audits of care plan updates will be completed by Dietician on a daily basis to ensure compliance until three consecutive months of greater than or equal to 95% compliance has been achieved. Results of the audits will be reported to the quarterly Quality Assurance Committee meeting for review and/or further recommendations. 5. Compliance date	10/15/18

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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	1. Resident #13 has been discharged on 8/28/18 from the facility. Both resident's #13 and #27 were seen by psych services. Resident #13 was seen prior to discharge on8/28/18, Resident #13 had their pulmonary appointment completed prior or to D/C. Resident #13 was admitted without a PICC x-ray. On 8/15/18 a call was placed to obtain hospital x-ray results. X-ray results obtained the same day indicated no discrepancies between the x-ray results and the assessment findings completed by facility staff. 2. The involved nursing employee was re-educated by DON regarding the failure to follow physician's orders to change oxygen humidifier water. Current residents in-house with oxygen requiring change in humidifier water were reviewed by ADON to ensure compliance of physician's orders. Current in-house resident records have been reviewed by ADON ensuring that all appointments and consultations have been set-up as per physician order. .	8/28/18 8/15/18 8/7/18 8/15/18

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L 052	Continued From page 9 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: A.Based on observation, record review and staff interview of three (3) of 19 sampled residents, sufficient nursing time was not given to follow the physician's orders to change oxygen humidifying water, failed to ensure that Psych consults was completed, failed to ensure that pulmonary appointment was completed, and failed to assess and measure the external length of the peripherally inserted central catheter (PICC) line and arm circumference for one (1) resident receiving antibiotic therapy. (Residents' #13, #27 and #134) Finding included ... 1. Failed to follow physician orders to change oxygen humidifying water. (Resident #13) Resident #13 admitted on June 6, 2018, with a diagnosis that included Chronic Obstructive Pulmonary Disease with acute exacerbation, Acute and Chronic Respiratory failure with hypoxia and Shortness of breath. Observation on August 7, 2018, Resident #13 oxygen humidifying bottle was not dated, to indicate when the bottle was last change. A review of the physician's order showed,	L 052	Currently there are no other residents in-house who have a PICC-line. 3. Licensed staff will be in-serviced on the oxygen therapy policy and changing oxygen humidifier water by the DON. The leadership team will monitor through weekly visual inspections for staff compliance to physician orders with further re-education of staff and/or disciplinary action enforced if indicated. The DON and/or designee will complete weekly audits x4 for staff compliance for oxygen therapy to physician order, then monthly x4. Results of the audits will be reported monthly at the quarterly quality assurance committee meeting. And correction of any identified deficiencies. Licensed staff will be re-educated by DON/ADON on how to obtain consults and coordination of family/resident requests for consultation to ensure appointments are made. The appointment log binder is located at the Skilled Nursing station.	8/14/18 8/15/18

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L 052	Continued From page 10 "Change oxygen humidifying water [every] 24 hour when the water level is low and PRN." A face-to-face interview conducted on August 15, 2018, at 3:15 PM, Employee # 2 acknowledged the findings. 2. Failed to ensure two (2) residents were seen by the psychologist, in accordance with the attending physician's order. (Residents #13 and #27) A. Resident #13 admitted on June 6, 2018, with a diagnosis that included Chronic Obstructive Pulmonary Disease with acute exacerbation, Acute and Chronic Respiratory failure with hypoxia and Shortness of breath. On June 20, 2018, Physician order directed Psych consult for medication review and [evaluation] PRN (as needed). Resident #13's medical record showed that Psych consults were scheduled for July 30, 2018, at 2:15 pm and August 6, 2018, at 2:15 pm. However, the results from the consultation were not on the resident's chart. The record lacked evidence that the resident was seen by the psychologist as ordered by the attending physician. A face-to-face interview conducted on August 15, 2018, at 3:15 PM, Employee #2 acknowledged the findings.	L 052	All clinical staff were re-educated on by ADON/DON regarding PICC care protocol to include: A) daily care, assessment, measurement of the external length of the peripherally-inserted central catheter (PICC-line) and arm circumference. B) to use the PICC-line protocol form for daily shift documentation. C) Protocol forms will be audited daily by DON/ADON for compliance 4. All Audit tools for reviewing staff compliance to: following physician orders related to changing oxygen humidifier water, obtaining and arranging psych consults, obtaining and arranging outside physician appointments and correct management of a PICC line will be reviewed weekly x4 weeks ~~to~~ at the risk meeting with resulting staff re-education and/or disciplinary actions for non-compliance. Results will also be presented monthly x3 to QAPI meeting, for review and/or further recommendations as indicated. 5. Compliance Date	10/18.18 10/15/18

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L 052	Continued From page 11	L 052		

B. Resident #27 was admitted to the facility on July 20, 2018 with diagnoses that include joint pain, insomnia, anxiety disorder, major depressive disorder, Hypertension and constipation.

A review of the physician's order for August 2018 showed the resident was to receive Pristiq 100 mg one tablet in the morning for Major Depressive Disorder, Quetiapine Fumarate 50 mg one table in the evening for Major Depressive Disorder and Cymbalta 60 mg one capsule two times a day for Depression.

A physician's order dated July 23, 2018, at 4:00 PM stipulated, "Psych consult for medication review when available"

At the time of this review August 14, 2018, the psychologist has not reviewed the resident's medication.

The record lacked evidence that the resident was seen by the psychologist as ordered by the attending physician.

A face-to-face interview conducted on August 15, 2018, at 3:15 PM, Employee #2 acknowledged the findings.

3. Facility staff failed to ensure that pulmonary appointment was completed. (Resident #13)

Resident #13 admitted on June 6, 2018, with a diagnosis that included Chronic Obstructive Pulmonary Disease with Acute Exacerbation, Acute and Chronic Respiratory Failure with

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L 052	Continued From page 12 Hypoxia and Shortness of Breath. On June 13, 2018, Physician's order directed, "Please schedule Appt [pulmonary appointment]" A review of the resident medical record showed pulmonary appointment scheduled for July 30, 2018, at 2:25 pm. However, the medical record showed the appointment was not completed. A face-to-face interview conducted on August 15, 2018, at 3:15 PM, Employee # 2 acknowledged the findings. 4. Failed to assess and measure the external length of the peripherally inserted central catheter (PICC) line and arm circumference for one (1) resident receiving antibiotic therapy. (Resident #143) Resident #134 was admitted to the facility on July 27, 2018, with diagnoses which included Complete Traumatic Amputation at Knee Level, End Stage Renal Disease, and Infection of Obstetric Surgical Wound. Also, the resident was admitted to the facility with a Peripherally Inserted Central Catheter (PICC) line located in the right upper arm. Physician's order dated July 28, 2018, directs: "IV (intravenous) PICC line dressing changed Q (every) week. Document length of external catheter if indicated. Document arm circumference one time a day every Friday for care ..." Ciprofloxacin in D5W (5% dextrose in water) solution 400 mg/200/ml use 200 ml intravenously	L 052		

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	HFD02-0014	A. BUILDING: ___ B. WING ___	08/15/2018

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L 052	Continued From page 13 every 12 hours for infection until 8/28/18." Review of the clinical record lacked evidence that facility staff recorded the length of the external catheter and the residents arm circumference on admission to obtain a baseline and weekly thereafter. During a face-to-face interview on August 10, 2018, at approximately 1:00 PM, Employee #2 acknowledged the findings. B.Based on record review, and staff interview for one (1) of 19 sampled residents, the charge nurse failed to honor Resident #18's request/preference to have her brief changed and did not treat the resident with dignity and respect, and failed to answer the resident's call for help in a timely manner (Resident #18). Findings included ... The charge nurse failed to honor the residents request/preference to have her brief changed and did not treat the resident with dignity and respect. Resident # 18 was admitted to the facility on July 3, 2018 with diagnoses, which included Joint pain, chronic embolism and thrombosis, and Hypothyroidism. According to the Admission Minimum Data Set (MDS) the Resident's Brief Interview for Mental Status (BIMS) score was 15 indicating she is cognitively intact. During a face-to-face interview with Resident #18 on August 7, 2018, at 4:00 PM, she stated. "Staff do not answer the call light. There have been times when it took an hour for staff to answer the	L 052	1. Resident #18 has been discharged from the facility. 2. All current in-house residents have been interviewed by the Nursing home Administrator and/or designee to determine currently if they feel that they are being treated with respect and dignity by the direct care staff. Residents currently in-house have been interviewed by the NHA and/or designee by and no issues with call-light response time has been noted. 3. The Nursing assistant involved in this incident was terminated. The direct care staff was in-serviced by the DON on resident Rights and the Provision of Care related to dignity and respect when briefs are being changed. Staff non-compliance will result in re-education and disciplinary action as indicated. All staff will be in-service by the DON on the expected response time to answering resident call lights. The D.O.N. and unit managers will be monitoring and following up as needed with re-education and/or disciplinary action as indicated to ensure timeliness of response and compliance.	8/30/18 8/30/18 10/15/18

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L 052	Continued From page 14 light..." During a follow up interview with the Resident on August 13, 2018, at approximately 2:30 PM, she stated it was okay for the writer to discuss the concern with the facility. Review of the "Alarm Average Response Time" Report [call light record] from August 1 to 11, 2018, showed that on August 5, 2018, it took staff 16 minutes to answer the resident's call light. During a face-to-face interview with Employee # 1 on 8/15/18, at 11:30 AM, she reviewed the "Alarm Average Response Time" report and acknowledged the findings.	L 052	4. NHA and/or designee will interview residents, document and report findings on a weekly basis x4, then monthly x3 related to the observance of resident rights by direct care staff. NHA and/or designee will review call light logs weekly x4, then monthly x3 to ensure call lights are responded to within the expected time frame. The NHA and/or designee will report findings to the Quality Assurance Performance Improvement Committee for review and evaluation on a monthly basis. 5. Compliance date	10/15/18
L 056	3211.5 Nursing Facilities Beginning January 1, 2012, each facility shall provide a minimum daily average of four and one tenth (4.1) hours of direct nursing care per resident per day, of which at least six tenths (0.6) hours shall be provided by an advanced practice registered nurse or registered nurse, which shall be in addition to any coverage required by subsection 3211.4. This Statute is not met as evidenced by: Based on record review and staff interview during a review of staffing [direct care per Resident day hours], it was determined that facility failed to provide a minimum daily average of four and one-tenth (4.1) hours of direct care per Resident	L 056	1. No specific residents were identified 2. As all residents have the potential to be affected, overtime has been used to fill staffing needs, however, it has not always been successful when there are call outs at the last minute. 3. Staff time and attendance is being monitored on a weekly basis and disciplinary actions are being taken for those not following policy as identified in the facility Time and Attendance Policy. The facility is in the process of hiring Additional staff.	

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L 056	Continued From page 15 per day for one of 18 (eighteen) days reviewed in accordance with Title 22 DCMR Section 3211, Nursing Personnel and Required Staffing Levels. The findings include: According the District of Columbia Municipal Regulations for Nursing Facilities: 3211.5 Beginning January 1, 2012, each facility shall provide a minimum daily average of four and one-tenth (4.1) hours of direct nursing care per resident per day, of which at least six tenths (0.6) hours shall be provided by an advanced practice registered nurse or registered nurse, which shall be in addition to any coverage required by subsection 3211.5. A review of Nurse Staffing was conducted on August 15, 2018, at approximately 1:00 PM. Of the eighteen (18) days reviewed, Five of the days failed to provide a minimum daily average of four and one-tenth (4.1) hours of direct care per resident per day as follows: Wednesday, March 25, 2018, showed that the facility provided direct nursing care per resident at a rate of 4.0 hours. Monday, June 8, 2018, showed that the facility provided direct nursing care per resident at a rate of 3.8 hours. Sunday, July 1, 2018, showed that the facility provided direct nursing care per resident at a rate of 3.8 hours.	L 056	4. The DON will monitor daily HPPD staff time and attendance weekly and report these findings to the NHA and/or ED in relation to meeting minimum staffing requirements. The result of the monitoring with plans for improvement will be presented to the quarterly QAPI Committee meeting for review and/or further recommendations as indicated. 5. Compliance date	10/15/18

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L 056	Continued From page 16 Tuesday, July 3, 2018, showed that the facility provided direct nursing care per resident at a rate 3.9 hours. Wednesday, July 4, 2018, showed that the facility provided direct nursing care per resident at a rate of 3.9 hours. A face-to-face interview was conducted with Employee #2 at the time of the staffing review, he/she acknowledged the findings.	L 056	1. 1. The Laundry room was cleaned immediately after being identified during the survey. The ceiling tile and the wall damage has been repaired and ceiling tile has been replaced. The staff will be in-serviced on the importance of adhering to infection prevention control program and policy. To include system for prevention, identifying, reporting, investigating and controlling infection and communicable diseases for all Residents, staff, volunteers, visitors and other individual providing services under a contractual agreement. 2. Environmental rounds, preventive maintenance service checks will be conducted weekly to ensure timely identification of any issues.	8/23/18 8/23/18
L 091	3217.6 Nursing Facilities The Infection Control Committee shall ensure that infection control policies and procedures are implemented and shall ensure that environmental services, including housekeeping, pest control, laundry, and linen supply are in accordance with the requirements of this chapter. This Statute is not met as evidenced by: Based on observations, and staff interview, the facility staff failed to ensure that resident laundry was processed in an environment free from dust. The facility census was 24. Findings include ... During tour on August 10, 2018, at approximately 12:50 PM, linen was observed uncovered on the folding table to include pads and sheets. Ceiling tiles were missing and wall damage was noted in the laundry room. During a face to face interview on August 10, 2018, 4:51 PM, Employee #3 stated that the	L 091	3. Plant operations will be notified when deficiencies are found and corrective actions will be taken. All housekeeping services staff had been reeducated by Housekeeping Director for the need to have all linens covered in accordance with infection control standard practice. The laundry room will be inspected daily by Housekeeping Director to ensure cleanliness and all linens are covered as required 4. The Director of Housekeeping will make rounds daily on all resident laundry and laundry rooms to ensure that a sanitary, orderly and all linens are covered at all times. Documentation will be completed and results monitored during weekly scheduled surveillance rounds. Results of the audits will be reports to the Administrator monthly and at the quarterly QAPI Committee Meeting for review and/or further recommendations.	10/15/18

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L 091	Continued From page 17 laundry room missing ceiling tiles and wall damage was due to the three- compartment sink flood in April of 2018. Employee #3 stated the laundry room has been this way since the incident in April 2018. When queried about clean-up process following the flood, Employee #3 stated that it was clean up by an outside company. During a face to face interview on August 14, 2018, Employee #1 and 2 stated that they we were not involved in the incident with the laundry. In addition, water damage to the walls and ceiling tiles in the laundry was not included as a part of the infection control process. The failure to ensure ceiling tile were in place and wall damage was repaired exposed the uncovered linen to potential dust contamination. Employee #1 acknowledged the findings.	L 091	1. All cooked foods that was stored beyond the expiration date in the walk-in refrigerator or the reach in refrigerator was discarded immediately after being identified during the survey. Cooked and or ready to eat foods that were not labeled or dated in the walk in refrigerator were all discarded immediately after being identified during the survey. A scoop that was improperly stored inside a floor bin was removed immediately after being identified during the survey. One solid can opener was removed immediately after being identified during the survey. Three missing knobs from the steamer table on the second floor has been replaced. The broken garbage disposals has been replaced with new ones. Missing slats from the walk-in freezer air curtain has been replaced. Raw foods that were inappropriately thawed in the walk-in refrigerator has been thrown away immediately after being identified during the survey. The improper food monitoring of food temperature on the steam table has been corrected. A new dietary manager has been hired who is in charge and present at the food establishment during all hours of operation.	
L 099	3219.1 Nursing Facilities Food and drink shall be clean, wholesome, free from spoilage, safe for human consumption, and served in accordance with the requirements set forth in Title 23, Subtitle B, D. C. Municipal Regulations (DCMR), Chapter 24 through 40. This Statute is not met as evidenced by: Based on observations and staff interview, the facility failed to prepare, distribute and serve foods under sanitary conditions as evidenced by cooked foods that were stored beyond their expiration date in the walk-in refrigerator or the reach-in refrigerator, cooked and/or ready-to-eat foods that were not labeled or dated in the walk-in refrigerator, a scoop that was improperly stored inside a flour bin, one (1) of one (1) soiled can opener, three (3) of three (3) missing knobs from	L 099	2. A review was conducted by plant operations director and Dining room manager no other component of the steamer was impacted by this practice. A review of the resident meal and holding temperatures and other all other identified issues was conducted by Dining room manager and no other issues were identified or impacted by this practice	8/23/18

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L 099	Continued From page 18 the steam table on the second floor, two (2) of three (3) broken garbage disposals, missing slats from the walk-in freezer air curtain, raw foods that were inappropriately thawed in the walk-in refrigerator and improper monitoring of food temperature on the steam table. The facility also failed to ensure that a PERSON IN CHARGE is present at the food establishment during all hours of operation. Findings included ... 1. During observations and record review on August 7, 2018, at approximately 9:30 AM various cooked food items were stored beyond their 'used by' date: A quarter pan of collard greens as of August 6, 2018 A pan of meatballs as of August 1, 2018 A pan of tuna salad as of August 2, 2018 A pan of egg salad as of July 30, 2018. 2. Food items were not labeled or dated in the walk-in refrigerator: A pan of cooked sweet peppers A pan of turkey bacon An open pack of chicken breast Ham covered in plastic wrap A pan of slice sausage. 3. A scoop was stored on top of the flour in one (1) of one (1) flour bin. 4. Metal shavings were observed on one (1) of one (1) commercial manual can opener. 5. Three (3) of three (3) knobs from the three-pan open well steam table were missing.	L 099	A new Director of dining services is actively reviewing, developing and implementing dining training to address, expiration dates, how and when to discard items, place a work order and maintain safety and sanitary condition of the kitchen. 3.A meeting with the ED, NHA and kitchen leadership was conducted to discuss identified issues. The dietary staff were re-educated dining room manager on appropriate and required holding temperatures. The dietary staff and nursing staff were reeducated by dining room manager and DON regarding meal service and tray delivery. Dietary staff will be in-serviced and trained by Dining room manger on proper storage, dating and labeling of food items. This training will also address expiration dates, how and when to discard these items, and on how to place a work order. 4. A review of meal services will be conducted monthly.	8/23/18 8/30/18 8/30/18 10/15/18

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L 099	Continued From page 19 6. Two (2) of three (3) garbage disposals in the main kitchen were not functioning. 7. Two (2) slats were missing from the air curtain in the walk-in refrigerator. 8. Raw food such as chicken was stored for thawing on the second shelf of the walk-in refrigerator above a container of carrot salad and a container of three-bean salad. 9. Staff failed to monitor the holding temperature for one (1) food item on the steam table on August 9, 2018 at approximately 12:30 PM. During a face-to-face interview on August 7, 2018, at approximately 10:30 AM and on August 9, 2018, at approximately 10:30 AM, Employee #8 and/or Employee #9 acknowledged the findings. Facility failed to adhere to the U.S. Food and Drug Administration (FDA) 2013 Food Code Chapter 2, Subpart 2-101. Food Code 2013 Recommendations of the United States Public Health Service Food and Drug Administration 2-101.11 Assignment. (A) Except as specified in (B) of this section, the PERMIT HOLDER shall be the PERSON IN CHARGE or shall designate a PERSON IN CHARGE and shall ensure that a PERSON IN CHARGE is present at the FOOD ESTABLISHMENT during all hours of operation.	L 099	The leadership team is conducting weekly documented visual inspections to ensure safety and sanitation. The kitchen manager/designee will review that the temperature holding forms are completed daily and will notify Dining room Director if consistent unacceptable temperatures are recorded.	

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L 099	Continued From page 20 (B) In a FOOD ESTABLISHMENT with two or more separately PERMITTED departments that are the legal responsibility of the same PERMIT HOLDER and that are located on the same PREMISES, the PERMIT HOLDER may, during specific time periods when food is not being prepared, packaged, or served, designate a single PERSON IN CHARGE who is present on the PREMISES during all hours of operation, and who is responsible for each separately PERMITTED FOOD ESTABLISHMENT on the PREMISES. "Person in charge" means the individual present at a FOOD ESTABLISHMENT who is responsible for the operation at the time of inspection. During observations on August 7, 2018, at approximately 10:00 AM, a PERSON IN CHARGE was not present at the facility. During a face-to-face interview on August 7, 2018, at approximately 10:30 AM, Employee #8 acknowledged the findings.	L 099		
L 212	3233.5 Nursing Facilities Each facility shall use its best efforts to resolve each grievance as soon as practicable, and shall report to the resident and the Resident's Representative on the status of the resolution of the grievance at least thirty (30) days. This Statute is not met as evidenced by: Based on record review and staff interviews, facility staff failed to act promptly upon the June 27, 2018, grievances of the Resident Council concerning issues related to resident care and life in the facility. The resident census was 24 on the	L 212	1. No resident was harmed by this deficient practice. 2. Grievances including resident council grievances brought up during the month of June, and July, August have been addressed and presented at the Resident Council meeting.	9/28/28

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L 212	Continued From page 21 first day of the survey. Findings included ... Grievance Policy Last revised 12/22/17 "Policy: The community will provide and adhere to a procedure for receiving, responding to, and resolving grievances of residents or their representatives. Procedure: 3. Upon receipt of a grievance, the Executive Director, Administrator, or a designee will schedule a formal meeting to discuss the problem and attempt to reach a solution satisfactory to all. 4. A written summary of the grievance and remediation/correction plan will be documented in the community's grievance log within 30 days of receiving the formal grievance form ..." Review of the resident council meeting minutes for June 27, 2018 conveyed resident concerns surrounding areas such as the laundry not returning their clothing, having to wait for long periods of time for toilet tissue, soap and etc..; trash not being taken out every day the room not being properly cleaned and missing laundry. Food and beverage- meat is tough, not enough snacks for people who are diabetics, food is not seasoned well, vegetables were hard to eat, what is on the menu is never available, needing hydration station on the neighborhood, being offered bread and more leafy vegetables during meals. Nursing: waiting long periods of time for assistance at night, feeling ignored by the staff when they request items or help, need staff diversity training, staff being impatient and not knowing what to do ..." A review of the July 31, 2018, and August 9,	L 212	3. Activities manager or designee 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. NHA or designee will in-service all department managers as to the new process. 4. Social worker or designee will audit and document findings related to timely and appropriate resolution of reported grievances weekly x4, then monthly x3. This will be reported to the QAPI Committee monthly for review, evaluation, and further recommendations as indicated. 5. Compliance date	1010/18 10/15/18

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L 212	Continued From page 22 2018, Resident Council Meeting minutes showed the residents continued the same concerns. Review of the facilities grievance log showed that resident concerns from the June 27, 2018 meeting were not addressed by the grievance official or department directors within 30 days. During a face-to-face interview on 8/9/18 at 5:55 PM with Employees #1 and #2, it was stated that the Resident Council Meeting minute concerns go to the all managers and the managers are expected to respond to the concerns. Employee #1 further acknowledged the grievances from the resident council were not act upon promptly.	L 212		
L 214	3234.1 Nursing Facilities Each facility shall be designed, constructed, located, equipped, and maintained to provide a functional, healthful, safe, comfortable, and supportive environment for each resident, employee and the visiting public. This Statute 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 remote bed controller cord that was frayed in one (1) of 17 resident's rooms. Findings included ... During observations throughout the facility on August 10, 2018, wires from a remote bed controller electrical cord were frayed and exposed in resident room #213, one (1) of 17 resident's rooms surveyed. The uncovered, exposed electrical wires created	L 214	1. The resident in room# 213 was not harmed. Remote bed controller cord that was frayed was repaired by plant operations director. 2. All remote bed controller cords in all residents' rooms were checked and corrected as needed by plant operations director. 3. Building services and clinical staff were re-educated by plant operations director on safety issues and requirements of functional remote bed controllers. Staff were also educated on the repair request process by plant operations director to ensure timely repairs are completed.	

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L 214	Continued From page 23 a potential electrical shock hazard to residents, staff and the public. During a face-to-face interview on August 10, 2018, Employee #3 acknowledged these findings at the time of observation.	L 214	4. Remote bed controller cords will be added as an indicator for the building services department to be monitored during weekly scheduled surveillance rounds. Results of the audits will be reported to the administrator monthly and at the quarterly Quality Assurance Committee meeting for review and recommendations if indicated. 5. Compliance date	10/15/18
L 410	3256.1 Nursing Facilities Each facility shall provide housekeeping and maintenance services necessary to maintain the exterior and the interior of the facility in a safe, sanitary, orderly, comfortable and attractive manner. This Statute is not met as evidenced by: Based on observations and interview, the facility failed to provide housekeeping services necessary to maintain a safe, clean, comfortable environment as evidenced a broken entrance door in one (1) of 17 resident's rooms, a warped carpet in one (1) of 17 resident's rooms, and a damaged wall in one (1) of 17 resident's rooms . Findings included ... During an environmental tour of the facility on August 10, 2018, between 9:30 AM and 11:00 AM, the following were observed: 1. The entrance door to resident room #202 was hanging off its hinges, one (1) of 17 resident room surveyed. 2. The carpet in resident room #214 was buckled and frayed and there was a hole in the wall, one (1) of 17 resident's rooms. 3. There was a hole in the wall located at the	L 410	1 No resident was harmed by this deficient practice. Room #202, the broken closet door noted at the time of the survey was repaired. Room #214 the warped carpet in the resident's room at the time of the survey was replaced. A damaged wall in room #214 noted at the time of the survey was repaired. 2 All closet doors, carpet and walls were inspected by Plant operations Director and corrections were made as required. 3 In-service was done with the maintenance staff by Plant operations Director regarding the process for inspection and replacement of closet doors, carpet and wall integrity on a routine basis to ensure their	8/13/18 8/15/18

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 ______	08/15/2018

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

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L 410	Continued From page 24 entrance of resident room #214, one (1) of 17 resident rooms. During a face-to-face interview on August 10, 2018, Employee #3 acknowledged these findings at the time of observation.	L 410	proper repair. The results of these inspections will be forwarded to the Director of Maintenance for task completion by maintenance staff. 4. The Director of Maintenance will audit his repair logs for task completion weekly x4 and then monthly x3. The Director of Maintenance will present his findings of these routine inspections to the NHA at a minimum weekly for further assistance as indicated. Results of these audits will be present to the QAPI Committee monthly for review and/or further recommendations as indicated. 5. Compliance date	10/15/18