STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0001	A. BUILDING: _____ B. WING _____	03/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INSPIRE REHABILITATION AND HEALTH	2131 O STREET NW WASHINGTON, DC 20037

(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 The Annual Licensure Survey was conducted at Inspire Rehabilitation and Health Center from February 27, 2019 through March 5, 2019. Survey activities consisted of a review of 55 sampled residents. The following deficiencies are based on observation, record review and resident and staff interviews. The resident census during the survey was 165. 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 AV- Arteriovenous BID - Twice- a-day B/P - Blood Pressure cm - Centimeters CFR- Code of Federal Regulations CMS - Centers for Medicare and Medicaid Services CNA- Certified Nurse Aide CRF - Community Residential Facility CRNP- Certified Registered Nurse Practitioner D.C. - District of Columbia DCMR- District of Columbia Municipal Regulations D/C- Discontinue Dl- Deciliter DMH - Department of Mental Health DOH- Department of Health	L 000	**INSPIRE REHABILITATION AND HEALTH CENTER DISCLAIMER.** **Facility submits this plan of correction under procedures established by the Department of Health in order to comply with the Department's directive to change conditions which the Department alleges are deficient under state Regulations relating to long term care. This should not be construed as either a waiver of the facility's right to appeal and to challenge the accuracy or severity of the alleged deficiencies or any admission of any wrong doing.**	5-10-19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: DONA JAKANSE — TITLE: NHA — (X8) DATE: 05/03/2019.

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L 000	Continued From page 1	L 000		

EKG - 12 lead Electrocardiogram
EMS - Emergency Medical Services (911)
F - Fahrenheit
G-tube- Gastrostomy tube
HR- Hour
HSC - Health Service Center
HVAC - Heating ventilation/Air conditioning
ID - Intellectual disability
IDT - Interdisciplinary team
IPCP- Infection Prevention and Control Program
LPN- Licensed Practical Nurse
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
NFPA - National Fire Protection Association
NP - Nurse Practitioner
O2- Oxygen
PASRR - Preadmission screen and Resident Review
Peg tube - Percutaneous Endoscopic Gastrostomy
PO- by mouth
POA - Power of Attorney
POS - physician ' s order sheet
Prn - As needed
Pt - Patient
Q- Every
QIS - Quality Indicator Survey
RD- Registered Dietitian
RN- Registered Nurse

Health Regulation & Licensing Administration

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L 000	Continued From page 2 ROM Range of Motion RP R/P - Responsible party SCC Special Care Center Sol- Solution TAR - Treatment Administration Record Ug - Microgram	L 000		
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; (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 medical record review and staff interview for one (1) of 55 sampled residents (closed record), the charge nurse failed to develop a baseline care plan for Resident# 155	L 051	**Corrective action for the residents affected:** 1. The facility cannot retroactively correct the deficiency. Resident #155 no longer reside In the facility. **Identification of others with the Potential to be affected:** 1. All residents residing in the facility have the potential to be affected. 2. Assistant Director of Nursing/Designee will complete house wide audit of residents to identify potential residents facility staff failed to develop a baseline care plan within 48 hours of the resident's admission to the facility. 3. Any issue found will be addressed. **Measures to prevent Reccurrence:** 1. Staff Development will provide education to the facility staff to develop baseline care plan within 48hours of the resident's admission to the facility.	5-10-19

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L 051	Continued From page 3 within 48 hours of resident's admission to the facility. Findings included.... Review of the medical record on 3/4/19 at 11:00 AM showed Resident# 155 was admitted to the facility on 12/4/18 and was discharged from the facility on 12/24/18. Review of Resident #155's Face Sheet showed that the Resident (self) was listed as the Responsible Party. Review of the medical record showed an Admission Minimum Data Set [MDS] dated 12/11/18; Section C -Cognitive Patterns: Brief Interview for Mental Status [BIMS] resident was scored as "15" which indicates resident is "cognitively intact." Section I- [Active Diagnoses] include: Atrial Flutter, Heart Failure, Hypertension, Arthritis and Asthma. Further review of the medical record failed to show evidence the facility staff developed a resident-centered baseline care plan with goals and approaches to address the care of the resident within 48 hours of admission. During an interview on 3/4/19 at 11:30 AM, Employee# 16 stated yes, I did an audit of the chart and I know the baseline care plan was not done. There was no evidence that facility staff developed a baseline care plan within 48 hours of the resident's admission to the facility. During a face-to-face interview on 3/4/19 at 11:30 AM Employee# 16 acknowledged the findings.	L 051	**Monitoring corrective action:** 1. Assistant Director of Nursing/Designee will complete house wide /audit of residents to identify potential residents facility staff failed to develop baseline care plan within 48 hours of the resident's admission to the facility weekly times 4, then monthly times 3 months. 2. Findings will be reported to the Quality Assurance Performance Improvement Committee monthly for the next 3 months. **Corrective action for the residents affected:** 1. The affected Resient#134 was reassessed on 3-4-19, resident suffered no negative outcome. 2. The affected Resident #156 no longer Reside in the facility. **Identification of others with the Potential to be affected:** 1. All residents residing in the facility have the potential to be affected. 2. Assistant Director of Nursing/Designee will complete house wide audit of residents residents facility staff failed to: a. To ensure a resident-centered care plan with specific goals and approaches are developed for residents with Dementia. b. Ensure a focus discharge care plan with goals and approaches addressing residents wishes to live in the community after therapy is completed.	5-10-19

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L 051	Continued From page 4 Based on record review and staff interviews for two (2) of 55 sampled residents, the charge nurse failed to develop a Dementia care plan for one (1) resident and failed to develop a focus discharge care plan with goals and approaches for (1) one resident who wishes to live in the community after her therapy is completed. Findings included ... 1. Resident# 134 was admitted to the facility on 2/5/19 with diagnoses which includes: Essential (Primary) Hypertension, Pain Unspecified, Generalized Anxiety Disorder, Major Depressive Disorder, Dementia without Behavioral Disturbance. Review of the medical record showed an Admission Minimum Data Set [MDS] dated 2/12/19; Section C-Cognitive Patterns: C0100. Cognitive Skills for Daily Decision Making (made decisions regarding tasks of daily life) "3" is selected to indicate cognition is severely impaired-never/rarely made decisions. Review of a physician telephone order dated 2/6/19 showed "psychiatric consult of medication management, diagnosis: "Dementia." On 3/4/19 a review of the Behavioral Services Management Assessment sheet dated 2/11/19 showed assessment "73 year old African	L 051	**Measures to prevent Reccurrence:** 1. Staff development will provide education to the facility staff to: a. Develop a resident-centered care plan with specific goals and approaches for residents with Dementia. b. Develop a focus discharge care plan with goals and approaches to address resident wishes to live in the community after therapy is completed. **Monitoring corrective action:** 1. Assistant Director of Nursing/Designee will complete house wide audit of residents to identify: a. Resident-centered care plan with specific goals and approaches for residents with Dementia. b. Focus discharge care plan with goals and approaches to address resident wishes to live in the community after therapy is completed. 2. Audits/reports will be reviewed weekly times 4, then monthly times 3months and reported to the Quality Assurance Performance Improvement Committee monthly for the next 3 months.	

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L 051	Continued From page 5 American Male with a history of Anxiety and Dementia is being evaluated for medication management." Behavioral Services Management Assessment sheet dated 2/25/19 showed "resident was started on Aricept for Dementia." Review of the resident care plans showed no evidence facility staff developed a care plan with specific goals and approaches to address the resident's diagnosis of Dementia. During an interview on 3/4/19 at 11:30 AM Employee# 16 stated "I know I should have a care plan for the resident's Dementia I must have missed it." Facility staff failed to develop a resident-centered care plan with specific goals and approaches for a resident with Dementia. During a face-to-face interview on 3/4/19 at 11:30 AM Employee # 16 acknowledged the findings. 2. A review of the closed record for Resident #156 revealed that she was admitted to the facility on November 29, 2018, and discharged on January 8, 2019. The Resident had diagnoses which included Type 2 Diabetes Mellitus with Ketoacidosis without Coma, Hypotension, Cirrhosis of Liver, Gastro-Esophageal Reflux Disease, Acute Kidney Failure, Cognitive Communication Deficit and Pneumonitis due to Inhalation of other solids and liquids. The progress note dated December 6, 2018, at 17:50 showed, the following note "IDT	L 051	**Corrective action for the residents affected:** 1. The facility cannot retroactively correct the deficiency. 2. The affected resident #135 was reassessed on 3-5-19. Resident suffered no negative outcome. **Identification of others with the Potential to be affected:** 1. All residents residing in the facility have the potential to be affected. 2. Assistant Director of Nursing/Designee will complete house wide audit of residents to identify potential residents facility staff failed to revise/update the care plan after change in residents pain medication. 3. Any issue found will be addressed. **Measures to prevent Reccurrence:** 1. Staff Development will provide education to the facility staff to revise/update the care plan after change in resident's pain medication. **Monitoring corrective action:** 1. Assistant Director of Nursing/Designee will complete house wide audit of residents to identify potential residents facility staff failed to revise/update the care plan after change in resident's pain medication weekly times 4, then monthly times 3 months. 2. Findings will be reported to the Quality Assurance Performance Improvement Committee monthly for the next 3 months.	5-10-19

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L 051	Continued From page 6 (Interdisciplinary Team) Care plan conference held 12/3/18 with resident present in her room and all team members ...adjust to unit at this time she is able to make her needs known and self RP (Responsible Party) ...Resident still has plan to return to community at the end of therapy." A review of Resident #156's care plan on March 5, 2019, lacked evidence that facility staff developed a focus discharge care plan with goals and approaches to address Resident #156 wishes to live in the community after her therapy is completed. During a face-to-face interview on March 5, 2019, at 3:00 PM, Employee #13 acknowledged the findings. Based on record review and staff interview for one (1) of 55 sampled residents the charge nurse failed to revise/update care plan after a change in pain medications for Resident #135. Findings included... Resident # 135 was admitted to the facility on 2/5/2019, with a diagnoses to include; Malignant Neoplasm of Prostate Ulcerative Colitis, Crohn's Disease, Depression, Asthma, Laceration Scalp, and Blindness. A Review of Resident #135's Admission Nursing Home Comprehensive Minimum Data Set [MDS]	L 051	**Corrective action for the residents affected:** 1. Resident #156 no longer reside in the facility **Identification of others with the Potential to be affected:** 1. All residents residing in the facility have the potential to be affected. 2. Facility MDS Director/Designee will complete house wide audit of residents to identify potential residents facility staff failed to accurately code section Q on admission Minimum Data Set (MDS). 3. Any issue found will be addressed. **Measures to prevent Reccurrence:** 1. Staff Development will provide education to the facility MDS staff to accurately code section Q on admission Minimum Data Set (MDS) for residents discharge disposition. **Monitoring corrective action:** 1. Facility MDS Director/Designee will complete house wide audit of section Q of residents admission Minimum Data Set (MDS) weekly times 4, then monthly times 3 months. 2. Findings will be reported to the Quality Assurance Performance Improvement Committee monthly for the next 3 months.	5-10-19

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L 051	Continued From page 7 dated 2/12/19, showed: Section C- Cognitive Brief Interview for Mental Status score was "15" indicating Resident #135 is cognitively intact. Section J0100 (Pain Management) showed the resident received pain medications both scheduled, PRN and indicated he was in pain at the time of the assessment. Physician's Orders directed the following: "2/20/2019- Tramadol 50 mg 1 tablet po, every 6 hours PRN ... mild abdominal pain." "3/4/2019 -Morphine Sulfate (Concentrate) Oral solution 20mg/ml 0.025 ml po, every 4 hours PRN for dyspnea ...mild pain ... " There was no evidence that the care plan was updated to include the use of opioids for treating the resident's pain. During a face-to-face interview with Employee #16 on March 5, 2019, at approximately 10:00 AM, she acknowledged the finiding. Based on record review and staff interview for one (1) of 55 sampled residents, the charge nurse failed to accurately code the Admission Minimum Data Set (MDS) under Section Q Discharge for Resident # 156. Findings included ... A review of the medical record for Resident #156 revealed that she was admitted to the facility on November 29, 2018, and discharged to from the	L 051		

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L 051	Continued From page 8 facility to home on January 8, 2019. The Resident had diagnoses which includes: Type 2 Diabetes Mellitus with Ketoacidosis without Coma, Hypotension, Cirrhosis of Liver, Gastro-Esophageal Reflux Disease, Acute Kidney Failure, Cognitive Communication Deficit and Pneumonitis due to Inhalation of other solids and liquids. The progress note dated December 6, 2018, at 17:50 showed, "IDT (Interdisciplinary Team) Care plan conference held 12/3/18, with resident present in her room and all team members ...adjust to unit at this time she is able to make her needs known and self RP (Responsible Party) ...Resident still has plan to return to community at the end of therapy." A review of Resident # 156's Admission MDS with an Assessment Reference Date of December 6, 2018, revealed that under Section Q0300 (Resident's Overall Expectation) was coded as unknown or uncertain related to discharge to the community expectations. Q0400 (Discharge Plan) was coded as "No" indicating there is no active discharge planning already occurring for the resident to return to the community. Q0500 (Return to the Community) was coded as "No" indicating the resident did not want to talk to someone about the possibility of leaving the facility and returning to live and receive services in the community. There was no evidence that facility staff coded the Admission MDS to reflect Resident # 156's wishes to be discharge to the community; and to talk to facility staff regarding her returning to live in the community.	L 051		

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L 051	Continued From page 9 During a face-to-face interview conducted on March 5, 2019, at approximately 3:00 PM with Employee #13 he stated it should have been coded for the discharge and acknowledged the findings.	L 051		
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	L 052	**Corrective action for the residents affected:** 1. The affected resident 3135 was reassessed On 3-5-19. Resident suffered no negative Outcome. **Identification of others with the Potential to be affected:** 1. All residents residing in the facility have the potential to be affected. 2. Assistant Director of Nursing/Designee will complete house wide audit of residents to identify potential residents facility staff failed to assess their pain level prior to administering medication for pain and to reassess the resident to determine the effectiveness after administering the medication. 3. Any issue found will be addressed. **Measures to prevent Reccurrence:** 1. Staff Development will provide education to to the facility staff to assess the resident prior to administering medication for pain and to reassess the resident to determine the effectiveness after administering the medication.	5-10-19

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L 052	Continued From page 10 (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 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 record review and staff interview for one (1) of 55 sampled residents, the charge nurse failed to assess Resident #135's pain level prior to administering the residents narcotic medication and failed to reassess the resident to determine the effectiveness after administering the medication. Findings included... Facility policy Titled: Policy on Pain Management..."Pain Management section", "Monitor the effectiveness of pain medication through reassessment ...Document nursing assessment, nursing intervention, behavior of resident during pain assessment; and resident response to interventions. Revised 5/30/2018" Resident # 135 was admitted to the facility on 2/5/2019, with a diagnoses to include; Malignant	L 052	**Monitoring corrective action:** 1. Assistant Director of Nursing/Designee will complete house wide audit of residents to identify potential residents facility staff failed to assess their pain level prior to administering medication for pain and to reassess to determine the effectiveness after administering the medication weekly times 4, then monthly times 3 months. 2. Findings will be reported to the Quality assurance Performance Improvement committee monthly for the next 3 months.	

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L 052	Continued From page 11 Neoplasm of Prostate Ulcerative Colitis, Crohn's Disease, Depression, Asthma, Laceration Scalp, and Blindness. A review of Resident #135's Admission Nursing Home Comprehensive Minimum Data Set [MDS] dated 2/12/19, showed: Section C- Cognitive Brief Interview for Mental Status score was "15" indicating Resident #135 is cognitively intact. Section J0100 (Pain Management) showed the resident received pain medications both scheduled, PRN and indicated he was in pain at the time of the assessment. A review of the Physician's Progress notes showed; GI Consult "February 20, 2019 (GI)- Imp [impression] pain secondary to abdominal wall hernia. Only cure would be surgery which does not seem to be an option considering limited intervention. Therefore will add tramadol prn for pain to make patient more comfortable." Physician's orders directed the following: 2/20/2019- Tramadol (a narcotic pain medication) 50 mg 1 tablet po, every 6 hours PRN for pain- mild, moderate and severe abdominal pain. 3/4/2019 -Morphine Sulfate (Concentrate) Oral solution (a narcotic pain medication) 20mg/ml 0.025 ml po, every 4 hours PRN for dyspnea (Difficult or labored breathing; shortness of breath), for pain- mild, moderate and severe A review of the Medication Administration Record	L 052		

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L 052	Continued From page 12 (MAR) revealed: February 23, 2019- Tramadol 50 mg was given to the resident however, there was no pain assessment or reassessment done. February 25, 2019- Tramadol 50 mg was given to the resident however, there was no pain assessment or reassessment done. February 27, 2019- Tramadol 50 mg was given to the resident however, there was no pain assessment or reassessment done. March 4, 2019- Tramadol 50 mg was given to the resident however, there was no pain assessment or reassessment done. March 5, 2019- Morphine Sulfate 0.25 mg was given to the resident however, there was no pain or dyspnea assessment or reassessment done. There was no evidence the facility staff consistently assessed and or reassessed the resident prior to/or after administering medication for pain to determine the residents pain level and if the narcotic given was effective. During a face-to-face interview, Employee #16 acknowledged the findings on March 5, 2019, at approximately 9:00 AM	L 052		
L 086	3217.1 Nursing Facilities	L 086		

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	HFD02-0001	A. BUILDING: _____ B. WING _____	03/05/2019

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L 086	Continued From page 13 The facility shall have an Infection Control Committee composed of the Administrator or designee and members of the medical, nursing, dietary, pharmacy, housekeeping, maintenance, and other services. This Statute is not met as evidenced by: Based on observation and staff interviews, it was determined that the charge nurse failed to maintain proper hand hygiene practices during the administration of medication for four (4) residents and testing the blood glucose level for one resident. Residents' #20, #79, #104 and #146 . Findings included... According to the Centers for Disease Control and Prevention (CDC) Guideline for Hand Hygiene in Healthcare Settings [PDF - 1.3 MB] recommends: "When cleaning your hands with soap and water, wet your hands first with water, apply the amount of product recommended by the manufacturer to your hands, and rub your hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers. Rinse your hands with water and use disposable towels to dry. Use towel to turn off the faucet. Avoid using hot water, to prevent drying of skin. Other entities have recommended that cleaning your hands with soap and water should take around 20 seconds. Either time is acceptable. The focus should be on cleaning your hands at the right times." Retrieved from: https://www.cdc.gov/handhygiene/providers/index	L 086	**Corrective action for the residents affected:** 1. Resident #20, #79, #104, and #146 were assessed and none of them suffered any negative outcome. 2. Employees #5, #11, #10 have been re-educated on proper hand washing techniques with soap and water before and after care including medication administration for the purpose of decreasing spread of infection. **Identification of others with the Potential to be affected:** 1. All nursing employees have the potential to be affected by this deficient practice. 2. Assistant Director of Nursing/Designee conducted random medication pass observation no deficient findings noted. 3. Staff Development will provide education to all nursing staff on the importance of proper hand hygiene before and after care including medication administration for the purpose of decreasing spread of infection. **Measures to prevent Reccurrence:** 1. Unit managers will conduct medication pass observation of the nursing staff to ensure appropriate and hygiene is demonstrated during resident encounters. 2. Results of audits will be forwarded to the Infection Control preventionist weekly times 4 then, monthly times 3.	5-10-19

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L 086	Continued From page 14 .html 1. Employee #5 failed to decrease the potential spread of infection by failing to wash and/or sanitize her hands prior to, during and after testing the resident's blood glucose and administering her Insulin. During a medication administration observation at approximately 10:30 AM on February 28, 2019, Employee #5 entered Resident #20's room and informed the resident that she was going to check her blood sugar level and administer her Insulin. The employee removed a pair of gloves from the resident's room and put them on her hands. The employee then sanitized the employee's fingertips, stuck the left middle finger and tested the blood glucose level after which the employee removed the gloves and discarded them along with the equipment. Employee #5 donned a new pair of gloves, sanitized the top of the Insulin bottle and drew up the Insulin. The employee then sanitized Resident #20's abdomen and administered the Insulin. The employee removed the gloves, discarded the gloves and other equipment and left the room. Employee #5 Failed to wash and/or sanitize her hands after she entered the resident's room and prior to touching the resident, prior to donning and/or removing gloves, prior to and after administering the blood test and/or the Insulin. A face-to-face interview was conducted with Employee #5 immediately after she completed the administration of the Insulin. In response to the question why she did not wash her hands prior to, during and after the procedures she	L 086	**Monitoring corrective action:** 1. Infection Control Preventionist will present results of audits to Quality Assurance Performance Improvement Committee monthly times 3 until sustained compliance is achieved.	

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L 086	Continued From page 15 stated that she does not like to use the resident's sink because the resident has her personal items (tooth brush, tooth paste, mouth wash etcetera) at the sink. The employee added that she meant to put some hand sanitizer in her pocket but she forgot. Employee #14 (Manager) acknowledged that Employee #5 failed to wash and/or sanitize her hands prior to, during and after testing the resident's blood glucose and administering her Insulin during a face-to-face interview at 2:00 PM on February 28, 2019. 2. Employee #11 failed to decrease the potential spread of infection by failing to use soap when washing her hands before administering medications to Resident #79. During a medication administration observation on March 5, 2019, at approximately 1:00 PM, Employee #11 prepared medications at her medication cart outside of Resident # 79's room. After entering the room, Employee #11 introduced herself to Resident #79, explained that she was there to administer medications and placed the tray of medicine on the over-the-bed table. Employee #11 then walked to the sink (inside the resident's room), turned on the faucet, placed her hands under the water for approximately 15 seconds, turned off the faucet using paper towels, returned to the resident's bedside and administered medications. After administering the medications to the resident. Employee #11 returned to the sink, turned on the faucet, placed her hands under the water for approximately 15 seconds, turned the faucet off using paper towels and exited the resident's room.	L 086		

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L 086	Continued From page 16 There was no evidence that Employee #11 used soap with the water when washing her hands. Employee #11 failed to maintained proper hand hygiene practices during the administration of medication to Resident #79. During a face-to-face interview with the Employee #11, RN, on March 5, 2019, at approximately 1:10 PM, she acknowledged the findings. 3. Employee #11 failed to decrease the potential spread of infection by failing to wash or sanitize her hands before administering medications to Resident #104. During a medication administration observation on March 5, 2019, at approximately 1:30 PM, Employee #11 prepared medications at her medication cart outside of Resident # 104's room. After entering the room, Employee # 11 introduced herself to Resident #104, explained that she was there to administer medications. The Employee then administered the medications to the resident, and then exited the resident's room without washing her hands. There was no evidence that Employee #11 washed her hands using soap and water or used hand sanitizer prior to and after administering medications to the resident. Employee #11 failed to maintained proper hand hygiene practices during the administration of medication to Resident # 104. During a face-to-face interview with the Employee #11, RN, on March 5, 2019, at approximately 1:40 PM, she acknowledged the findings.	L 086		

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L 086	Continued From page 17 4. Employee #10 failed to decrease the potential spread of infection by failing to use soap when washing her hands before and after administering medications to Resident #146. During a medication administration observation on March 5, 2019, at approximately 8:50 AM, Employee #10 prepared medications at her medication cart outside of Resident #146's room. After entering the room, Employee # 10 explained to Resident #146 that she was there to administer medications and placed the tray of medicine on the over-the-bed table. Employee # 10 then walked into the bathroom (inside of the resident's room), turned on the faucet at the sink, ran her hands under the water for approximately 15 seconds, turned off the faucet using paper towels, returned to the resident's bedside and administered medications to Resident #146. After administering the medications to the resident. Employee #10 returned to the bathroom, turned on the faucet at the sink, placed her hands under the water for approximately 15 seconds, turned the faucet off using paper towels and exited the resident's room. There was no evidence that Employee #10 used soap with the water when washing her hands. Employee #10 failed to maintained proper hand hygiene practices during the administration of medication to Resident # 146. During a face-to-face interview with the Employee #10, LPN Preceptor, on March 5, 2019, at approximately 9:00 AM, she acknowledged the findings.	L 086		

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L 190	Continued From page 18	L 190	**Corrective action for the residents affected:**	5-10-19
L 190	3231.1 Nursing Facilities The facility Administrator or designee shall be responsible for implementing and maintaining the medical records. This Statute is not met as evidenced by: Based on medical record review and staff interview for two (2) of 55 sampled residents, the charge nurse failed to maintain facility documents with residents preferred name for one (1) resident and to maintain a medical record that accurately documented the date and time that a controlled substance was administered to one (1) resident. Residents' # 65 and #76. Findings included ... 1. The charge nurse failed to maintain facility documents for Resident# 65 under his preferred name to ensure the medical record is accurate and systematically organized in accordance with professional standards of practice. Observation on 3/2/19 at 10:30 AM showed the signage (name) on the resident's door was not the resident's preferred name (showed Resident# 65). Resident #65 was admitted to the facility on 11/6/14 with diagnoses to include Epilepsy, unspecified not intractable with Status Epilepticus, Altered Mental Status, Essential (Primary) Hypertension, Acute Kidney Failure and Lymphangioma any Site. Review of the Admission Record Face Sheet showed in the box allocated for Resident name	L 190	1. Resident #65 medical records, room signage and other facility documents was updated on 03-02-19 to reflect resident's preferred name to ensure accurate and systematically organized medical record in accordance with accepted professional standards and practices. 2. Resident #76 was re-assessed. Resident did not suffer any negative outcome from the identified deficient practice. **Identification of others with the Potential to be affected:** 1. All residents residing in the facility have the potential to be affected. 2. Facility wide audit of medical records was completed 3-5-19 on resident's choice regarding name preference. 3. Facility wide audit of controlled drug record documentation was completed 3-5-19 on legible handwriting. 4. Facility narcotic utilization record has been reviewed and replaced to facilitate legible documentation. 5. Identified issues have been corrected. **Measures to prevent Reccurrence:** 1. Staff Development will provide education to facility staff on the importance of maintaining facility documents with resident's preferred name to ensure accurate and systematically organized medical record.	

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L 190	Continued From page 19 showed [Resident# 65] and in the box allocated for preferred name showed [GJ1] (allocated boxes showed different names). Review of the Comprehensive Minimum Data Set [MDS] dated 10/11/18 and the Quarterly Minimum Data Set [MDS] dated 1/9/19 showed Section A: Identification Information, A1300.Optional Resident Items C. Name by which resident prefers to be addressed shows [GJ1]. Further review of the medical record showed the following documents listed under the resident's preferred name [GJ1]: 1. Physician Orders for Life Sustaining Treatment (dated 5/27/15) 2. Agreement for Admissions to the Facility (dated 12/23/14) 3. Admission Order and Plan of Care (dated 11/6/14) 4. Medication Regimen Reviews Review of the following of the medical record showed the following documents listed under the resident's name [Resident# 65] 1. Progress Notes 2. Nursing Care Plans 3. Pain Assessments 4. Situation, Background, Assessment, Recommendation [SBAR] Communication Forms 5. Discharge Summary (post-hospitalization) On 3/2/19 at 1:00 PM observed resident standing in the hallway approached resident and resident did not respond or answer any questions. Observation on 3/2/19 at 2:00 PM showed medications stored in the medication cart has packets of medications with the resident's name [Resident# 65]. Further review of the medication	L 190	2. Staff Development will educate nursing staff on the importance of legible and accurate documentation on controlled drug record. **Monitoring corrective action:** 1. Social Worker/Designee will review admission face sheet information with resident family member during care conference to ensure that facility record has resident's preferred name. Review will be discussed during risk meeting weekly times 4, then monthly times 3. 2. Assistant Director of Nursing will review controlled drug record daily during clinical round to ensure that nursing staff are documenting accurately and legibly, findings will be reviewed weekly times 4, during risk meeting and reported monthly times 3	

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L 190	Continued From page 20 administration record and the treatment administration record showed in the space allocated for Resident name both the resident's name [Resident# 65] and preferred name [GJ1] are listed (preferred name was in parentheses). During an interview on 3/2/19 at 2:30 PM Employee# 13 stated we are working to resolve the issue it's complicated but the administrators know about the issue and the staff call him Mr. [Resident#65] his room is [GJ1]. During an interview on 3/2/19 at 2:30 PM with Employee # 1, Administrator at 3:00 PM, the Administrator acknowledged the finding and states this has been a problem for the past five years and the Ombudsman is aware of the problem we are working on changing the documents so all of the facility documents have the same resident name. Facility staff failed to maintain all facility documents with the resident's preferred name to ensure an accurate and systematically organized medical record in accordance with accepted professional standards and practices. During an interview on 3/2/19 at 2:30 PM Employee#1 acknowledged the finding at the time of the review. 2. The charge nurse failed to maintain a medical record that accurately documented the date and time that a controlled substance was administered to Resident #76. Resident #76 was admitted to the facility on June	L 190		

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L 190	Continued From page 21 7, 2012, with diagnoses which include Epilepsy, Anxiety Disorder, Schizophrenia and Chronic Pain Syndrome. According to the Physician's orders dated February 3, 2019, Resident #76 was to receive Vimpat 200 mg (used to treat partial onset of seizures) 1 tablet by mouth two times a day 9:00 Am and 5:00 PM. Review of the February and March 2019 Medication Administration Records, the resident received the medication as ordered. Review of the Resident #76's Controlled Drug Record from March 1, 2019 to March 2, 2019. showed the following entries: Date- March 1, 2019; Time- 9:00 AM; Number of medication remaining-4; nurses signature indicating that the controlled drug was removed from the drug box to administer to the resident. Date- March 1, 2019; Time- 5:00 PM; Number of medication remaining-3; nurses signature indicating that the controlled drug was removed from the drug box to administer to the resident. Date- unable to read; Time- unable to read; Number of medication remaining-2; nurses signature indicating that the controlled drug was removed from the drug box to administer to the resident. Date- March 2, 2019; Time- 5:00 PM; Number of medication remaining-1; nurses signature indicating that the controlled drug was removed	L 190		

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L 190	Continued From page 22 from the drug box to administer to the resident. During the face-to-face interview on March 4, 2019 at approximately, 4:00 PM with Employee #3 and Employee #10 (the nurse who signed that she administered the medication), they showed the writer the electronic Medication Administration record which indicated that Vimpat 200 mg 1 tablet was administered to the resident on March 2, 2019, at 9:00 AM. The Employees' further acknowledge that the entry written on the controlled drug record was illegible. The charge nurse failed to maintain a Controlled Drug Record with a legible documented date and time to reflect when medication was removed from the controlled drug box to administer to the resident.	L 190		
L 306	3245.10 Nursing Facilities A call system that meets the following requirements shall be provided: (a)Be accessible to each resident, indicating signals from each bed location, toilet room, and bath or shower room and other rooms used by residents; (b)In new facilities or when major renovations are made to existing facilities, be of type in which the call bell can be terminated only in the resident's room; (c)Be of a quality which is, at the time of installation, consistent with current technology; and	L 306	**Corrective action for the residents affected:** 1. The call bell in resident's room 314A and 320B that that failed to initiate an alarm when tested was replaced during the time of survey. **Identification of others with the Potential to be affected:** 1. Other call bells in residents' rooms were checked. No other failed call bells were found. **Measures to prevent Reccurrence:** 1. The Maintenance Director will educate facility Staff to report call bell issues.	**5-10-19**

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L 306	Continued From page 23 (d)Be in good working order at all times. This Statute is not met as evidenced by: Based on observations and staff interview, facility staff failed to maintain the call bell system in good working condition as evidenced by call bells in two (2) of 46 resident's rooms that failed to trigger an alarm when tested. Findings included... During observations on the third floor on February 27, 2019, at approximately 12:05 PM, call bells in two (2) of 46 resident's rooms (#314A and 320B) did not alarm when activated. These breakdowns could prevent or delay the resident, staff or the public from alerting staff in an emergency. Employee #7 and/or Employee #8 acknowledged the findings during a face-to-face interview on February 27, 2019, at approximately 3:30 PM.	L 306	2. Director of Maintenance/Designee will conduct weekly audits for proper functioning of call bells in residents rooms weekly times 4 then, monthly times 3. **Monitoring corrective action:** 1. The Maintenance Director will present audit to Quality Assurance Performance Improvement Committee for the findings or until sustained compliance is achieved.	
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, facility staff failed to provide housekeeping services necessary to maintain a safe, clean, comfortable environment as evidenced by ceiling light sensor switches without a lens cover in two (2) of 46 resident's rooms, frayed remote bed controllers in two (2) of 46 resident's rooms, eight (8) of 28	L 410	**Corrective action for the residents affected:** 1. The lens covers of ceiling light sensor in the identified room #315C/D and room #515C/D were replaced on 2-27-19. 2. The remote bed controllers of the identified resident's rooms #110 and #210 were replaced on 2-27-19. 3. The eight (8) Isosource identified were Discarded on 2-27-19.	5-10-19

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L 410	Continued From page 24 expired Isosource 1.5 Cal, 250 ml nutritional drinks, marred walls, doors and ceilings in 10 of 46 resident's rooms and broken floor tiles next to the dishwashing machine. Findings included ... During an environmental tour of the facility on February 27, 2019, between 11:00 AM and 3:30 PM the following observations were made: 1. Ceiling light sensor switches located in two (2) of 46 resident's rooms, did not have a lens cover. (Room #315 C/D and room #515 C/D). 2. Electrical wires to remote bed controllers in two (2) of 46 resident's rooms (#110 and #210) were visible and accessible. 3. Eight (8) of 28 Isosource 1.5 Cal, 250 ml nutritional drinks were stored for use beyond their expiration date of December 16, 2018, in the clean linen room on the third floor. 4. Walls, doors and ceilings were marred in 10 of 46 resident's rooms as follows: Room #101: Bathroom door Room #113: Bathroom ceiling Room #115 A/B: Bathroom ceiling Room #120: Bathroom ceiling and walls Room #215 C/D: Walls Room #216: Bathroom walls Room #310: Room ceiling Room #316: Bathroom walls Room #519: Walls behind bed Room #520: Room ceiling	L 410	4. Marred walls, doors and ceilings in resident's Room #101: Bathroom door Room #113: Bathroom ceiling Room # 115 A/B: Bathroom ceiling Room #120: Bathroom ceiling and walls Room #215 C/D: Walls Room #216: Bathroom walls Room #310: Room ceiling Room #316: Bathroom walls Room #519: Walls behind bed Room #520: Room ceiling were all corrected on 2-27-19. 5. The identified floor tiles next to the Dishwashing machine in the main kitchen Were replaced on 2-27-19. 6. Dishwasher machine in he main kitchen was replaced on 2-27-19. 7. Residents suffered no negative outcome. **Identification of others with the Potential to be affected:** 1. All residents residing in the facility have the potential to be affected. 2. An inspection was done **throughout** the facility by the Director of Housekeeping/ Designee and Director of Maintenance/ Designee to ensure that: a. Ceiling light sensor switches located in residents' rooms have lens cover. b. The electrical wires to remote bed controllers of residents' rooms are not frayed. c. There are no expired food items in the facility.	

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	HFD02-0001	A. BUILDING: _____ B. WING _____	03/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INSPIRE REHABILITATION AND HEALTH	2131 O STREET NW WASHINGTON, DC 20037

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L 410	Continued From page 24 expired Isosource 1.5 Cal, 250 ml nutritional drinks, marred walls, doors and ceilings in 10 of 46 resident's rooms and broken floor tiles next to the dishwashing machine. Findings included ... During an environmental tour of the facility on February 27, 2019, between 11:00 AM and 3:30 PM the following observations were made: 1. Ceiling light sensor switches located in two (2) of 46 resident's rooms, did not have a lens cover. (Room #315 C/D and room #515 C/D). 2. Electrical wires to remote bed controllers in two (2) of 46 resident's rooms (#110 and #210) were visible and accessible. 3. Eight (8) of 28 Isosource 1.5 Cal, 250 ml nutritional drinks were stored for use beyond their expiration date of December 16, 2018, in the clean linen room on the third floor. 4. Walls, doors and ceilings were marred in 10 of 46 resident's rooms as follows: Room #101: Bathroom door Room #113: Bathroom ceiling Room #115 A/B: Bathroom ceiling Room #120: Bathroom ceiling and walls Room #215 C/D: Walls Room #216: Bathroom walls Room #310: Room ceiling Room #316: Bathroom walls Room #519: Walls behind bed Room #520: Room ceiling	L 410	d. Ensure that there are no walls, doors and ceiling in the resident's rooms are marred. e. There are no missing or broken titles in the facility. f. Any issue found will be addressed. **Measures to prevent Reccurrence:** 1. Staff development will provide education to facility staff to ensure that facility staff provide housekeeping services necessary to maintain a safe, clean and comfortable environment with focus on: a. Ceiling light sensor switches located in residents' rooms have lens cover b. The electrical wires to remote bed controllers of the residents' rooms are not frayed. c. There are no expired food items in the facility. d. Ensure that no walls, doors and ceiling in the resident's rooms are marred. e. Floor tiles next to the dishwashing machine in the main kitchen are not broken and/or missing **Monitoring corrective action:** 1. An inspection will be done throughout the facility by the Director of Housekeeping/ Designee and Director of Maintenance/ Designee to ensure that facility staff provide housekeeping services necessary to maintain a safe, clean and comfortable environment weekly times 4 then monthly times 3.	

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L 410	Continued From page 25 5. Floor tiles next to the dishwashing machine in the main kitchen were broken and/or missing. Employee #7 and/or Employee #8 acknowledged the findings during a face-to-face interview on February 28, 2019, at approximately 3:30 PM.	L 410	1. Findings will be reported to Quality Assurance Performance Improvement Committee monthly for the next 3 months.	
L 442	3258.13 Nursing Facilities The facility shall maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This Statute is not met as evidenced by: Based on observations and staff interview, facility staff failed to maintain essential equipment in safe condition as evidenced by remote bed controllers with frayed electrical wires in two (2) of 46 resident's rooms. Findings included ... During an environmental tour of the facility on February 27, 2019, between 11:00 AM and 3:30 PM, remote bed controllers in two (2) of 46 resident's rooms (#110 and #210) were frayed. This deficient practice could expose the resident, staff or visitors to electrical hazards. Employee #7 and/or Employee #8 acknowledged the findings during a face-to-face interview on February 27, 2019, at approximately 3:30 PM.	L 442	**Corrective action for the residents affected:** 1. Frayed remote bed controller for resident #119 and #210 were replaced on 02-27-19. 2. No negative outcome suffered. **Identification of others with the Potential to be affected:** 1. All residents residing in the facility have the Potential to be affected. 2. An inspection was done throughout the facility by the director of Maintenance/ designee to ensure that: a. Remote bed controllers in residents' rooms are not frayed. 3. No other remote bed controller identified to be frayed.	**5-10-19**
L 534	3270.1 Nursing Facilities A transfer or discharge of a resident from a nursing facility shall be done in accordance with the Nursing Home and Community Residence Facility Residents' Protection Act of 1985,	L 534		

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L 442	3258.13 Nursing Facilities The facility shall maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This Statute is not met as evidenced by: Based on observations and staff interview, facility staff failed to maintain essential equipment in safe condition as evidenced by remote bed controllers with frayed electrical wires in two (2) of 46 resident's rooms. Findings included ... During an environmental tour of the facility on February 27, 2019, between 11:00 AM and 3:30 PM, remote bed controllers in two (2) of 46 resident's rooms (#110 and #210) were frayed. This deficient practice could expose the resident, staff or visitors to electrical hazards. Employee #7 and/or Employee #8 acknowledged the findings during a face-to-face interview on February 27, 2019, at approximately 3:30 PM.	L 442	**Measures to prevent Reccurrence:** 1. Remote bed controllers will be checked daily during grand round on an ongoing basis. Deficiencies will be documented in REQQUER (Facility electronic Job order/request site) and reported to the Director of Maintenance for immediate action. 2. Staff development to provide education to facility staff on ensuring remote bed controller in residents rooms is not frayed. **Monitoring corrective action:** 1. Findings from daily grand rounds will be presented by Director of Maintenance to Quality Assurance Performance Improvement Committee monthly for 3 months or until sustained compliance is achieved.	
L 534	3270.1 Nursing Facilities A transfer or discharge of a resident from a nursing facility shall be done in accordance with the Nursing Home and Community Residence Facility Residents' Protection Act of 1985,	L 534		

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L 534	Continued From page 26 effective April 18, 1986 (D.C. Law 6-108; D.C. Official Code §§ 44-1003.01, et seq. (2005 Repl. & 2011 Supp.)). This Statute is not met as evidenced by: Based on staff interviews and record review, it was determined that the charge nurse failed to follow the correct procedure for maintaining 6-108 forms in the medical record for (5) of five (5) residents who were relocated from the facility to another location, according to the District of Columbia Code, Title 44, Subtitle I, Chapter 10, §44.1003.02 . Resident #'25, #113, #127,#148, and #Dg1. Findings included ... 1. During a medical record review, it was noted that Resident #25 was discharged to the hospital on 3/1/19. There was no evidence of the 6-108 in the medical record. A face-to-face interview was conducted with Employee #4 on March 5, 19, at 10:30 AM. She stated that all 6-108 forms are kept in a binder in the assigned social worker's offices. She acknowledged the 6-108 is not kept in medical record. 2. During a medical record review, it was noted that resident #113 discharged to the hospital on 1/31/19. There was no evidence of the 6-108 in the medical record. A face-to-face interview was conducted with Employee #4 on March 5, 2019, at 10:30 AM. She stated that all 6-108 forms are kept in a binder in the assigned social worker's office. She acknowledged the 6-108 is not kept in medical	L 534	**Corrective action for the residents affected:** 1. The 6-108 records for resident #25, 113, 127, 148 and Dg1 have been removed from the binder and uploaded to the clinical records of the assigned resident's on Point Click care (PCC). **Identification of others with the Potential to be affected:** 1. Al other residents have the potential to be affected by this deficient practice. **Measures to prevent Reccurrence:** 1. The Administrator/Designee will educate all Social Workers and Medical Records staff who are responsible for completing the 6-108 process on the need for all 6-108 forms to be uploaded to resident 's individual clinical record on Point Click Care (PCC). 2. Medical Record Staff have removed all 6-108 binders and have completed a 100% audit of all residents while ensuring all active residents' 6-108 forms are uploaded to the clinical record on PCC. **Monitoring corrective action:** 1. The medical record staff will complete a 100% of all 6-108 transfers and discharge once a week to ensure they were properly uploaded to the resident's clinical record on PCC. 2. The result of the audit will be shared with the Quality Assurance and Performance Improvement Committee monthly over the next 3 months.	5-10-19

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L 534	Continued From page 27 record. 3. During a medical record review, it was noted that resident #127 relocated to another room on 2/25/19. There was no evidence of the 6-108 in the medical record. A face-to-face interview was conducted with Employee #4 on 3/5/19, at 10:30 AM. She stated that all 6-108 forms are kept in a binder in the assigned social worker's office. She acknowledged the 6-108 is not kept in medical record. 4. During a medical record review, it was noted that Resident #148 discharged to the hospital on 3/1/19. There was no evidence of the 6-108 in the medical record. A face-to-face interview was conducted with Employee #4on March 5, 2019, at 10:30 AM. He/she stated that all 6-108 forms are kept in a binder in the assigned social worker's office. She acknowledged the 6-108 is not kept in medical record. 5. During a medical record review, it was noted that Resident #Dg1was discharged to the home on 2/6/19. There was no evidence of the 6-108 in the medical record. A face-to-face interview was conducted with Employee #4on March 5, 2019, at 10:30 AM. She stated that all 6-108 forms are kept in a binder in the assigned social worker's office. She acknowledged the 6-108 is not kept in medical record.	L 534		