Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0022	A. BUILDING: _____ B. WING _____	06/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KNOLLWOOD HSC	6200 OREGON AVE NW WASHINGTON, DC 20015

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L 000	Initial Comments An unannounced Long Term Care Licensure Survey was conducted at Knollwood Nursing Center from June 23,, 2019 through June 28, 2019. Survey activities consisted of a review of 32 sampled residents. The following deficiencies are based on observation, record review and resident and staff interviews. The resident census during the survey was 59. 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 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 HR- Hour HSC - Health Service Center HVAC - Heating ventilation/Air conditioning ID - Intellectual disability	L 000	This plan of correction is prepared and/or executed solely because it is required by the Provisions of Federal and State law. The plan of correction is the Army Distaff Foundation and Knollwood's credible Allegation of Compliance.	

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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 O2- Oxygen 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 ROM Range of Motion Rp, R/P - Responsible party SCC Special Care Center Sol- Solution TAR - Treatment Administration Record	L 000		
L 001	3200.1 Nursing Facilities Each nursing facility shall comply with the Act, these rules and the requirements of 42 CFR Part 483, Subpart B, Sections 483.1 to 483.75; Subpart D, Sections 483.150 to 483.158; and Subpart E, section 483.200 to 483.206, all of which shall constitute licensing standards for	L 001		

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L 001	Continued From page 2 nursing facilities in the District of Columbia. This Statute is not met as evidenced by: Based on observation, document review staff interview, the facility staff failed to ensure the contact information to include the names, mailing and email addresses for all pertinent State agencies and advocacy groups were posted and included a statement that the resident may file a complaint with the State Survey Agency and failed to post notice of the availability of survey results in a format (font) readable by residents/resident representatives. The resident census was 59 on the first day of survey. Findings included ... 1. During tour of the facility on 6/23/19 at 9:30 AM, the signage was observed posted on a bulletin board near the nurse's station. The signage contained a list of names of all pertinent State agencies and advocacy groups, adult protective services and the Office of the State Long-Term Care Ombudsman and the Medicaid Fraud Control. However, the signage failed to display the names, accurate phone numbers, mailing or email address for aforementioned organizations. In addition, the posting did not include a statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation. During a face-to-face interview on 6/23/19, at 9:30 AM, Employee #2 was shown the required posting of contact information and acknowledged the finding. 2. During tour of the facility on 6/23/19 at 9:30 AM	L 001	1. The posting was updated immediately to include the names, accurate phone numbers, or email addresses for aforementioned organizations and a statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community. 2. A walk-through of the unit was conducted for other informational materials to verify correct contact information. 3. The Social Services Manager will review the contact information posted quarterly to verify that the contact information is current. 4. The Social Services Manager or designee will audit the required posting quarterly for compliance to be sure accurate information remains posted. Results will be shared at the QAPI meeting.	6/23/19 6/23/19 6/23/19 And on-going On-going

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L 001	Continued From page 3 the posted signage was found on the bulletin board on a blue card with yellow coloring in the middle of other postings which reads "results may be found on top of the fireplace in the HSC units' dinning/common area, directly below the large screen television." However, the posted signage was not in a format (font) readable by residents/resident representatives. During a face-to-face interview on 6/23/19 at 9:30 AM Employee #2 acknowledged the finding.	L 001		
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.	L 051		

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L 051	Continued From page 4 This Statute is not met as evidenced by: Based on record review and staff interview for four (4) of 32 sampled residents, the charge nurse failed to develop baseline care plans with goals and approaches to properly care for four (4) newly admitted residents. Residents' # 38,53, 62 and 160. Findings included... 1. The charge nurse failed to ensure that Resident # 38 had a baseline care plan completed within 48 hours of admission. Resident #38 was admitted to the facility on May 8, 2019, with diagnoses, which included Chronic Pain, Gastro-Esophageal Reflux Disease, Vascular Dementia with Behavioral Disturbance, Hypertension, and Spinal Stenosis. Review of the facility's "48-hour baseline care plan" showed the care plan was signed by the resident and the facility on May 14, 2019 (seven days after admission). There was no evidence that the charge nurse ensured Resident # 38 had a Baseline Care Plan completed within 48 hours of admission. The findings were acknowledged during a face-to-face interview with Employee #2 on June 27, 2019 at approximately 2:45 PM. 2. The charge nurse failed to ensure that Resident #53 had a baseline care plan completed within 48 hours of admission. Resident #53 was admitted to the facility on 5/31/19, with diagnoses to include Essential Hypertension, Unspecified Atrial Fibrillation, Heart	L 051	1.The baseline care plans of Residents #38, #53, #62, and #160 could not be reissued. 2. The form used to complete baseline care plans was modified to indicate that the baseline care plan will be developed within 48 hours of admission instead of being developed within seven days of a resident's admission. 3. The Interdisciplinary Team will be inserviced on developing baseline care plans within 48 hours of a resident's admission. 4. An audit of baseline care plans will be conducted weekly X4, then monthly X 3, then quarterly X 2 to verify that baseline care plans are being developed within 48 hours of a resident's admission with a threshold of 95%. The results of this audit will be presented to the QAPI Committee for further recommendations.	6/28/19 6/25/19 8/10/19 On-going

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L 051	Continued From page 5 Failure and Cerebral Infarction. Review of the facility's "48-hour baseline care plan" showed the care plan was signed by the resident and the facility staff on 6/5/19 (five days after admission). There was no evidence that the charge nurse ensured Resident # 53 had a baseline care plan completed within 48 hours of admission. During a face-to-face interview conducted on 6/26/19 at approximately 10:00 AM Employee #2 acknowledged the findings. 3. The charge nurse failed to ensure that Resident # 62 had a baseline care plan completed within 48 hours of admission. Resident #62 was admitted to the facility on March 27, 2019, with diagnoses to include Congestive Heart Failure, Pulmonary Edema, Muscle Weakness and Hypoxemia. Review of the facility's "48-hour baseline care plan" showed the care plan was signed by the resident and the facility on April 2, 2019 (seven days after admission). There was no evidence that the charge staff ensured Resident # 62 had a baseline care plan completed within 48 hours of admission. During a face-to-face interview on June 27, 2019 at approximately 4:45 PM, Employee #2 acknowledged the findings. 4. The charge nurse failed to ensure that Resident #160 baseline care plan was developed	L 051		

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L 051	Continued From page 6 within 48 hours of admission. A review of the medical record showed Resident # 160 was admitted to the facility on June 13, 2019, with diagnoses to include: Malignant Pleural Effusion, Chronic Kidney Disease, Age-related Osteoporosis, Anemia, and Hypertension. A review of Resident #160's 48-hour baseline care plan showed the care plan was signed by the resident and designated staff on June 18, 2019 (five days after admission). There was no evidence that the charge nurse ensured Resident # 160 had a baseline care plan completed within 48 hours of admission During a face-to-face interview on June 26, 2019, at approximately 10:45 AM, Employee #14 acknowledged the findings.	L 051		
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	L 056		

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L 056	Continued From page 7 hours], the Nursing Facility failed to meet the 0.6 [six tenths] hour for Registered Nurses/Advanced Practice Registered Nurse hours on one (1) of the twelve (12) days reviewed, in accordance with Title 22 DCMR Section 3211, Nursing Personnel and Required Staffing Levels. 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 Jul,y 28, 2019, at approximately 1:30 PM. Of the 12 days reviewed, one (1) of the day facility staff failed to meet the 0.6 [six tenths] hours of direct nursing care per resident day for Registered Nurse/APRN [Advanced Practice Registered Nurse] as follows: Monday, March 18, 2019, showed that the facility provided total RN coverage at a rate of 0.5 hours. The review was made in the presence of the Employee #2 who acknowledged the findings.	L 056	1. The staffing level for March 18, 2019, could not be corrected. 2. Knollwood has hired two additional Registered Nurses to supplement the current pool of nurses available to work on an as needed basis. Staffing will be audited for the monthly of July 2019 for compliance given the additional RNs. 3. The Administrative Assistant or designee will review the staffing schedule 3 times per week and will adjust the number of Registered Nurses to ensure 0.6 hours per resident per day are scheduled. 4. An audit of worked RN hours based on the schedule will be completed by the Administrative Assistant or designee weekly X 8, then monthly X 4 to ensure that 0.6 hours per resident per day was worked by RNs. The result of this audit will be presented to the QAPI Committee for further recommendations.	6/25/19 8/10/19 8/10/19 On-going

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L 099	Continued From page 8	L 099	1A. The thermometer was replaced immediately and food temperatures were taken as soon as the thermometer was replaced.	6/23/19
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 interview, the facility failed to store, serve and distribute foods under sanitary conditions as evidenced by staff who were observed serving breakfast foods to residents before food temperatures were completed, soiled equipment such as four (4) of four (4) convection ovens, one (1) of one (1) deep fryer, one (1) of one (1) grill and the interior of one (1) of one (1) oven, 20 of 20 six-inch, one-third steam pans that were stored wet, four (4) of 20 six-inch one-third pans that were dented throughout. Findings included ... The following observations were made during a walkthrough of the kitchen on the Special Care Center (SCC) on June 23, 2019, at approximately 8:15 AM. 1. Breakfast food temperatures from the Special Care Center (SCC) kitchen were not completed before foods were served to residents on June 23, 2019, at approximately 8:10 AM. Employee #4 was asked why food temperatures were not taken before residents were served and she explained that someone had removed the thermometer from the kitchen and she did not have one.	L 099	2A. An audit was done for food thermometers. No other food service areas were missing thermometers for taking food temperatures. 3A. The uniform for those dining services workers taking food temperatures has been modified to require a thermometer on the person. All dining services employees were inserviced on the importance of making sure all temperatures are taken for foods. 4A. Dining Services leadership will conduct monthly audits for compliance. Results of the monthly audits will be reported to the QAPI Committee. 1B. The convection ovens, deep fryer, grill and oven were cleaned. 2B. No other convention ovens, deep fryers, grills, or ovens were found to be soiled. 3B. Convection ovens, deep fryers, grills and ovens have been upgraded for daily sanitation and weekly heavy duty cleaning. 4B. Leadership will perform monthly compliance observations. Documentation of results of the observations will be reported to the quarterly QAPI Committee for review.	6/23/19 6/26/19 On-going 6/23/19 6/23/19 6/26/19 On-going

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L 099	Continued From page 9 Employee #4 was asked if she could get another thermometer and check food temperatures. Employee #4 left and came back in about five (5) minutes and proceeded to check the temperature of foods on the tray line. All food items tested above 140 degrees Fahrenheit. A review of the food temperature logs for the previous week confirmed that food temperatures were completed for breakfast, lunch and dinner throughout the week. Employee #4 acknowledged the findings during a face-to-face interview on June 23, 2019, at approximately 8:20 AM. During a walkthrough of the main kitchen on June 23, 2019, at approximately 8:30 AM: 2. Four (4) of four (4) convection ovens, one (1) of one (1) deep fryer, one (1) of one (1) grill and the interior of one (1) of one (1) oven were soiled. 3. 20 of 20 six-inch, one-third steam pans stored on a shelf in the clean, and ready-for-use area were stored wet, one on top of the other. 4. Four (4) of 20 six-inch one-third pans were dented throughout. Employee #3 acknowledged the findings during a face-to-face interview on June 23, 2019, at approximately 9:15 AM	L 099	1C. The steam pans were re-washed immediately and properly stored. 2C. No other steam pans or other items drying were found to be wet nested. 3C. Utility employees were re-trained on properly storing wet items after washing. 4C. Leadership will perform monthly compliance observations. Documentation of results of the observations will be reported to the quarterly QAPI Committee for review. 1D. The dented pans were disposed of immediately. 2D. An check was done for any other dented pans, no other pans were found to be dented. 3D. Utility employees were re-trained to discard dented pans when identified as such and advise the Chef of the need for replacement pan/s. 4D. Leadership will perform monthly compliance observations. Documentation of results of the observations will be reported to the quarterly QAPI Committee for review.	6/23/19 6/23/19 6/26/19 On-going 6/24/19 6/25/19 6/26/19 On-going
L 150	3227.1 Nursing Facilities Medication shall be stored in accordance with this	L 150		

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L 150	Continued From page 10 section. This Statute is not met as evidenced by: Based on record review and staff interviews for one (1) of (2) nursing units, the facility staff failed to ensure the system used for acceptable standard of practice to account for the receipt, usage, disposition, and reconciliation of controlled medications was followed by staff. The census was 59 on the first day of the survey. Findings included... Controlled Drug Shift Change Audit Sheet instructions showed "controlled drugs (scheduled II to schedule V) must be counted by two nurses at the change of shift, the nurse going off duty and the nurse coming on." A review of the "Controlled Drug Shift Change Audit Sheet" on 6/26/19 at 9:30 AM showed the spaces allotted for nurse signature going off duty to reconcile the narcotic count for the 7:00 AM to 3:00 PM and 3:00 to 11:00 PM shift for 6/20/19 were left blank indicating reconciliation of controlled medications was "Not Done". The evidence showed that the system use for acceptable standard of practice to account for the receipt, usage, disposition, and reconciliation of controlled medications was not followed by staff. A face-to-face interview was conducted with Employee #15 on 6/26/19, 2019, at 9:30 AM; she acknowledged the finding at the time of the review.	L 150	1. The controlled drug audit sheet for 6/20/19 was signed by the nurse who completed the reconciliation of the controlled medications. 2. An audit of the controlled drug sheet from 6/20/19 until 7/20/19 was completed; all drug sheets were fully reconciled. 3. Licensed nurses will be inserviced to make sure that they sign the controlled audit sheet after completing the reconciliation of controlled medications. 4. The Assistant Director of Nursing or designee will audit controlled drug sheets weekly X 4, then monthly X 4 then quarterly to verify that the controlled sheets were signed when the reconciliation of controlled medications was completed. The results of this audit will be presented to the QAPI Committee for further recommendations.	6/25/19 7/23/19 8/10/19 On-going
L 170	3228.2 Nursing Facilities	L 170	1. The Podiatrist was contacted and an inservice is scheduled before the end of July, 2019.	7/30/19

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L 170	Continued From page 11 Podiatry services shall include direct services to residents, as well as consultation and in-service training for nursing employees. This Statute is not met as evidenced by: Based on staff interview and a review of records, facility staff failed to ensure a podiatrist conducted in-service training for nursing employees. Findings included... District of Columbia Municipal Regulations for Nursing Facilities: "Podiatry services shall include direct services to residents, as well as consultation and in-service training for nursing employees." A review of the in-service training files revealed no podiatry in-services were provided during the survey look-back period. During a face-to-face interview conducted on June 28, 2019, at approximately 3:00 PM, Employee#16 acknowledged the findings	L 170	2. The next podiatry inservice will be scheduled for early 2020 by the Assistant Director of Nursing or designee. 3. The Assistant Director of Nursing will be reminded to schedule consultants' inservices that are mandated trainings by the State by February of 2020. 4. The Assistant Director of Nursing or designee will review the inservice records quarterly to ensure that the consultants' inservices mandated by the State are scheduled and run within the year. The results of this audit will be reported to the QAPI Committee for further recommendations. 1.The 12 bed control cords were replaced. 2. All other bed control cords were examined and no others were found to be deficient. 3. The vendor for bed control cords was changed out in favor of a more durable product. Visual checks of the bed control cords were added to the bi-weekly bed inspection checklist. 4. The Director of Engineering or designee will audit the bi-weekly bed control checklists monthly X 12. The Director of Engineering or designee will also conduct monthly random inspections of bed control cords in 4 rooms. All audit results will be reported to the quarterly QAPI meeting for follow up.	8/10/19 8/10/19 On-going 6/28/19 6/28/19 8/1/19 On-going
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 frayed remote bed controller cords in 12 of 20 resident's rooms.	L 214		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0022	A. BUILDING: _____ B. WING _____	06/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KNOLLWOOD HSC	6200 OREGON AVE NW WASHINGTON, DC 20015

(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 214	Continued From page 12 Findings included ... During an environmental tour of the facility on June 25, 2019, at approximately 11:00 AM, remote bed controllers' cords in 12 of 20 resident's rooms were frayed. The uncovered, exposed electrical wires created a potential electrical shock hazard to residents, staff and the public During a face-to-face interview on June 25, 2019, at approximately 12:30 PM, Employee #6 acknowledged the findings.	L 214	1.The 12 bed control cords were replaced. 2. All other bed control cords were examined and no others were found to be deficient. 3. The vendor for bed control cords was changed out in favor of a more durable product. Visual checks of the bed control cords were added to the bi-weekly bed inspection checklist. 4. The Director of Engineering or designee will audit the bi-weekly bed control checklists monthly X 12. The Director of Engineering or designee will also conduct monthly random inspections of bed control cords in 4 rooms. All audit results will be reported to the quarterly QAPI meeting for follow up.	6/28/19 6/28/19 8/1/19 On-going
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 interview, facility staff failed to maintain electrical equipment in good condition as evidenced by frayed remote bed controller cords in 12 of 20 resident's rooms. Findings included ... During an environmental tour of the facility on June 25, 2019, at approximately 11:00 AM, remote bed controllers' cords in 12 of 20 resident's rooms were frayed. During a face-to-face interview on June 25, 2019, at approximately 12:30 PM, Employee #6 acknowledged the findings.	L 442		