STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095026	A. BUILDING _____ B. WING _____	04/01/2015

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KNOLLWOOD HSC	6200 OREGON AVE NW WASHINGTON, DC 20015

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F 000	INITIAL COMMENTS	F 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.	

A Recertification Quality Indicator Survey (QIS) was conducted at your facility on March 25, 2015 through April 1, 2015.

The following deficiencies are based on observations, record reviews, resident and staff interviews for 34 sampled residents.

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
IDT - interdisciplinary team
L - Liter

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

[signature] | INHA | 5/11/15

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

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F 000	Continued From page 1 Lbs - Pounds (unit of mass) MAR - Medication Administration Record MD- Medical Doctor MDS - Minimum Data Set Mg - milligrams (metric system unit of mass) mL - milliliters (metric system measure of volume) mg/dl - milligrams per deciliter mm/Hg - millimeters of mercury MN midnight Neuro - Neurological NP - Nurse Practitioner PASRR - Preadmission screen and Resident Review Peg tube - Percutaneous Endoscopic Gastrostomy PO- by mouth POS - physician ' s order sheet Prn - As needed Pt - Patient Q- Every QIS - Quality Indicator Survey Rp, R/P- Responsible party SCC Special Care Center Sol- Solution TAR - Treatment Administration Record	F 000		
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations made on March 27, 2015 at approximately 10:30 AM, it was determined	F 253	It is the Army Distaff Foundation and Knollwood's practice to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. 1. On March 27, 2015, the one privacy curtain in 4B in the HSC, with the one square that was disconnected in the netting was taken down and repaired. 2. A privacy curtain audit was completed on March 27, 2015 and out of 72 privacy curtains, no other privacy curtains were found to be in need of repair.	05/15/15 05/15/15

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F 253	Continued From page 2 that the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior as evidenced by one (1) of two (2) torn privacy curtains in one (1) of eight (8) resident's rooms on the Health Service Center (HSC). The findings include: One (1) of two (2) privacy curtains in one (1) of eight (8) resident's rooms (Room #4B) on the HSC unit was torn. This observation was made in the presence of Employee #21 who acknowledged the finding.	F 253	3. Privacy curtain audits will be conducted by the Environmental Services Manager or designee monthly for three months. Findings from the audits will be addressed immediately. Privacy curtains will also be monitored when taken down for washing, and repaired as needed, prior to rehanging. 4. Audits will be submitted to the Quality Assurance and Performance Committee for further recommendations. Findings will be submitted to the committee for two quarters. The Committee will determine if further action is needed.	05/15/15 05/15/15
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined that facility staff failed to ensure that services provided met professional standards of quality, as evidenced by failure to ensure a registered nurse, who did not have a current license, was qualified to practice. The findings include: Title 22B of the District of Columbia Municipal Regulations for Nursing Facilities section 3209.2(b) stipulates, " Each Nursing Services	F 281	It is the Army Distaff Foundation and Knollwood's practice to ensure that services provided meet professional standards of quality. 1. Employee #14 employment was terminated effective March 27, 2015. There were no identified incidents of a resident's care or safety being negatively affected during the time employee #14 did not hold a renewed District of Columbia license. Employee #14 was a weekend supervisor and did not provide direct resident care.	05/15/15

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F 281	Continued From page 3 Supervisor shall be currently licensed as a registered nurse in the District of Columbia. " Title 17 of the District of Columbia Municipal Regulations for Registered Nursing section 5409.1 stipulates, " A licensee shall renew his or her license by submitting a complete application on the forms required by the Board and paying the required fees prior to the expiration of the license. " A review of the personnel record for Employee #14 revealed that his/her license to practice as a Registered Nurse expired on June 30, 2014. The summary of his/her job description under the section titled Certificates, Licenses, and Registrations revealed that the he/she must be a Registered Nurse with current license to practice in the District of Columbia. A review of the "Timecard Manager" [method for clocking in and out] revealed that Employee #14 worked the following shifts without a District of Columbia nursing license: July 5, 6, 12, 13, 20, 26 and 27, 2014 August 2, 3, 9, 10, 16, 17, 23, 24, 30 and 31, 2014 September 6, 13, 14, 20, 21, 27 and 28, 2014 October 4, 5, 11, 12, 18, 19, 25 and 26, 2014 November 1, 2, 8, 9, 15, 16, 22, 23, 29 and 30, 2014 December 6, 13, 14, 20, 21, 27 and 28, 2014	F 281	2. Adhoc Quality Assurance and Improvement Meetings were held on March 27, 30, and April 2, 2015. The tracking log for RN licenses was reviewed and RN licenses were verified to be current. 3. The RN license tracking log will be updated by the Executive Assistant and reviewed monthly by the Executive Assistant to identify potential areas of concern. The Administrator or designee will review and validate the RN license log with a paper copy of the professional license in order to validate that District of Columbia RN licenses are up-to-date and in compliance with federal and state regulations. 4. The Executive Assistant developed a quality assurance audit tool and is submitting the tool and findings of the monthly audit reviews to the Quality Assurance and Improvement Committee. Findings will be submitted to the committee for two quarters. The Committee will determine if further action is needed.	05/15/15 05/15/15 05/15/15

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F 281	Continued From page 4 January 3, 4, 10, 11, 17, 18, 24, 25 and 31, 2015 February 1, 14, 15 and 28, 2015 March 1, 14 and 15, 2015 On April 1, 2015 at approximately 3:00PM, a face-to-face interview was conducted with Employee #1 and Employee #3 regarding Employee #14, who worked without a license. Employee #1 and #3 acknowledged the aforementioned findings. The records were reviewed on March 31, 2015. Cross Reference Cross reference CFR 483.75, F492	F 281		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations made on March 25, 2015 at approximately 9:30 AM and on March 27, 2015 at approximately 1:00 PM, it was determined that the facility failed to prepare and serve food under sanitary conditions as evidenced by soiled fire sprinklers located above the grill in the main	F 371	It is the Army Distaff Foundation and Knollwood's practice to prepare, distribute and serve food under sanitary conditions. 1. Fire Sprinklers a. Immediate action was taken by the Chef to remove and clean the plastic covers to the fire suppression system. b. The Executive Chef conducted an audit on March 27, 2015 to assure the plastic covers to the fire suppression system were properly cleaned and sanitized. There were no additional findings. c. Utility/Dining Services cleaning schedules were revised to include the weekly cleaning of the fire suppression rods. In addition, the monitoring of this cleaning was added to the weekly operations audit.	05/15/15 05/15/15 05/15/15

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F 371	Continued From page 5 kitchen; and staff failed to obtain food temperatures before serving residents in the country kitchen located in the HSC (Health Care Services) Unit. The findings include: 1. Three (3) of five (5) fire sprinklers located above the grill were soiled with dust. 2. Staff failed to obtain food temperatures before serving residents lunch in the country kitchen located in the HSC unit on March 27, 2015. On March 25, 2015 at approximately 1:00 PM, facility staff was observed serving lunch to residents on the HSC Unit. Upon review of the food temperature log it was noted that the designated staff did not record the temperature of the foods on the steam table prior to plating and serving food to the residents for lunch. The first observation was made in the presence of Employee #18 and the second observation was made in the presence of Employee #21. They both acknowledged the findings.	F 371	d. The cleaning schedule and audits for the identified area has been added to the Quality Assurance process for Dining Services. Findings will be submitted to the Quality Assurance and Improvement Committee for two quarters. The Committee will determine if further action is needed. 2. Food Temperature a. The identified staff member was immediately re-educated following the identified finding on 3/25/2015, regarding the proper procedure for taking food temperatures at the point of service for meals. b. Dining Staff was inserviced on May 3, 5, & 7, 2015, on the proper procedures, techniques, and standards for temperature recording. The procedures and practices for taking and recording food temperatures are being reviewed daily by the Food Service Manager and/or Skilled Care Supervisor for Dining Services. c. An audit of the temperature logs will be conducted by the Dining Service Manager weekly for four weeks, then monthly for three months, and thereafter quarterly for three quarters, to ensure compliance. d. The result of the audits will be presented to the Quality Assurance and Improvement Committee. The Committee will determine if further actions is needed.	05/15/15 05/15/15 05/15/15 05/15/15 05/15/15
F 386 SS=D	483.40(b) PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress	F 386		

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F 386	Continued From page 6 with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for four (4) of 34 sampled residents, it was determined that the attending physician failed to sign and date the resident's progress notes at each visit for four (4) residents. Residents' #24, 26, 60 and 64. The findings include: 1. The attending physician for Resident #24 failed to sign and date his/her progress note. A review of the physician's progress notes revealed that on October 27, 2014 the resident was seen by his/her physician. However, the progress note was not authenticated with the physician's signature and date. There was no evidence that the physician signed and dated his/her progress note at the time of the visit. On April 1, 2015 at approximately 4:00 PM, a face-to-face interview was conducted with Employees #1 and #2. They acknowledged the aforementioned findings. The clinical record was reviewed on April 1, 2015.	F 386	It is the practice of the Army Distaff and Foundation and Knollwood's physicians to sign and date residents' progress notes at the time the progress notes are written. 1. The attending physician who wrote progress notes on residents #24, #26, # 60, and #64 is no longer a contracted physician at the Army Distaff Foundation and Knollwood. 2. The attending physician who wrote progress notes on residents #24, #26, #60, and #64 did not use the facilities electronic medical record system to complete his documentation. An audit of progress notes of residents under this physician's care was conducted and no other notes were identified as not being signed and dated. The Army Distaff Foundation and Knollwood physicians use this organizations approved electronic medical record system where their notes automatically have a date and the name of the physician who is documenting.	05/15/15 05/15/15

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F 386	Continued From page 7 2. The physician failed to sign and date the progress note for Resident #26. A review of the physician's history and physical signed and dated March 25, 2015 revealed that the resident was admitted to the facility on November 30, 2011. Further review revealed diagnoses that included Dementia, Hypertension, Leukocytosis, and Parkinsonism. A continued review of the record revealed the following physician's note, "Seen by: [physician's name] on Sunday October 5, 2015." The progress note was not authenticated with the physician's signature and date. There was no documented evidence of the physician's signature on the progress note. On April 1, 2015 at approximately 4:00 PM, a face-to-face interview was conducted with Employee #1, regarding the signature omission. He/she acknowledged the aforementioned findings. The clinical record was reviewed on April 1, 2015. 3. The attending physician for Resident #60 failed to sign and date his/her progress note. A review of the physician's history and physical signed and dated October 12, 2014 revealed that the resident was admitted to the facility on October 10, 2014 with diagnoses that included: Hyperlipidemia, Hypertension, Diabetes Mellitus, GERD (Gastroesophageal Reflux Disease), and BPH (Benign Prostatic Hypertrophy.)	F 386	3. Physicians were asked by our Medical Director to complete progress notes in our electronic medical records system. 4. An audit of physicians' progress notes will be conducted by the Director of Nursing and/or designee weekly for four weeks, then monthly for three months, then quarterly for two quarters. The results of these audits will be presented to the Quality Assurance Performance Improvement Committee for further recommendations.	05/15/15 05/15/15

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F 386	Continued From page 8 Further review of the record revealed the following physician's note, "Seen by: [physician's name] on Sunday October 12, 2014, Monday October 13, 2014 and Monday October 20, 2014." There was no documented evidence of the physician's signature on the note. On April 1, 2015 at approximately 4:00 PM, a face-to-face interview was conducted with Employee #1, regarding the signature omission. He/she acknowledged the aforementioned findings. The clinical record was reviewed on April 1, 2015. 4. The attending physician for Resident #64 failed to sign and date his/her progress note. A review of the physician's progress notes revealed that on October 15, 2014 the resident was seen by his/her physician. However, the progress note was not authenticated with the physician's signature and date. There was no evidence that the physician signed and dated his/her progress note at the time of the visit. On April 1, 2015 at approximately 4:00 PM, a face-to-face interview was conducted with Employees #1 and #2. They acknowledged the aforementioned findings. The clinical record was reviewed on April 1, 2015.	F 386		

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F 387	Continued From page 9	F 387		
F 387 SS=E	483.40(c)(1)-(2) FREQUENCY & TIMELINESS OF PHYSICIAN VISIT The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. This REQUIREMENT is not met as evidenced by: A.Based on record review and staff interview for four (4) of 34 sampled residents, it was determined that the attending physician failed to conduct a resident visit at least once every 30 days for the first 90 days after admission for four (4) residents. Residents' #43, 52, 63 and 65. The findings include: 1. The physician failed to ensure that Resident #43 was seen at least once every 30 days for the first 90 days after admission to the facility. A review of the physician's history and physical signed and dated July 28, 2014, and timed 4:23 PM revealed that Resident #43 was admitted to the facility on July 28, 2014 at 12:00 MN [mid night] for management of Parkinson's. Further review of the record revealed the subsequent physician visit dates and notes: September 29 and 30, 2014, October 31, 2014,	F 387	A- It is the practice of the Army Distaff Foundation and Knollwood's physicians to conduct residents' visits at least once every 30 days for 90 days after admission. B- It is the practice of the Army Distaff Foundation and Knollwood's physicians to ensure that residents are seen at least once every 60 days following 90 days after admission.	05/15/15 05/15/15

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F 387	Continued From page 10 November 3, 2014, December 12, 2014, January 1, 2015, and March 25 and 27, 2015. From July 28 to September 29, 2014, there was no documented evidence of a physician visit for 61 days. On April 1, 2015 at approximately 4:00 PM, a face-to-face interview was conducted with Employee #1, regarding the visit absences. He/she acknowledged the aforementioned findings. The clinical record was reviewed on March 31, 2015. 2. The physician failed to ensure that Resident #52 was seen at least once every 30 days for the first 90 days post admission to the facility. A review of the Resident's record revealed that he/she was admitted to the facility on September 24, 2014 with diagnoses which included: Advanced Dementia, Frailty, Osteoarthritis, Peripheral Vascular Disease, and Atrial fibrillation. A review of the clinical record revealed that the resident was seen by the physician on the following dates: September 25, 2014, October 15, 2014, and December 27, 2014. From October 15, 2014 to December 27, 2014, there was no documented evidence of a physician visit for 58 days. On April 1, 2015 at approximately 4:00 PM, a face-to-face interview was conducted with Employees #1 and 2. They acknowledged the	F 387	1-A- Residents #43, #52, #63, and #65 were seen by their attending physician, however, the visits didn't follow the required 30 days sequence for 90 days after admission. 1-B- Resident # 32 was seen March 25, 2015, April 24th, 2015 and May 5th, 2015. Resident # 46 was seen December 27, 2014, January 26, 2015, March 9th, 2015, and March 27th, 2015. 2-A- An audit of residents' records was conducted which identified 14 residents presently in the window of requiring every 30 days visits. The audit identified three residents that were out of compliance, needing visits. The physician was contacted and the visits were made. 2-B- An audit of residents' records identified 45 residents who require a visit every 60 days, and 45 out of 45 records were in compliance.	05/15/15 05/15/15 05/15/15 05/15/15

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F 387	Continued From page 11 aforementioned findings. The clinical record was reviewed on March 31, 2015. 3. The physician failed to ensure that Resident #63 was seen at least once every 30 days for the first 90 days post admission to the facility. A review of the physician's history and physical signed and dated July 10, 2014, and timed 6:02 PM revealed that Resident #63 was admitted to the facility on July 8, 2014 at 1:30 PM with diagnoses that included: Acute Kidney Failure, Hypertension, Diverticulitis, Encephalopathy, Pneumonia, Breast Malignancy and Mental Disorder. Further review of the clinical record revealed the subsequent physician visit dates and notes: July 12 and 28, 2014, September 30, 2014, January 1, 2015, and March 26, 2015. From September 30, 2014 to January 1, 2015, there was no documented evidence of a physician visit for 91 days. On April 1, 2015 at approximately 4:00 PM, a face-to-face interview was conducted with Employee #1, regarding the visit absences. He/she acknowledged the aforementioned findings. The clinical record was reviewed March 31, 2015. 4. The physician failed to ensure that Resident #65 was seen at least once every 30 days for the first 90 days post admission to the facility. A review of Resident #65's record revealed that the resident was admitted to the facility on July 18, 2014. An attending admission note and a	F 387	3-A-B- The Medical Director issued a letter to the attending physicians reminding them that residents need to be seen at least once every 30 days for the first 90 days following admission and at least 60 days thereafter. 4-A- Audits of residents' records will continue to be conducted to ensure that residents are seen at least once every 30 days for the first 90 days following admission. The audit will be conducted weekly for four weeks, then monthly for three months, then quarterly for two quarters. 4-B- Audits of residents' records will continue to be conducted to ensure that residents are seen at least once every 60 days. The audit will be conducted weekly for four weeks, then monthly for three months, and then quarterly for two quarters. The results of these audits will be presented to the Quality Assurance and Performance Improvement Committee for further recommendations	05/15/15 05/15/15 05/15/15

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F 387	Continued From page 12 history and physical examination was completed on July 21, 2014. The physician visited the resident on July 28, 2014, August 14, 2014, December 18, 2014 and December 27, 2014, as evidenced by his/her progress notes in the resident's clinical record. The resident's clinical record lacked documented evidence that the physician visited the resident, and wrote a progress note during the months of September and October 2014. A face-to-face interview was conducted with Employee #6 on March 31, 2015 at approximately 11:50 AM. After reviewing the resident's clinical record, he/she acknowledged the aforementioned findings. The clinical record was reviewed March 31, 2015. B. Based on record review and staff interview for two (2) of 34 sampled residents, it was determined that the attending physician failed to conduct a resident visit at least once every 60 days for two (2) residents. Residents' #32 and 46. The findings include: 1. The physician failed to ensure that Resident #32 was seen at least once every 60 days. A review of the physician's history and physical signed and dated July 1, 2014, and timed 6:20 PM revealed that Resident #32 was admitted to the facility on June 13, 2011 at 5:00 PM with diagnoses that included Dementia, Depression, Dysrhythmia, Hypertension, Hypothyroidism, Congestive Heart Failure, and Cerebrovascular	F 387		

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F 387	Continued From page 13 Accident. A review of physician visits for the period of July 2014 through January 2015 revealed physician progress notes were recorded on July 27, 2014 and January 1, 2015. There was no evidence that the physician conducted visits for approximately five (5) months between July 2014 and January 2015. On April 1, 2015 at approximately 4:00 PM, a face-to-face interview was conducted with Employee #1, regarding the visit absences. He/she acknowledged the aforementioned findings. The clinical record was reviewed on March 31, 2015. 2. The physician failed to ensure that Resident #46 was seen at least once every 60 days. A review of the clinical record revealed that the resident was seen by the physician on the following dates: July 1, 2014, October 15, 2014 and November 16, 2014. From July 1, 2014 to October 15, 2014, there was no documented evidence of a physician visit note for 105 days. On April 1, 2015 at approximately 4:00 PM, a face-to-face interview was conducted with Employees #1 and #2. They acknowledged the aforementioned findings. The clinical record was reviewed on March 31, 2015.	F 387		
F 456 SS=E	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION	F 456		

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F 456	Continued From page 14 The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: A. Based on observations during the Medication Storage review, record review and staff interview, it was determined that facility staff failed to maintain patient care equipment in safe operating condition as evidenced by failing to act on out-of-range quality control test results while assessing glucometers [a medical device for determining the approximate concentration of glucose in the blood] for accuracy in two (2) of two (2) log books reviewed. The findings include: Facility staff failed to act on quality control test results that were outside of manufacturer's established ranges when verifying glucometer devices for accuracy. The quality control method that facility staff used to verify the accuracy of glucometers included the use of " Assure Dose Control Solution" [a testing solution]. A review of the manufacturer ' s guidelines for use of the testing solution included the following: Under the section labeled "Troubleshooting:" " If the result is outside the range printed on the test strip bottle [established range], repeat the	F 456	It is the Army Distaff Foundation and Knollwood's practice to maintain all essential mechanical, electrical and patient care equipment in a safe operating condition and ensure that daily quality checks are consistently conducted. 1. A modified Glucose Monitoring Log Sheet was immediately put into effect on 3/25/15 to include parameters for glucose monitoring based on the information on the test strips being used. Staff was inserviced on how to complete the logs. .	05/15/15

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F 456	Continued From page 15 test. One or more of the following may cause an out of range result: · The meter was not placed in control solution mode before adding solution. Refer to manual or test strip insert for more information · The control solution is expired or contaminated · The control solution was stored below 35 (degrees) (2 C) [2 degrees Celsius] or above 86 F [86 degrees Fahrenheit] (30C) [30 degrees Celsius] · The test strip was not stored correctly · The test strip was no used after the expiration date on the bottle · The test strip was open for more than 90 days (3 months) · The test strip is inserted incorrectly · The meter has been damaged or has malfunctioned · The first drop of control solution was not discarded · The control solution is contamination as the tip of the control solution bottle touched the test strip Repeat the test, using new control solution or a new test strip, as appropriate. Compare the result with the range printed on the test strip bottle you are using...Please Note: If your Assure Dose Control Solution result continues to read outside	F 456	2. On 3/25/15, an audit was completed and staff was inserviced on the protocol to follow when the values are outside of the parameters. On 5/5/15 an audit was completed and addressed. In addition, a modified form was designed. 3. Nursing Staff will be inserviced on how to: -Maintain the Glucometer in a safe operating condition -Perform daily control quality checks and document results accurately on the Glucometer Monitoring Log Sheet.	05/15/15 05/15/15

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F 456	Continued From page 16 the required range printed on the test strip label, the system may not be working correctly. DO NOT USE the system to test your blood glucose until the control solution result is within the acceptable range ... " A review Glucometer Log sheets for the Health Services Center [HSC] residential unit revealed testing was conducted on two (2) glucometers; identified as " Device [handheld glucometer machine] #1 and Device #2 " with results that were less than the manufacturer ' s established range as follows: " High control test range " 233 - 291 [Range established by manufacturer; when the device functions accurately, the " high " results should fall within this range] · December 21, 2014 - Device #2; Result: 227; Actions: No comment recorded Normal control test range 90 - 113 [Range established by manufacturer; when the device functions accurately, the " normal " results should fall within this range] · December 21, 2014 - Device #2; Result: 82; Actions: No comment recorded · December 27, 2014 - Device #1 Result: 89; Actions: No comment recorded · December 27, 2014 - Device #2; Result: 87;	F 456	-Trouble shoot, using the manufactures trouble shooting guidelines, when the Glucose Test is out of range, to ensure accuracy of the glucometer readings. 4. The ADON/Designee will conduct a weekly audit for four weeks, then monthly for three months, then quarterly for two quarters to ensure that the glucometer is operating in a safe condition as well as the daily quality control checks are accurately and consistently conducted and documented. The result of this audit will be reported to the Quality Assurance and Performance Committee for further recommendations.	05/15/15

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F 456	Continued From page 17 Actions: No comment recorded · December 28, 2014 - Device #1; Result: 86; Actions: No comment recorded · December 28, 2014 - Device #2; Result: 89; Actions: No comment recorded · February 1, 2015 - Device #2; Result: 89; Actions: No comment recorded A review of the "Glucometer Log" sheets for the Special Care Center [SCC] residential unit revealed that one (1) glucometer device was tested with results that were less than the manufacturer ' s established range as follows: " Normal control test " range 96 - 120: · December 30, 2014 - Result 95; Actions: No comment recorded " High control test " range 255 - 318: · March 6, 2015 - Result: 243; Actions: No comment recorded · March 8, 2015 - Result: 244; Actions: No comment recorded · March 9, 2015 - Result: 236; Actions: No comment recorded · March 10, 2015 - Result: 243; Actions: " Out of range " recorded with no evidence of further actions There was no evidence that when the quality	F 456		

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F 456	Continued From page 18 control values were out of range, facility staff implemented " troubleshooting" measures to verify the accuracy of the glucometer devices. A face-to-face interview was conducted with Employees' #4 and 9 on March 25, 2015 at approximately 2:30 PM, regarding the aforementioned glucometer log concerns. They both acknowledged the findings. The records were reviewed on March 25, 2015. Based on Medication Storage observations and record review for two (2) of two (2) glucometers logs, it was determined that the facility staff failed to maintain equipment in safe operating condition as evidenced by out of range glucometer control test results that were not addressed. B. Based on Medication storage observations and record review for one (1) of two (2) glucometers [a medical device for determining the approximate concentration of glucose in the blood], it was determined that the facility staff failed to consistently monitor glucometer devices to ensure that they were in safe operating condition. The findings include: A review of the "Glucometer Logs" for the Health Services Center (HSC) revealed that daily quality control checks were inconsistently conducted. Glucometer Logs for the period of December 2014 to March 2015 revealed that there were no	F 456		

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F 456	Continued From page 19 recorded glucometer control checks on the dates listed below. The logs were blank in the allotted spaces for the test results. December 8, 2014 January 2, 6, 16, 19, and 30, 2015 March 8, 2015 March 24, 2015 There was no evidence that facility staff monitored glucometer devices on the aforementioned days to ensure that they were in safe operating condition. A face-to-face interview was conducted with Employee #4 on March 25, 2015 at 2:30 PM. He/she acknowledged the findings.	F 456		
F 492 SS=E	483.75(b) COMPLY WITH FEDERAL/STATE/LOCAL LAWS/PROF STD The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. This REQUIREMENT is not met as evidenced by: A.Based on record review and staff interview for two (2) of 34 sampled residents, it was determined that the facility staff failed to comply with federal and state laws, as evidenced by failure to ensure that the attending physician, who admitted Resident #76, and prescribed a	F 492	It is the Army Distaff Foundation and Knollwood's practice to operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility.	

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F 492	Continued From page 20 controlled substance for Resident #7, had a current District of Columbia license to practice medicine and a current District of Columbia Controlled Substances registration. The findings include: 1. The facility staff failed to ensure that the attending physician had a current District of Columbia license to practice. According to Title 22B DCMR 3207.1 (h), "The Medical Director shall ensure that attending medical professionals who treat residents in the facility have current District of Columbia licenses and U.S. Drug Enforcement Agency and District of Columbia Controlled Substances registration on file in the facility... " A review of Resident #76's record revealed that the resident was admitted to the facility on January 6, 2015 for skilled care, under Employee #11's medical service. A review of the clinical record revealed "Admission Orders" were signed and dated by Employee #11 on January 8, 2015. A review of Employee #11's District of Columbia license revealed an expiration date of December 31, 2014. There was no documented evidence that Employee #11 had a current District of Columbia license to administer medical services to residents in the facility. The clinical record was reviewed on March 31, 2015. This was a closed record.	F 492	1. Contracted services with Employee #11 was terminated, effective March 26, 2015. At this time, Contracted Employee #11's medical licenses are in processing for reinstatement and to be retroactive. As of 5/6/15, DC Department of Health records indicate that Contracted Employee #11 licenses are identified as "reinstatement pending."	05/15/15

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F 492	Continued From page 21 A face-to-face interview was conducted with Employees #1 and #3 on March 31, 2015 at approximately 1:00 PM. Both acknowledged the aforementioned findings. Employee #1 further stated that the physician had been contacted three times in regards to his /her license renewal. Employee #23 added that the physician was asked on January 6, 2015, January 22, 2015, and February 2, 2015 to provide evidence of license renewal. Employee #1 stated, "[He/she] just did not do it." 2. Facility staff failed to ensure that the attending physician had a current District of Columbia Controlled Substances registration. According to Title 22B DCMR 3207.1 (h) , "The Medical Director shall ensure that attending medical professionals who treat residents in the facility have current District of Columbia licenses and U.S. Drug Enforcement Agency and District of Columbia Controlled Substances registration on file in the facility... " The facility staff failed to ensure that the attending physician had a current District of Columbia Controlled Substances registration on file in the facility. A review of Resident #7's record revealed that the resident was admitted to the facility on February 13, 2015 for skilled care, under Employee #11's medical service. A review of a physician's order signed and dated by Employee #11 on February 13, 2015 revealed the following, "Oxycodone [narcotic analgesic] 5mg [milligrams], Quantity #120, ½ tablet (2.5 mg) po [by mouth] q [every] 4h [hours] prn [as	F 492	2. On March 25, 26, and 27, 2015, an Adhoc Quality Assurance and Improvement Committee Meetings were held. An action plan was developed and acted upon. Residents that were assigned to Contract Employee #11's were immediately reassigned to another attending physician. Under the care of their new attending physician, they were re-evaluated and their medical records were reviewed on March 27, 2015. 3. Knollwood will continue to monitor physician medical licenses along with the controlled substance license and discontinue services with physicians that do not renew their licenses timely. The Medical Director has sent out a correspondence to attending physicians, outlining the requirements of all physicians, in order to maintain good standing at this organization.	05/15/15 05/15/15

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F 492	Continued From page 22 needed] moderate pain ... " A review of Employee #11's District of Columbia Controlled Substances registration revealed an expiration date of December 31, 2014. There was no documented evidence that Employee #11 had a current District of Columbia Controlled Substances registration. A face-to-face interview was conducted with Employees #1 and #3 on March 31, 2015 at approximately 1:00 PM. Both acknowledged the aforementioned findings. Employee #1 further stated that the physician had been contacted three times in regards to his /her District of Columbia Controlled Substances registration renewal. Employee #23 added that the physician was asked on January 6, 2015, January 22, 2015, and February 2, 2015 to provide evidence of registration renewal. Employee #1 stated, " He just did not do it." The records were reviewed on March 31, 2015. B. Based on record review and staff interviews it was determined that the facility failed to operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services as evidenced by employing a registered nurse that did not have a current District of Columbia license to practice. The findings include: Title 22B of the District of Columbia Municipal Regulations for Nursing Facilities section 3209.2(b) stipulates, "Each Nursing Services	F 492	4. A physician credentialing log, consisting of license renewal dates, will continue to be maintained to ensure DC physician licenses are current. The physician credentialing log will continue to be updated by the Administrator or designee and reviewed monthly by the Chief Operating Officer (COO) to identify potential areas of concern. The COO will review and validate the credentialing log with a paper copy of the licenses in order to keep credentialing up-to-date and in compliance with federal and state regulations. The Administrator or designee will develop a quality assurance audit tool and submit the tool and findings of the monthly audit reviews to the Quality Assurance and Improvement Committee for two quarters. The results of the audits will be reviewed by the Quality Assurance Performance and Improvement Committee. The Committee will determine if further action is needed.	05/15/15

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F 492	Continued From page 23 Supervisor shall be currently licensed as a registered nurse in the District of Columbia." Title 17 of the District of Columbia Municipal Regulations for Registered Nursing section 5409.1 stipulates, "A licensee shall renew his or her license by submitting a complete application on the forms required by the Board and paying the required fees prior to the expiration of the license." A review of the personnel record for Employee #14 revealed that his/her license to practice as a Registered Nurse expired on June 30, 2014. The summary of his/her job description under the section titled Certificates, Licenses, and Registrations revealed that he/she must be a Registered Nurse with a current license to practice in the District of Columbia. A review of the "Timecard Manager" [method for clocking in and out] revealed that Employee #14 worked the following shifts without a District of Columbia nursing license: July 5, 6, 12, 13, 20, 26 and 27, 2014 August 2, 3, 9, 10, 16, 17, 23, 24, 30 and 31, 2014 September 6, 13, 14, 20, 21, 27 and 28, 2014 October 4, 5, 11, 12, 18, 19, 25 and 26, 2014 November 1, 2, 8, 9, 15, 16, 22, 23, 29 and 30, 2014 December 6, 13, 14, 20, 21, 27 and 28, 2014	F 492	It is the Army Distaff Foundation and Knollwood's practice to monitor and ensure that health care professionals renew their licenses timely 1. Employee #14 employment terminated effective March 27, 2015. There were no identified incidents of a resident's care or safety being negatively affected during the time employee #14 did not hold a renewed District of Columbia license. Employee #14 was a weekend supervisor and did not provide direct resident care. 2. Adhoc Quality Assurance and Improvement Meetings were held on March 27, 30, 2015 and April 2, 2015. The tracking log for District of Columbia RN licenses was reviewed and RN licenses were verified to be current.	05/15/15 05/15/15

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F 492	Continued From page 24 January 3, 4, 10, 11, 17, 18, 24, 25 and 31, 2015 February 1, 14, 15 and 28, 2015 March 1, 14 and 15, 2015 On April 1, 2015 at approximately 3:00PM, a face-to-face interview was conducted with Employees #1 and 3 regarding Employee #14, who worked without a District of Columbia license. Employee #1 and 3 acknowledged the aforementioned findings. The records were reviewed on March 31, 2015. C. Based on observations made on March 27, 2015 at approximately 10:30 AM, it was determined that the facility failed to maintain the resident's environment free of accident hazards as evidenced by elevated water temperatures in six (6) of eight (8) resident's rooms on the Health Services Center unit. The findings include: 22 DCMR 3236.4 stipulates "The temperature of hot water of each fixture that is used by each resident shall be automatically controlled and shall not exceed one-hundred and ten degrees Fahrenheit (110 F) nor be less than ninety-five degrees Fahrenheit (95 F). " Water temperatures were tested in resident's rooms on the HSC Unit. In six (6) of eight (8) resident rooms water temperatures were above 110 degrees Fahrenheit including rooms #4, #7,	F 492	3. The RN license tracking log will be updated by the Executive Assistant and reviewed monthly by the Executive Assistant to identify potential areas of concern. The Administrator or designee will review and validate the RN license log with a paper copy of the professional license in order to validate employees District of Columbia RN licenses are up-to-date and in compliance with federal and state regulations. 4. The Executive Assistant developed a quality assurance audit tool and is submitting the tool and findings of the monthly audit reviews to the Quality Assurance and Improvement Committee. Findings will be submitted to the committee for two quarters. The Committee will determine if further action is needed.	05/15/15 05/15/15

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	095026	A. BUILDING _____ B. WING _____	04/01/2015

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F 492	Continued From page 25 #13, #15, #18, and #25. Room #4 tested at 113.0 degrees F Room #7 tested at 110.3 degrees F Room #13 tested at 117.0 degrees F Room #15 tested at 117.0 degrees F Room #18 tested at 118.4 degrees F Room #25 tested at 120.0 degrees F Water temperatures for all rooms noted above were tested again at approximately 2:00 PM on March 27, 2015. They were all between 95 degrees F and 110 degrees F. These observations were made in the presence of Employee #17 who acknowledged the findings.	F 492	It is the Army Distaff Foundation and Knollwood's practice to monitor and ensure that all water temperatures are within acceptable range. 1. The water temperatures that were found on March 27, 2015 to be out of acceptable range were immediately corrected. The temperatures were tested again that same day and found to be between the acceptable range of 95 and 110 degrees. 2. The Engineering staff tested water temperatures throughout the units and found no other water temperatures to be out of acceptable range. 3. Water temperatures are checked by the engineering staff on a daily basis and immediately adjusted as needed to remain within acceptable range.	05/15/15 05/15/15 05/15/15
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.	F 514	4. The Chief Engineer/designee will conduct in-services and training for Engineering staff to reinforce the proper water temperature checking procedures to ensure compliance monthly for three (3) consecutive months and then quarterly for (3) consecutive quarters. The trainings will be presented to and reviewed by the Quality Assurance Performance and Improvement Committee quarterly. The Committee will determine if further action is needed.	05/15/15

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F 514	Continued From page 26 This REQUIREMENT is not met as evidenced by: A. Based on record review and staff interviews for three (3) of 34 sampled residents, it was determined that the facility staff failed to maintain clinical records in accordance with accepted professional standards and practices as evidenced by: failure to correct inaccurate documentation in one (1) resident's medical record; the physician's failure to document one (1) resident's allergy to sulfur and all pertinent diagnoses on the admitting history and physical; and staff's failure to accurately transcribe an order for Lasix (diuretic medication) for one (1) resident. Residents' #50, 71, and 87. The findings include: 1. Facility staff failed to correct inaccurate documentation in Resident #50's electronic medical record. A review of Resident #50's annual history and physical dated May 24, 2015 revealed the following diagnoses: "Past Syncope without clear etiology, Hyperlipidemia with Carotid Atherosclerosis, GERD (Gastroesphogeal Reflux Disease), Status Post Right Knee Replacement and Advanced Dementia." A review of Resident #50's nursing note dated September 4, 2014 revealed: "Resident [family member] in hallway at 6:15 PM calling nurse to room, resident in distress, displaying universal signs of choaking [choking]. Heimlich performed, after several maneuvers resident cough[ed] up a large piece of chicken. Monitored closely until stable. Resident alert and responsive, requested	F 514	It is the Army Distaff Foundation and Knollwood's practice to maintain complete and accurate clinical records. 1(a) The nurse's note and care plan record of resident # 50 were corrected to show that the entry was an error. 1(b) The admitting H&P for resident #71 was amended by the attending physician to include all pertinent diagnoses and allergy to sulfur. 1(c) The clinical records of resident #87 was corrected on 3/26/15 to reflect Lasix (Furosemide) 40mg po QD for Edema, CHF (hold for systolic blood pressure less than 100). Employee #16 was inserviced on how to correctly document telephone/verbal physician orders. 2(a) A random audit will be conducted by the ADON/Designee to ensure that accurate documentation is entered in the resident's clinical record. 2(b) An audit will be conducted by the ADON/Designee to ensure that allergies and pertinent diagnoses are included in the resident's H&P. 2(c) An audit will be conducted by the ADON/Designee to ensure that physician's telephone/verbal orders are accurately documented on the Physician Order Sheet (POS).	05/15/15 05/15/15 05/15/15 05/15/15 05/15/15

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F 514	Continued From page 27 more food. Offered apple sauce, tolerated well. Stated that [he/she] is doing well. [Physician named] called and informed. No new orders. [Family member] on scene during the entire incident." A review of the resident's care plan revealed it was amended to include that Resident #50 experienced a "choking incident " on September 4, 2015. A face-to-face interview was conducted on March 31, 2015 with Employees #3 regarding the aforementioned findings. After reviewing the record, he/she stated that the documentation in Resident #50's clinical record was "an error." He/she explained that the incident occurred with another resident, and that Resident #50 had not experienced any "choking" episodes. There was no evidence that facility staff corrected inaccurate documentation in Resident #50's electronic medical record. The clinical record was reviewed on March 31, 2015. 2. The physician failed to document Resident #71's sulfur allergy and other diagnoses, in the physician's admitting history and physical. A review of the Admission Minimum Data Set [MDS] dated November 23, 2014 revealed that Resident 371 was admitted to the facility on November 17, 2014 with diagnoses that included: Asthma, Chronic Obstructive Pulmonary Disease, Emphysema, Edema, Urinary Retention, Depression, and Drug Allergy. A review of the physician's admission orders signed and dated November 18, 2014 revealed that the resident was allergic to sulfur and the	F 514	3(a) Licensed Nursing Staff will be inserviced on how to document accurately in the nurses notes and how to correct erroneous entries. 3(b) A letter was drafted by the Medical Director to all physicians reminding them to include allergies and pertinent diagnoses in the admitting H&P of residents. 3(c) Licensed Nursing staff will be inserviced on how to document physician's telephone/verbal orders accurately on the POS. 4. An audit of the clinical records will be conducted weekly for three weeks, then monthly for four months, then quarterly for three quarters to ensure compliance. The result of these audits will be presented to the Quality Assurance Performance and Improvement Committee for further recommendations.	05/15/15 05/15/15 05/15/15 05/15/15

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F 514	Continued From page 28	F 514		

resident ' s medication regimen included: Fluoxetine [anti-depressant], furosemide [diuretic for treatment of edema], Spiriva [bronchodialator], tamsulosin [relaxes prostate muscle], and ipratropium-albuterol [bronchodialator].

A review of the physician's admitting history and physical dated November 19, 2014 and timed 23:24 [11:24 PM] revealed the following: "Allergies to food, medications, and other" were left blank. The admitting diagnoses documented were "Advanced COPD [Chronic Obstructive Pulmonary Disease] and debility."

There was no evidence that the physician documented/recorded the resident's medication allergy and active diagnoses in the admission history and physical examination.

On March 27, 2015 at approximately 11:30 AM, a face-to -face interview was conducted with Employee #20 regarding the allergy and diagnoses omissions. He/she acknowledged the aforementioned findings. The clinical record was reviewed on March 27, 2015.

3. Facility staff failed to accurately transcribe an order for Lasix for Resident #87.

A review of the physician's history and physical signed and dated March 10, 2015 revealed that the resident was admitted to the facility on March 9, 2015 with diagnoses that included Congestive Heart Failure, Atrial Fibrillation, Chronic Obstructive Pulmonary Disease, Cerebrovascular Accident, and Acute Renal Failure.

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F 514	Continued From page 29 A review of Interim physician's orders dated March 18, 2015 and timed at 4:00 PM revealed an order to "increase Furosemide [generic name for Lasix] to 40mg [milligrams] once daily for Edema and CHF [Congestive Heart Failure]." A review of a telephone order dated March 18, 2015, and timed 20:15 [8:15PM] by staff revealed the following, " T.O. [telephone order] [named physician]/[staff signature] Clarification of Furosemide order: Furosemide 4mg once daily for Edema and CHF. Hold for SBP [systolic blood pressure] less than 100. A review of the March 2015 Medication Administration Record revealed the following: "Furosemide oral tablet 40 mg, one tablet po [by mouth] one time a day 9:00 AM, for Edema and CHF. Hold for SBP less than 100." A face-to-face interview was conducted on March 26, 2015 at approximately 4:00 PM with Employee #16, regarding the telephone order and the transcribed dose for the Lasix. He/she stated, "I meant to write 40mg of Lasix, not 4mg. That should read 40mg." The clinical record was reviewed on March 25, 2015.	F 514		
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the	F 520	It is the Army Distaff Foundation and Knollwood practice of the Quality Assurance Performance Improvement Committee to develop, implement and/ or revise appropriate corrective actions for identified deficient practices.	

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F 520	Continued From page 30 facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: A. Based on observations, clinical record reviews and staff interviews, it was determined that the facility's Quality Assessment and Assurance (QAA) committee failed to develop, implement, and/or revise appropriate corrective actions for identified deficient practices. The findings include: During the recertification survey, the following areas of concern were identified: A. Physician Services	F 520	1-A- The issues of a physician failing to sign and date residents' progress notes, and the frequency of physician visits were identified prior to the survey process. The facility had informed the physician in January, 2015 that he needed to provide a copy of his current license. Multiple contacts had been made to him requesting such. The indication in his response to requests was that he had a current license and could provide a copy. On March 25, 26, and 27, 2015, Adhoc Quality Assurance and Improvement Committee Meetings were held and an action plan was developed and acted on. A part of the action plan included the notification to the DC Department of Health and termination of this attending physician's ability to continue to see residents. 1-B- Employee # 14 expired licensed was identified March 27th, 2015. Adhoc Quality Assurance and Improvement Meetings were held on March 27, 30, 2015 and April 2, 2015. An action plan was developed and acted on. The DC DOH and Nursing Board were notified. The tracking log for RN licenses was reviewed and RN licenses were verified to be current. 2-A- Physician failing to sign and date residents' progress notes, the frequency of physician visits, and the failure to ensure that one attending physician had a current license were all brought to the Quality Assurance Performance Improvement Committee on May, 5th 2015.	05/15/15 05/15/15 05/15/15

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F 520	Continued From page 31 483.40 (b) F386, Physician Visits - the attending physician failed to sign and date the resident's progress notes at each visit. 483.40 (c) F387, Frequency of Physician Visits - the attending physician failed to conduct a resident visit at least once every 30 days for the first 90 days after admission for four (4) residents; and the attending physician failed to conduct a resident visit at least once every 60 days for three (3) residents. 483.75, CFR 492, Comply with Federal, State, and local laws and professional standards - facility staff failed to comply with federal and state laws, as evidenced by failure to ensure that the attending physician, who admitted Resident #76, and prescribed a controlled substance for Resident #7, had a current District of Columbia license and a current District of Columbia Controlled Substances registration. On April 1, 2015 at approximately 3:00 PM, a face-to-face interview was conducted with Employees #1, 3, and 23, regarding their QAA Committee Meetings and identification of the concerns listed above. Employee #1 stated that the committee met on August 13, 2014, November 5, 2014 and February 4, 2015. He/she further stated, "[Staff names] conduct audits when the physician completes the history and physical and sign the orders. They are not doing 30 and 60 day audits for physician visits. We have one person reviewing licenses now. We will have two people moving forward. The	F 520	3-A-Audit systems are in place to identify deficient practices in the facility. For those deficient practices identified, appropriate corrective actions were taken and the deficient practices, along with the corrective actions, were and will continue to be brought to the Quality Assurance Performance Improvement Committee. 3-B- The facility has established a double check system, on a monthly basis to ensure that RN nursing employees have a current District of Columbia license. 4-A-B- Findings will be submitted to the committee for two quarters. The Committee will determine if further action is needed.	05/15/15 05/15/15 05/15/15

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F 520	Continued From page 32 physician was asked to provide [his/her] license multiple times. He/she just did not do it." Employee #1 stated that they had an issue with obtaining the physician's current license. However, there was no evidence that the Quality Assurance Committee developed corrective measures to address the identified issue and to address the subsequent concerns related to the physician's failure to have an active license to practice in the District of Columbia. B. Nursing Services 483.75, CFR 492 Facility failed to operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services as evidenced by employing a registered nurse that did not have a current license. (Cross reference to 483.20 (k) (3)(i), F281 Services Provided Meet Professional Standards) Title 22B of the District of Columbia Municipal Regulations for Nursing Facilities section 3209.2(b) stipulates, "Each Nursing Services Supervisor shall be currently licensed as a registered nurse in the District of Columbia." Title 17 of the District of Columbia Municipal Regulations for Registered Nursing section 5409.1 stipulates, "A licensee shall renew his or her license by submitting a complete application on the forms required by the Board and paying the required fees prior to the expiration of the license."	F 520		

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F 520	Continued From page 33 A review of the personnel record for Employee #14 (Registered Nurse) revealed that his/her license to practice as a Registered Nurse expired on June 30, 2014. The summary of his/her job description under the section titled Certificates, Licenses, and Registrations revealed that he/she must be a Registered Nurse with a current license to practice in the District of Columbia. On April 1, 2015 at approximately 3:00PM, a face-to-face interview was conducted with Employees #1 and 3 regarding Employee #14, who worked without a District of Columbia license. Employee #1 and 3 acknowledged the aforementioned findings. The records were reviewed on March 31, 2015.	F 520		