Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0020	A. BUILDING: ______ B. WING ______	02/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANSITIONS HEALTHCARE CAPITOL CITY	**2425 25TH STREET SE WASHINGTON, DC 20020**

(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 Transitions Healthcare Capitol City from January 25, 2018 through February 2, 2018. Survey activities consisted of a review of 70 sampled residents. The following deficiencies are based on observation, record review and staff interviews. 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 Lbs - Pounds (unit of mass) MAR - Medication Administration Record MD- Medical Doctor	L 000	Transitional Care Center Capitol City is filing this Plan of Correction in accordance with State requirements. Submission of this Plan of Correction is not an admission of any of the deficiencies identified are correct. This Plan of Correction is to serve as the facility's credible allegation of compliance with all the State requirements of participation for Licensure.	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 3/21/18

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L 000	Continued From page 1 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 Trach- Tracheostomy 3. Nursing staff were inserviced on care	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;	L 051	3210.4 Nursing Facilities Resident #179, #494, #646 1. Care plans for sever anemia, continuous oxygen, and seizure disorder were completed upon discovery. 2. All care plans were reviewed and no other care plans were required to be developed. 3. Nursing staff were inserviced on care plan development and implementation which reflects relevant resident diagnoses. The Nursing Quality Improvement Team will monitor the development and implementation of relevant care plans on a monthly basis and forward the results of their monitoring to the Director of Nurses. 4. The Director of Nurses will present his analysis of these monitoring efforts with any action plans for improvement to the Quality Assurance/Quality Improvement Committee which meet monthly and is chaired by the Administrator.	2/1/18 2/1/18 3/10/18 3/16/18

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L 051	Continued From page 2	L 051		

(c)Reviewing residents' plans of care for appropriate goals and approaches, and revising them as needed;

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

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

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

A. Based on observations, record review and interviews for three (3) of 70 sampled residents, the facility staff failed
to develop care plans with appropriate goals and approaches to address care services for one (1) resident with a diagnosis of Severe Anemia; for one (1) resident who receives oxygen therapy and for one (1) resident with a diagnosis of Seizure Disorder. Residents #179, 494 and 646

Findings included...

1. Facility staff failed to develop and implement a person-centered care plan to reflect a resident's current diagnosis of Severe Anemia. Resident #179.

On February 1, 2018, a review of the Resident #179 medical admission record showed the following diagnoses: Squamous cell Carcinoma of skin, Hypertension, Chronic Pain, Chronic Obstructive Pulmonary Disease.

On February 1, 2018, a review of the medical record laboratory data sheet with a date of

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December 13, 2017, showed a hemoglobin of 9.1 g/dL (Grams per Deciliter) [normal 13.5-17.5] and hematocrit of 28.7 g/dL (Grams per Deciliter) [normal 41.0-53.0].

A review of the medical record Interim Order Form with a date of January 7, 2018, stipulated, "Please arrange for transfusion to (hospital name) on Tuesday, January 9th Monday for transfusion of packed red blood cells (RBCs)."

A further review of the medical record showed "(hospital name) discharge/transfer summary with a date of January 9, 2018, revealed the admitting and discharge diagnosis was Severe Anemia, [an abnormally low hemoglobin level and/or level of circulating red blood cells, decreases the blood's oxygen-carrying capacity within the body] s/p (status-post) transfusion.

Retrieved from:
http://nursing.ceconnection.com/ovidfiles/00152193-201301000-00013.pdf.

On February 1, 2018, a review of the resident's laboratory data form with a date of January 24, 2018 showed the "hemoglobin 8.7 g/dL and hematocrit 26.0 g/dL".

A review of the resident's care plan on February 1, 2018, at approximately 10:00 AM did not show the facility staff initiated a person-centered care plan with goals and interventions to address the care and treatment for the resident's active diagnosis of Severe Anemia.

During a face-to-face interview on February 1, 2018, at approximately 10:30 AM with Employee # 7, she stated, "Yes, the [Resident # 179] has

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L 051	Continued From page 4	L 051		

Anemia and I should have created a care plan." Employee #7 acknowledged the findings.

2. Facility staff failed to develop a care plan with goals and approaches to address care needs for Resident #494 who receives continuous oxygen (O2).

During an interview with Resident #494 on January 31, 2018, at 1:40 PM, the resident was observed receiving oxygen via nasal cannula. She stated, "I need longer oxygen tubing so I can move about my room without interrupting the flow of oxygen and lose my breath".

A review of the Resident #494's medical record showed an admission date of January 1, 2018, which include diagnoses: Human Immunodeficiency Disease Pneumoycstosis, Pneumonia, and Asthma.

A Physician's order signed and dated January 20, 2017, directed, Oxygen via nasal cannula at 2 liters titrate to keep oxygen saturations greater than or equal 95 percent every six (6) hours as needed for shortness of breath or wheezing.

A review of the care plan section of the clinical record revealed that there was no plan of care developed with goals and approaches to address the care needs of Resident #494 receiving oxygen therapy.

During a face-to-face interview with Employee #8 on January 31, 2018, at 11:00 AM, the employee acknowledged the findings after reviewing the resident's care plan.

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L 051	Continued From page 5 3. Facility staff failed to initiate and implement a person-centered care plan with goals and interventions to address a resident's diagnosis of Seizure Disorder. Resident #646. Resident #646 admitted to the facility on November 15, 2017, with diagnoses of Encephalopathy, Extrapyramidal Reaction, History of Cerebrovascular Accident (CVA), Hypertension and Seizure Disorder. A review of the Physician's order with a dated of November 15, 2017, directed, Levetiracetam tablet 1000 mg - give one (1) tablet by mouth two (2) times a day for Seizure Disorder. Section I [Active Diagnoses] of the admission Minimum Data Set completed on December 8, 2017, included a diagnosis of Seizure Disorder. A review of Resident #646's clinical record lacked evidence that facility initiated a care plan to include goals and interventions to address the resident's active diagnosis of Seizure Disorder. During a face-to face-interview with Employee #9 on January 31, 2018, at 4:45 PM, the employee 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	L 052		

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L 052	Continued From page 6 rehabilitative nursing care as needed; (b)Proper care to minimize pressure ulcers and contractures and to promote the healing of ulcers: (c)Assistants in daily personal grooming so that the resident is comfortable, clean, and neat as evidenced by freedom from body odor, cleaned and trimmed nails, and clean, neat and well-groomed hair; (d) Protection from accident, injury, and infection; (e)Encouragement, assistance, and training in self-care and group activities; (f)Encouragement and assistance to: (1)Get out of the bed and dress or be dressed in his or her own clothing; and shoes or slippers, which shall be clean and in good repair; (2)Use the dining room if he or she is able; and (3)Participate in meaningful social and recreational activities; with eating; (g)Prompt, unhurried assistance if he or she requires or request help with eating; (h)Prescribed adaptive self-help devices to assist him or her in eating independently; (i)Assistance, if needed, with daily hygiene, including oral acre; and j)Prompt response to an activated call bell or call for help.	L 052		

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This Statute is not met as evidenced by:
A. Based on observation, record review and staff interview for four (4) of 70 sampled residents, the facility failed to provide resident-directed care in accordance with professional standards of practice as evidenced by failure: to follow the physician's order for the use of an assistive device (scoop plate) to serve one (1) resident all meals; to administer normal saline in accordance with the mid-line flushing protocol for one (1) resident; and to administer one (1) resident their antihypertensive medications in accordance with the physician's orders. Residents' # 180, #331 and #648.

Findings included...

1. The Charge Nurse failed to follow doctor's order to use a scoop plate (a high rimmed adaptive plate used to promote independence while eating) to serve Resident #180 all of her meals.

A review of the medical record showed an Interim Order Form dated January 19, 2018," OT (Occupational Therapist) clarification order: Pt. (patient) to be served all meals on a scoop plate with suction base to improve efficiency and indep (independence) during feeding.

A further review of the medical record showed an Occupational Therapist Progress note dated January 31, 2018, "The patient is able to feed utilizing scoop dish for of meal requiring set up (assist for device retrieval or modification of environment while seated upright) [sic].

Provider's Plan of Correction:

3211.1 Nursing Facilities
1. Resident #180
1. Resident was re-evaluated for the need for a scoop plate. The order was discontinued. — 2/1/18
2. A facility-wide audit was done for all residents ordered an assistive device and all were in compliance. — 2/2/18
3. Nursing staff were inserviced to ensure that all orders for assistive devices are carried out. The Nursing Quality Improvement Team will monitor the use of and orders for assistive devices monthly. The results their monitoring efforts will be forwarded to the Director of Nurses for his analysis. — 3/10/18
4. The Director of Nurses will present his analysis of these monitoring efforts with any action plans for improvement to the Quality Assurance/Quality Improvement Committee which meet monthly and is chaired by the Administrator. — 3/16/18

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Observation on February 1, 2018, at approximately 12:45 PM showed, Employee #28 CNA, (Certified Nurse Assistant) feeding the resident lunch from a plate without a high rim and suction base. At the time of the observation, Employee #4, Registered Nurse, was asked to observe the resident eating. Employee# 44 stated, "Yes, she is my patient, and I don't know anything about a scoop plate, I see her eating from a regular plate."

According to the annual Minimum Data Set (MDS) completed on November 21, 2017, Under Section G Functional Status the resident is coded as "independent with eating and required set up help from staff."

During an interview on February 1, 2018, at approximately 1:30 PM with Employee #22, Occupational Therapist, she stated, "She can eat independently with a scoop plate I would take her breakfast off of the regular plate and put it on a scoop plate." Employee #7, Clinical Nurse Manager, stated, "I did not know anything about a scoop plate, if there is a new order they would come and tell me, I will send this down to the kitchen so she can get her scoop plate, I missed this order."

Employee#7 and #22 acknowledged the finding at the time of the observation.

2. The Charge Nurse failed to administer normal saline in accordance with the mid-line flushing protocol for Resident # 331.

A review of the Mid-line Catheter Protocol dated October 16, 2017, stipulated the flushing protocol

Provider's Plan of Correction:

2. Resident #331

1. This resident experienced no adverse effects as a result of this finding. — 2/1/18
2. There were no other residents affected. The facility batch orders were revised for IVs in the electronic health record, Point Click Care, to be reflective of the inclusion of normal saline flushes which is actual IV protocol used in the facility. — 2/2/18
3. Licensed nurses were inserviced about the corrected IV protocol. The Nursing Quality Improvement Team will monitor the IV protocol monthly. The results their monitoring efforts will be forwarded to the Director of Nurses for his analysis. — 3/10/18
4. The Director of Nurses will present his analysis of these monitoring efforts with any action plans for improvement to the Quality Assurance/Quality Improvement Committee which meet monthly and is chaired by the Administrator. — 3/16/18

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L 052	Continued From page 9 as: "Use SASH (Saline antibiotic saline and heparin) Technique Intermittent Meds ...5 ML NSS (Normal saline solution) before Med, 5 ML NSS After Med, then 5 ML 10 units/ML Heparin Flush." The Physician's order dated October 17, 2017, at 0000 [12:00 AM] directed, Normal saline flush solution 0.9 %, use 10 ml intravenously every six (6) hours for IV [intravenous] until 10/25/17. According to the October 2017 Medication Administration Record, the facility staff administered 10 mls of normal saline every six (6) on October 17 at 12:00 AM, 6:00 PM, 12:00 PM, and 6:00 PM on October 18, at 12:00 AM. There was no evidence that facility staff administered 5mls of normal saline solution before and after administration of the antibiotic in accordance with the flushing protocol (SASH). During a face-to-face, interview with Employee #2 on February 2, 2018, at approximately 11:30 AM, he acknowledged the findings. 3. The Charge Nurse failed to withhold an antihypertensive medication when blood pressure dropped below the parameters for administration outlined in the physician's orders for Resident #648. Physician's orders for January 2018, directed, Metoprolol Tartrate (anti-hypertensive) tablet 50mg- Give one (1) tablet by mouth two (2) times a day for tachycardia. Hold for systolic blood pressure less than 110 or diastolic blood pressure	L 052	3. Resident #648 1. This resident was not adversely effected by these findings. 2. A review of the Medicine Administration Records of all residents on anti-hypertensives with their stated parameters was done with no other corrections needed. 3. Licensed nurses were inserviced about anti-hypertensive parameters. The Nursing Quality improvement Team will monitor for compliance monthly. The results their monitoring efforts will be forwarded to the Director of Nurses for his analysis. 4. The Director of Nurses will present his analysis of these monitoring efforts with any action plans for improvement to the Quality Assurance/Quality Improvement Committee which meet monthly and is chaired by the Administrator	2/2/18 2/4/18 3/10/18 3/16/18

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L 052	Continued From page 10 less than 60. Review of the MAR (Medication Administration Record) dated January 2018 showed: Metoprolol Tartrate 50mg- Give one (1) tablet by mouth two (2) times a day for tachycardia. Hold for systolic blood pressure less than 110 or diastolic blood pressure less than 60. Resident's blood pressure readings recorded on the MAR were 102/60 mmHg on January 6, 2018, and 106/75 mmHg on January 25, 2018. On both dates, Resident #648 received the medications. The facility staff failed to withhold the medication when the systolic readings were less than the prescribed parameter for the systolic blood pressure of 110mmHg. During a face-to-face interview with Employee #8 on February 1, 2018, at approximately 4:15 PM, Employee #8 acknowledged both findings. B. Based on observations, record review, resident and staff interviews of two (2) of 70 sampled residents, facility failed to provide sufficient nursing time to ensure that one (1) resident's call system was connected, functioning, and within reach, and failed to respond to one (1) resident's call light to provide him with necessary assistance. Residents' #12 and #193. Findings included... 1. The Charge Nurse failed to ensure that Resident #12's call system was connected,	L 052	B. 1. Resident #12 1. The call light was re-positioned upon discovery. 2. All other call lights were reviewed and corrections made whenever necessary. 3. Nursing staff were inserviced on the need to have the call light always visible and within reach. The Nursing Quality Improvement Team will monitor call light placement, visibility and response time on a monthly basis and report their findings to the Director of Nurses. 4. The Director of Nurses will present his findings and any action plans for improvement to the Quality Assurance/ Quality Improvement Committee which meets monthly and is chaired by the Administrator.	1/29/18 1/29/18 3/10/18 3/16/18

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L 052	Continued From page 11 functioning and within his reach. On January 29, 2018, at approximately 2:00 PM during a face-to-face interview with Resident #12 his call bell was not visible and within his reach. Employee #8 queried as to the whereabouts of the resident's call light. She looked around the room and found the call light behind the privacy curtains in his roommate's area. The resident's Quarterly Minimum Data Set (MDS) dated October 11, 2017, revealed the following: Under Section I-Active Diagnoses included Heart Failure, Hypertension, Pneumonia, Diabetes Mellitus, Hyperlipidemia, Depression, and Asthma. Under Section G, Functional Status - the resident required extensive assistance with bed mobility, transfer, and was totally dependent on staff for toilet use. During a face-to-face interview with Employee #8 on January 29, 2018, at approximately 2:10 PM, she acknowledged the findings. 2. Then nursing staff failed to respond to Resident #193's call light to provide him with assistance. On January 26, 2018, at 1:45 PM, Resident #193 was lying in her bed watching television and pressing the call light. Someone answered the call light and the resident stated, "I need help to use the bathroom." The Staff replied, "I will let your nurse know." It was 30 minutes later as the	L 052	2. Resident #193 1. The resident was assisted immediately upon discovery. 2. There were no other issues with call light response time noted. 3. Nursing staff will be inserviced regarding quick response to call lights from residents. The Nursing Quality Improvement Improvement Team will monitor call light placement, visibility and response time on a monthly basis and report their findings to the Director of Nurses. 4. The Director of Nurses will present his findings and any action plans for improvement to the Quality Assurance/ Quality Improvement Committee which meets monthly and is chaired by the Administrator.	1/29/18 1/29/18 3/10/18 3/16/18

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(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 052	Continued From page 12 surveyor was leaving the resident's room the Certified Nurse Aide (CNA) came to assist the resident. The CNA told the resident, "I am sorry, I was with another resident." The resident's Quarterly Minimum Data Set (MDS) dated October 11, 2017, revealed the following: Under Section I - Active Diagnoses included Hypertension, Diabetes Mellitus, Seizure Disorder, Anxiety Disorder, and Depression. Under Section G, Functional Status - the resident required extensive assistance with bed mobility, transfer, and was totally dependent on staff for toilet use. During a face-to-face interview conducted on January 26, 2018, at 2:00 PM with Employee #6, he acknowledged the findings.	L 052		
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	3211.5 Nursing Facilities 1. Nursing hours of 4.1 per patient day was not met on the day of review. 2. There were no untoward effects on the residents. 3. The Director of Human Resources and the Director of Nurses have increased their attention on the hiring and retention of licensed nurses and certified nursing assistants. The facility has been working with the CNA program at the University of the District of Columbia in an effort to recruit their students who have attended this facility during their clinical rotation. Scheduling and staffing requirements are Reviewed constantly throughout each day to ensure the appropriate levels are achieved. The Director of Human Resources and Director of Nurses will monitor these efforts at recruitment, retention and scheduling on a daily basis. 4. The results of these monitoring efforts along with any plans of action for improvement will be presented by the Director of Human Resources and the Director of Nurses to the Quality Assurance/ Quality Improvement Committee which meets monthly and is chaired by the Administrator.	2/2/18 2/2/18 3/9/18 3/9/18

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	HFD02-0020	A. BUILDING: ________ B. WING ________	02/02/2018

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L 056	Continued From page 13	L 056		

hours], it was determined that the facility failed to meet four and one tenth (4.1) hours of direct nursing care per resident day for11 of 22 days reviewed, in accordance with Title 22 DCMR Section 3211, Nursing Personnel and Required Staffing Levels.

Findings include:

A review of Nurse Staffing was conducted with the Staffing Coordinator on February 02 at approximately 11:00AM.

According to the District of Columbia's 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.

The review of the direct nursing care per resident per day hours determined that the staffing levels failed to meet the required four and one tenth (4.1) hours of direct nursing care per resident day on 11 of 22 days reviewed. The staffing for the 11 days is outlined below.

January 11, 2018 = 4.06
January 12, 2018 = 3.95
January 13, 2018 = 3.6
January 14, 2018 = 3.4
January 15, 2018 = 3.77
January 16, 2018 = 4.0
January 20, 2018 = 4. 0
January 22, 2018 = 4.0
January 25, 2018 = 3.9

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L 056	Continued From page 14 January 27, 2018 = 4.0 January 28, 2018 = 4.06 February01, 2018 = 4.0 As outlined above the facility failed to comply with the requirement of the District of Columbia's Municipal Regulation; Title 22 DCMR Section 3211, Nursing Personnel and Required Staffing Levels which stipulates that, "each facility shall provide a minimum daily average of four and one tenth (4.1) hours of direct nursing care per resident per day. The finding was acknowledged by Employee #29 at the time of the review.	L 056		
L 108	3220.2 Nursing Facilities The temperature for cold foods shall not exceed forty-five degrees (45°F) Fahrenheit, and for hot foods shall be above one hundred and forty degrees (140°F) Fahrenheit at the point of delivery to the resident. This Statute is not met as evidenced by: Based on observations during a test tray assessment on January 30, 2018, at approximately 1:15 PM, it was determined that hot foods temperatures were not maintained at the point of service at a minimum temperature of 140 degrees Fahrenheit (F) as required. Findings included ... According to 22 DCMR 3220.2, "The temperature for cold foods shall not exceed forty-five (45	L 108	3220.2 Nursing Facilities 1. Temperatures taken at the residents did not meet standards. 2. Temperatures in the kitchen and at the serving lines in the dining rooms were in excess of the standard but regrettably the temperatures fell at the point of delivery to the residents. 3. Dining Services is now calling each unit as the trays are ready to be rolled on to the unit to ensure the quick delivery of food at the proper temperatures. Additionally, residents are being encouraged to take their lunch and dinner in the dining rooms for quickness of services, maintenance of appropriate temperatures and socialization. CNAs and nurses have been inserviced about the need to quickly deliver trays to the residents to ensure proper temperatures. The Director of Dining Services and the Nursing QI Team will monitor food temperatures on a routine basis. 4. The results of these monitoring efforts will be presented by the Director of Dining Services to the QAPI Committee which is chaired by the Administrator.	1/30/18 1/30/18 3/10/18 3/10/18

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L 108	Continued From page 15 degrees) Fahrenheit, and for hot foods shall be above one hundred and forty (140 [degrees]) Fahrenheit at the point of delivery to the resident." Hot foods such as Fried Fish (137.5 degrees F), Macaroni and Cheese (128.5 degrees F), Cooked Spinach (135.9 degrees F), Puree Fish (123.4 degrees F), Puree Macaroni and Cheese (124 degrees F), Puree Spinach (127.8 degrees F) tested at less than the required minimum of 140 degrees Fahrenheit (F). These observations were made in the presence of Employee #11 who acknowledged the findings.	L 108		
L 128	3224.3 Nursing Facilities The supervising pharmacist shall do the following: (a)Review the drug regimen of each resident at least monthly and report any irregularities to the Medical Director, Administrator, and the Director of Nursing Services; (b)Submit a written report to the Administrator on the status of the pharmaceutical services and staff performances, at least quarterly; (c)Provide a minimum of two (2) in-service sessions per year to all nursing employees, including one (1) session that includes indications, contraindications and possible side effects of commonly used medications; (d)Establish a system of records of receipt and disposition of all controlled substances in	L 128		

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L 128	Continued From page 16 sufficient detail to enable an accurate reconciliation; and (e)Determine that drug records are in order and that an account of all controlled substances is maintained and periodically reconciled. This Statute is not met as evidenced by: Based on observations during medication administration, medication storage and staff interview for one () of 70 sampled residents, the facility staff failed to assure that services being provided meet professional standards of quality as evidenced by failure to reconcile controlled medications for one (1) resident. Residents' #179. Findings included... 1.Facility failed to reconcile the control substance medication record for Resident # 179. On January 29, 2018, a review of Resident #179's, clinical record showed diagnoses to include Squamous cell Carcinoma of the skin, Hypertension, Chronic Pain, and Chronic Obstructive Pulmonary Disease. Medication reconciliation process observation on January 29, 2018, at approximately 3:30 PM with Employee #7, Clinical Nurse Manager, showed a discrepancy with the narcotic count for Resident #179. At the time of the observation, Resident #179's individual controlled substance record showed a pill count of 19 for Oxycodone/APAP/ Tab 5/325 mg (milligrams) [RX #24417636]. However, the blister pack containing the medication Oxycodone/APAP/ Tab 5/325 mg showed a pill count of 18.	L 128	1. Resident #179 1. The narcotic book was signed immediately upon discovery. The involved nurse was given education on the correct protocol for signing for the administration of Controlled Substances. 2. A review of all of the Narcotic Books was performed and all were in compliance. 3. Licensed nurses were inserviced about The policy of signing off on Narcotic Logs The Nursing Quality Improvement Team will monitor for compliance monthly. The results their monitoring efforts will be forwarded to the Director of Nurses for his analysis. 4. The Director of Nurses will present his analysis of these monitoring efforts with any action plans for improvement to the Quality Assurance/Quality Improvement Committee which meet monthly and is chaired by the Administrator	1/29/18 1/29/18 3/10/18 3/16/18

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L 128	Continued From page 17 During an interview with Employee #24, Registered Nurse, stated, "I did not sign for the medication can I sign it out now, I gave it already, I forgot to sign." Employee #24, Clinical Nurse Manager, stated, "You were supposed to sign it before now." Facility staff failed to document the administration of a controlled drug after administering the medication to Resident#179, in accordance with acceptable standards of clincal practice. Employees #7 and #24 acknowledged the finding at the time of the observation.	L 128		
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 (d)Be in good working order at all times. This Statute is not met as evidenced by: Based on observations, resident and staff	L 306	3245.10 Nursing Facilities 1. Resident #12 1. The call light was re-positioned upon discovery. 2. All other call lights were reviewed and Corrections made whenever necessary. 3. Nursing staff were inserviced on the need to have the call light always visible and within reach. The Nursing Improvement Team will monitor call light placement, visibility and response time on a monthly basis and report their findings to the Director of Nurses. 4. The Director of Nurses will present his findings and any action plans for improvement to the Quality Assurance/ Quality Improvement Committee which meets monthly and is chaired by the Administrator.	1/29/18 1/29/18 3/10/18 3/16/18

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L 306	Continued From page 18	L 306		

interviews, the facility staff failed to ensure that one (1) resident's call system was within reach, and three (3) of six (6) call bells did not alarm when tested.

Findings included...

1. On January 29, 2018, at approximately 2:00 PM during a face-to-face interview with Resident #12, the call bell was not visible or within reach.

When Employee #8 was asked about the location of the resident's call light, she looked around the room and found the call light behind the privacy curtains in the roommate's area.

The resident's Quarterly Minimum Data Set (MDS) dated October 11, 2017, showed the following:

Under Section I-Active Diagnoses included Heart Failure, Hypertension, Pneumonia, Diabetes Mellitus, Hyperlipidemia, Depression, and Asthma.

Under Section G, Functional Status - the resident required extensive assistance with bed mobility, transfer, and was totally dependent on staff for toilet use.

The facility staff failed to ensure the call bell was within reach for Resident #12 to facilitate contacting the staff.

During a face-to-face interview with Employee #8 on January 29, 2018, at approximately 2:10 PM,

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L 306	Continued From page 19 she acknowledged the findings. 2. Observations on January 31, 2018, between 11:45 AM and 4:00 PM and February 1, 2018, between 9:20 AM and 11:30 AM, showed three (3) call bells failed to alarm when activated as follows: A. Two (2) resident room call lights in Rooms #212A and 359A B. One (1) of four (4) call bells in the 3 North shower room The observations made, in the presence of Employee #15, were acknowledged.	L 306	2. Resident Rooms #212A and 359A, 3N Shower Room 1. Maintenance staff repaired the cited call bells immediately upon discovery. 2. Call bells throughout the facility were checked and repairs provided if necessary. All call bells were in compliance. 3. The Maintenance staff was inserviced on the repair and upkeep of the call bells. and continue to monitor them in resident rooms every day. Results of their monitoring efforts are brought to the Director of Facilities for his review. 4. The Director of Facilities will present his findings and any action plans for improvements to the Quality Assurance/ Quality Improvement Committee which meets monthly and is chaired by the Administrator.	2/1/18 2/2/18 2/16/18 3/16/18
L 359	3250.1 Nursing Facilities Each food service areas shall be planned, equipped, and operated in accordance with Title 23 DCMR, Chapter 22, 23 and 24, and with all other applicable District laws and regulations. This Statute is not met as evidenced by: Based on observations made in the kitchen on January 25, 2018, at approximately 9:30 AM, the facility failed to prepare and distribute foods under sanitary conditions as evidenced by plastic debris inside the ice scoop holder and two (2) of two (2) soiled grease fryers. Findings included... 1. A piece of plastic debris observed inside the ice scoop holder.	L 359	3250.1 Nursing Facilities 1. The plastic debris inside the ice scoop holder and the grease found on the outside of the fryer were taken care of immediately upon discovery. 2. All other areas of the kitchen were in compliance. 3. These cited areas were added to the cooks' walk through protocol to ensure on-going compliance. Any areas of concern are forwarded to the Director of Dining Services for his analysis. 4. The Director of Dining Services will present his analysis of these monitoring efforts with any action plans for improvement to the Quality Assurance/Quality Improvement Committee which meet monthly and is chaired by the Administrator	1/25/18 1/25/18 2/15/18 3/16/18

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L 359	Continued From page 20 2. Two (2) of two (2) grease fryers soiled on the outside with grease stains. The observations made in the presence of Employee #11 were acknowledged.	L 359	3256.4 Nursing Facilities 1. Surge Protector 1. The noted surge protector was secured immediately upon discovery. 2. All other surge protectors were properly secured. 3. The securing of surge protectors was Inserviced to the Maintenance Staff. The Maintenance Quality Improvement Team will inspect/monitor the surge protectors monthly. The results of these monitoring efforts will be brought to the Director of Facilities for his review. 4. The Director of Facilities will present his findings and any action plans for improvements to the Quality Assurance/ Quality Improvement Committee which meets monthly and is chaired by the Administrator. 2. Call bell cords 1. The noted call bell cords were replaced immediately upon discovery. 2. All other call bell cords were inspected and all were in compliance. 3. The Maintenance staff was inserviced on the inspection and replacement of call bell cords. The Maintenance Quality Improvement will inspect the call bell cords monthly. The results of these monitoring efforts will be brought to the Director of Facilities for his review. 4. The Director of Facilities will present his findings and any action plans for improvement will be presented to the Quality Assurance/Quality Improvement Committee which meets monthly and is chaired by the Administrator.	2/1/18 2/1/18 2/16/18 3/16/18 2/1/18 2/1/18 2/16/18 3/16/18
L 413	3256.4 Nursing Facilities Each housekeeping employee shall keep the facility free from offensive odor accumulation of dirt, rubbish, dust, and hazards. This Statute is not met as evidenced by: Based on observations made during an environmental tour of the facility on , facility failed to provide an environment that is free from accident hazards. Findings included ... Observations on January 31, 2018, between 11:45 AM and 4:00 PM and on February 1, 2018, between 9:20 AM and 11:30 AM showed potential accident hazards as follows: 1. A surge protector in use, unsecured, on the floor and under the bed of one (1) resident in one (1) of 53 resident rooms. 2. Call bells cords frayed in two (2) of 53 resident rooms including Rooms #121 (Beds A and B) and 132 (Bed A). The observations made in the presence of Employee #15 were acknowledged.	L 413		