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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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L. 000	Transitions Healthca 25, 2018 through Fe activities consisted residents. The follo observation, record The following is a di acronyms that may Abbreviations AMS - Altered ARD - assess BID - Twice B/P - Blood cm - Centir CMS - Centel Services CNA- Certifi CRF - Comp D.C District Regulations D/C Discontinu DI - decilit DMH - Depart EKG - 12 lea EMS - Emerg G-tube Gastr HSC Heal HVAC - Heating ID - Intell IDT - interdis L - Liter Lbs - Poun MAR - Medica	d Pressure meters rs for Medicare and Medicar ed Nurse Aide munity Residential Facility ct of Columbia of Columbia Municipal	d on didon	Transitional Care Center Capitol (filing this Plan of Correction in acc with State requirements. Submis this Plan of Correction is not an act of any of the deficiencies identified correct. This Plan of Correction is serve as the facility's credible alled compliance with all the State requirements of participation for Licensure.	ordance sion of dmission d are s to gation of
Health Regul	ation & Licensing Administ PIRECTOR'S OR PROYUGE	ration (SUPPLIER REPRÉSENTATIVE'S SIG	NATURE /	TALE	(X6) DATE

STATE FORM

FORM APPROVED Health Regulation & Licensing Administration (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: _ B. WING 02/02/2018 HFD02-0020 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2425 25TH STREET SE TRANSITIONS HEALTHCARE CAPITOL CITY WASHINGTON, DC 20020 (X5) COMPLETE DATE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) L 000 Continued From page 1 L 000 : Minimum Data Set MDS milligrams (metric system unit of Mq mass) milliliters (metric system measure of mL volume) milligrams per deciliter mg/dl millimeters of mercury mm/Hg midnight MN Neurological Neuro -NP -Nurse Practitioner PASRR - Preadmission screen and Resident Review Peg tube - Percutaneous Endoscopic Gastrostomy POby mouth POS physician 's order sheet Prn -As needed Patient Pt -3210.4 Nursing Facilities Every Q-Resident #179, #494, #646 Quality Indicator Survey QIS -1. Care plans for sever anemia, continuous Responsible party Rp, R/P -2/1/18 oxvaen, and seizure disorder were Special Care Center SCC completed upon discovery. Sol-Solution Treatment Administration Record 2. All care plans were reviewed and no TAR -2/1/18 other care plans were required to be Trach- Tracheostomy developed. 3. Nursing staff were inserviced on care 3. Nursing staff were inserviced on care plan development and implementation L 051 L 051 3210.4 Nursing Facilities which reflects relevant resident diagnoses. 3/10/18 The Nursing Quality Improvement Team will A charge nurse shall be responsible for the monitor the development and implementation following: of relevant care plans on a monthly basis and forward the results of their monitoring to (a)Making daily resident visits to assess physical the Director of Nurses. and emotional status and implementing any 4. The Director of Nurses will present his 3/16/18 required nursing intervention; analysis of these monitoring efforts with any action plans for improvement to the

(b)Reviewing medication records for completeness,

accuracy in the transcription of physician orders,

and adherences to stop-order policies;

Quality Assurance/Quality Improvement

Committee which meet monthly and is

chaired by the Administrator.

Health R	<u>equiation & Licensinc</u>	Administration	······································			LUIS BATE OUR VEV
	OF DEFICIENCIES	(X1) PROVIDER/SUPP		(X2) MULTIPLE ((X3) DATE SURVEY COMPLETED	
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L 051	Continued From page	ge 2	and the second	L 051		
	(c)Reviewing reside appropriate goals at them as needed;	nts' plans of care nd approaches, ar	for nd revising			
	(d)Delegating respo direct resident nursi	ng care of specific	residents;			:
	(e)Supervising and employee on the ur		ursing			·
	(f)Keeping the Direct her designee inform This Statute is not	ned about the stati	us of residents.			
	A. Based on observe interviews for three facility staff failed	vations, record rev (3) of 70 sampled	iew and residents, the			
	to develop care pla approaches to addr resident with a diag (1) resident who recone (1) resident w Disorder. Residents	ess care services mosis of Severe A ceives oxygen the with a diagnosis of	for one (1) nemia; for one rapy and for Seizure			
	Findings included		10			:
	1. Facility staff faile person-centered cacurrent diagnosis of the control of the	are plan to reflect and f Severe Anemia. 18, a review of the record showed the country cell Carcinomic Pain, Chronic	a resident's Resident #179. Resident #179 e following a of skin,	Ì		
	On February 1, 20 ² laboratory data she	18, a review of the	medical record			

Health Re	egulation & Licensing	Administration		- LONG	
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY COMPLETED
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L 051	Continued From pag	ge 3	L 051		
	g/dL (Grams per De	r, showed a hemoglobin of 9.1 eciliter) [normal 13.5-17.5] and g/dL (Grams per Deciliter)			!
	with a date of Janua arrange for transfus	dical record Interim Order Form ary 7, 2018, stipulated, "Please sion to (hospital name) on oth Monday for transfusion of ells (RBCs)."			
	"(hospital name) dis date of January 9, 2 discharge diagnosis abnormally low hen circulating red blood	the medical record showed scharge/transfer summary with 2018, revealed the admitting an swas Severe Anemia, [an noglobin level and/or level of d cells, decreases the blood's pacity within the body] s/p usion.	a		
	Retrieved from: http://nursing.cecor 201301000-00013.	nnection.com/ovidfiles/0015219 pdf.	93-		
:	laboratory data form	18, a review of the resident's m with a date of January 24, hemoglobin 8.7 g/dL and /dL".			
	2018, at approxima facility staff initiated with goals and inter	ident's care plan on February 1 ately 10:00 AM did not show the d a person-centered care plan rventions to address the care a esident's active diagnosis of	•		
	at approximately 10	ce interview on February 1, 20 0:30 AM with Employee # 7, sh Resident # 179] has	18, le		

Health R	equlation & Licensing	<u> Administration</u>			
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:	ONSTRUCTION	(X3) DATE SURVEY COMPLETED
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L 051	Continued From pag	ge 4	L 051		
	Anemia and I should	d have created a care plan." wledged the findings.			
	2. Facility staff failed	d to develop a care plan with es to address care needs fo	r		
	Resident #494 who (O2).	receives continuous oxygen			
	31, 2018, at 1:40 PM receiving oxygen via need longer oxygen	with Resident #494 on Janu M, the resident was observed a nasal cannula. She stafed, tubing so I can move about upting the flow of oxygen and	d "I my		: .
	lose my breath".				!
	showed an admission which include diagn	ident #494's medical record on date of January 1, 2018, loses: Human Immunodeficie stosis, Pneumonia, and Asth	ency nma.		
	2017, directed, Oxy titrate to keep oxyge	signed and dated January 2 gen via nasal cannula at 2 li en saturations greater than o very six (6) hours as needed or wheezing.	ters or		
	record revealed that developed with goa	e plan section of the clinical t there was no plan of care Is and approaches to addres tesident #494 receiving oxyg	ss jen		
	January 31, 2018, a	ce interview with Employee #at 11:00 AM, the employee findings after reviewing the i.	#8 on		

Health R	<u>egulation & Licensing</u>	Administration			
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L 051	Continued From pag	ge 5	L 051		
	person-centered car	d to initiate and implement a re plan with goals and ress a resident's diagnosis of esident #646.			:
	15, 2017, with diagr Extrapyramidal Rea	itted to the facility on November noses of Encephalopathy, action, History of acident (CVA), Hypertension and			:
	November 15, 2017	sician's order with a dated of ', directed, Levetiracetam table (1) tablet by mouth two (2) cure Disorder.	it		
	Minimum Data Set	agnoses] of the admission completed on December 8, agnosis of Seizure Disorder.			:
	evidence that facilit	nt #646's clinical record lacked y initiated a care plan to include ions to address the resident's Seizure Disorder.			
į	During a face-to face January 31, 2018, a acknowledged the f	ce-interview with Employee #9 o at 4:45 PM, the employee findings.	n l		
L 052	3211.1 Nursing Fac		L 052		
	Sufficient nursing ti resident to ensure to receives the following		· One of the second sec		į
	(a)Treatment, medi supplements and fl	ications, diet and nutritional uids as prescribed, and			

	of DEFICIENCIES	(X1) PROVIDER/SUF	PPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
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IRANOIII				TON, DC 20	PROVIDER'S PLAN OF CORREC	TION (X5)
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∟ 052	Continued From page	ge 6		L 052		!
	rehabilitative nursin	g care as needed	d;	:		
į	(b)Proper care to m contractures and to	ninimize pressure promote the hea	ulcers and iling of ulcers:			i
	(c)Assistants in dail resident is comfortatevidenced by freed trimmed nails, and hair;	able, clean, and n om from body od	eat as or, cleaned and			: : : :
ļ	(d) Protection from	accident, injury, a	and infection;	:		
	(e)Encouragement, self-care and group	, assistance, and activities;	training in			ł
	(f)Encouragement	and assistance to	o;	;		i
'	(1)Get out of the be or her own clothing shall be clean and	j; and shoes or sl	e dressed in his ippers, which	A Commence of the Commence of		
	(2)Use the dining re	oom if he or she	is able; and			# :
	(3)Participate in me activities; with eatir	eaningful social a ng;	ind recreational			
	(g)Prompt, unhurrie requires or request	ed assistance if h t help with eating	ne or she ;			
	(h)Prescribed adap him or her in eating independently;		vices to assist			
	(i)Assistance, if ne including oral acre		nygiene,			
	j)Prompt response help.	to an activated c	call bell or call for	•		
1	i			1		į.

Health Re	equiation & Licensing	Administration				,,
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SU	JRVEY LETED
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TRANSIT	IONS HEALTHCARE C	CAPITOL CITY WASHING	TON, DC 20)		
	OLDMANDY CT	ATEMENT OF DEFICIENCIES	1D	PROVIDER'S PLAN OF CORRECTION	٧	(X5)
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		dance yr.				
L 052	Continued From pag	no 7	L 052			
L 002	Continued From pay	ge i				į
:		met as evidenced by:				
	A. Based on observ	ation, record review and staff		3211.1 Nursing Facilities		
	interview for four (4)	of 70 sampled residents, the	į	1. Resident #180	لدمومو	2/4/49
	facility failed to prov	ide resident-directed care in		1. Resident was re-evaluated for th	ie need	2/1/18
	accordance with pro	ofessional standards of practice		for a scoop plate. The order was	!	
	as evidenced by fail	lure: to follow the physician's		discontinued. 2. A facility-wide audit was done for	r all	
	order for the use of	an assistive device (scoop]	residents ordered an assistive device		2/2/18
	plate) to serve one	(1) resident all meals; to saline in accordance with the	i	all were in compliance.	o arra	2.2.10
	administer normal s	otocol for one (1) resident; and to	; `	Nursing staff were inserviced to e	nsure	
	mid-line liustiing pro	esident their antihypertensive	, ,	that all orders for assistive devices		
	modications in acco	ordance with the physician's		carried out. The Nursing Quality Imp		:
	ordere Residents'	# 180, #331 and #648.		Team will monitor the use of and ord		
	Oldela, Residents	1 100, 100 Talia ii o te.		for assistive devices monthly. The	results	
				their monitoring efforts will be forwa	rded	3/10/18
	: Findings included		:	to the Director of Nurses for his ana	lysis.	
	i		j	4. The Director of Nurses will presen	nt his	3/16/18
				analysis of these monitoring efforts	with any	
	1. The Charge Nurs	se failed to follow doctor's order		action plans for improvement to the		
	to use a scoop plate	e (a high rimmed adaptive plate	į	Quality Assurance/Quality Improver		
	used to promote inc	dependence while eating) to	1	Committee which meet monthly and	IS	ı
	serve Resident #18	0 all of her meals.	1	chaired by the Administrator.		
		dical record showed an Interim	1			
	Order Form dated	January 19, 2018," OT				
	(Occupational Ther	apist) clarification order: Pt.	:	}		
	(patient) to be serve	ed all meals on a scoop plate o improve efficiency and indep	1			
	(independence) du	ring fooding	į			
	. (maepenaence) aui	mig recuirg.	ļ.			1
	A further review of	the medical record showed an				
	Occupational Thera	apist Progress note dated				
	January 31, 2018	The patient is able to feed				
	utilizina scoop dish	for of meal requiring set up	1			
	(assist for device re	etrieval or modification of				
	environment while	seated upright) [sic].				
		· - · - ·	it.			
1						

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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L 052	Continued From pag	ge 8	L 052		
	12:45 PM showed, Nurse Assistant) for plate without a high time of the observations.	ruary 1, 2018, at approxim Employee #28 CNA, (Certi eeding the resident lunch f rim and suction base. At t tion, Employee #4, Registe o observe the resident eati	ified from a he ered	 Resident #331 This resident experienced no adverfiects as a result of this finding. There were no other residents af 	fected.
i	Employee# 44 state don't know anything eating from a regula	ed, "Yes, she is my patient. g about a scoop plate, I sec ar plate."	, and l e her	The facility batch orders were revifor IVs in the electronic health recorpoint Click Care, to be reflective of inclusion of normal saline flushes wactual IV protocol used in the facility	rd, 2/2/18 the rhich is
	completed on Nove Functional Status th	nual Minimum Data Set (Number 21, 2017, Under Sec ne resident is coded as eating and required set up	ction G	3. Licensed nurses were inserviced the corrected IV protocol. The Nurs Improvement Team will monitor the protocol monthly. The results their monitoring efforts will be forward to the Director of Nurses for his and 4. The Director of Nurses will present the service of Nurses will present the correction of Nurses will be corrected to the corrected to the correction of Nurses will be corrected to the c	about ing Quality IV arded 3/10/18 alysis.
	approximately 1:30 Occupational Thera independently with breakfast off of the scoop plate." Emplo stated, "I did not kn plate, if there is a n tell me, I will send t	on February 1, 2018, at PM with Employee #22, apist, she stated, "She can a scoop plate I would take regular plate and put it on byee #7, Clinical Nurse Malow anything about a scool ew order they would come his down to the kitchen so plate, I missed this order."	e her a anager, p e and	analysis of these monitoring efforts action plans for improvement to the Quality Assurance/Quality Improve Committee which meet monthly and chaired by the Administrator.	with any ment
	Employee#7 and #2 the time of the obse	22 acknowledged the findi ervation.	ng at		:
	2. The Charge Nurs saline in accordance protocol for Reside	se failed to administer non se with the mid-line flushing th # 331.	mal g		
	A review of the Mid October 16, 2017,	I-line Catheter Protocol da stipulated the flushing prot	ted tocol		
1			i.		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2)	MULTIPLE C	ONSTRUCTION	(X3) DATE SU	
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L 052	Continued From page	ge 9	<u>L</u> :	052		!	
	Technique Intermitte saline solution) before then 5 ML 10 units/ The Physician's ord 0000 [12:00 AM] dis	antibiotic saline and hepa ent Meds5 ML NSS (No ore Med, 5 ML NSS After M ML Heparin Flush." der dated October 17, 207 rected, Normal saline flush 10 ml intravenously every	ormal Med, 17, at	9	3. Resident #648	:	
	According to the Oc Administration Rec	enous] until 10/25/17. ctober 2017 Medication ord, the facility staff admin aline every six (6) on Octol PM, 12:00 PM, and 6:00	istered ber 17		1. This resident was not adversely elby these findings. 2. A review of the Medicine Administ Records of all residents on anti-hypewith their stated parameters was dorno other corrections needed. 3. Licensed nurses were inserviced.	ration ertensives ne with about	2/2/18
	administered 5mls and after administra accordance with th	ence that facility staff of normal saline solution b ation of the antibiotic in e flushing protocol (SASH)).		anti-hypertensive parameters. The Nouality improvement Team will mon compliance monthly. The results their monitoring efforts will be forward to the Director of Nurses for his anal 4. The Director of Nurses will preser analysis of these monitoring efforts to the control of the contro	itor for ded ysis. nt his	3/10/18 3/16/18
	During a face-to-fa on February 2, 201 acknowledged the	ace, interview with Employ 8, at approximately 11:30 findings.	ree #2 AM, he		action plans for improvement to the Quality Assurance/Quality Improven Committee which meet monthly and chaired by the Administrator	nent is	! : :
	antihypertensive m dropped below the outlined in the phys	se failed to withhold an nedication when blood pres parameters for administra sician's orders for Residen for January 2018, directed	ation nt #648.				
	Metoprolol Tartrate 50mg- Give one (1 day for tachycardia	e (anti-hypertensive) tablet) tablet by mouth two (2) to a. Hold for systolic blood p lastolic blood pressure	imes a				:

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	X3) DATE SURVEY COMPLETED
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L 052 Continued From pa	age 10	L 052		
less than 60.				
Record) dated Jan Tartrate 50mg- Giv times a day for tac	R (Medication Administration uary 2018 showed: Metoprolol re one (1) tablet by mouth two (2) hycardia. Hold for systolic blood 110 or diastolic blood pressure			
MAR were 102/60 106/75 mmHg on	ressure readings recorded on the mmHg on January 6, 2018, and January 25, 2018. On both dates, eived the medications.			
when the systolic r	iled to withhold the medication eadings were less than the eter for the systolic blood pressure			;
February 1, 2018,	ace interview with Employee #8 o at approximately 4:15 PM, nowledged both findings.	n :	В.	
and staff interview residents, facility f time to ensure that was connected, further failed to respond to	ervations, record review, resident is of two (2) of 70 sampled ailed to provide sufficient nursing t one (1) resident's call system inctioning, and within reach, and o one (1) resident's call light to lecessary assistance. Residents'		Resident #12 The call light was re-positioned u discovery. All other call lights were reviewed corrections made whenever necessa Nursing staff were inserviced on need to have the call light always vis and within reach. The Nursing Qualit Improvement Team will monitor call lighacement, visibility and response tin a monthly basis and report their findi	I and ry. 1/29/18 the 3/10/18 y ght ne on
Findings included 1. The Charge Nu #12's call system	irse failed to ensure that Residen	t ·	to the Director of Nurses. 4. The Director of Nurses will prese findings and any action plans for improvement to the Quality Assurance Quality Improvement Committee whi meets monthly and is chaired by the Administrator.	nt his

Health R	<u>equlation & Licensing</u>	Administration				
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION N		• •	CONSTRUCTION	X3) DATE SURVEY COMPLETED
				A. BOILDIIVG.		
		HFD02-0020		B. WING		02/02/2018
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L 052	Continued From pag	ge 11		L 052		
	functioning and with	in his reach.				
	On January 29, 201 during a face-to-face his call bell was not Employee #8 querie resident's call light, and found the call lig in his roommate's an The resident's Quar dated October 11, 2 Under Section I-Act Failure, Hypertensic Mellitus, Hyperlipide Under Section G, For required extensive a transfer, and was to use.	e interview with Resivisible and within his das to the whereab She looked around to ght behind the privace. Iterly Minimum Data 017, revealed the foice Diagnoses included in Pneumonia, Diabemia, Depression, arunctional Status - the assistance with bedivisible and the second of the	dent #12 s reach. outs of the he room cy curtains Set (MDS) flowing: ded Heart etes nd Asthma. e resident mobility,			
	During a face-to-face January 29, 2018, a acknowledged the f	it approximately 2:10	oloyee #8 on) PM, she		 Resident #193 The resident was assisted immediupon discovery. There were no other issues with call light response time noted. 	1/29/18
	#193's call light to p On January 26, 201 was lying in her becomessing the call light and the residen	ff failed to respond to rovide him with assi 8, at 1:45 PM, Resid watching television ht. Someone answernt stated, "I need hel aff replied, "I will let nutes later as the	stance. dent #193 and red the call p to use the		3. Nursing staff will be inserviced reguick response to call lights from restraining Quality Improvement Improvement Team will monitor call I placement, visibility and response tire a monthly basis and report their findit to the Director of Nurses. 4. The Director of Nurses will present findings and any action plans for improvement to the Quality Assurance Quality Improvement Committee whimeets monthly and is chaired by the Administrator.	ight 3/10/18 me on ings at his ce/ ich 3/16/18

Health Re	equiation & Licensing	Administration			
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TE SURVEY COMPLETED
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NAME OF PE	ROVIDER OR SUPPLIER	STREET /	ADDRESS, CITY, ST.	ATE, ZIP CODE	
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TRANSITI	IONS HEALTHCARE C	CAPITOL CITY WASHI	NGTON, DC 2		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETE DATE
L 052	Continued From page	ge 12	L 052		
	Certified Nurse Aide	ig the resident's room the e (CNA) came to assist the told the resident, "I am sorry, I sident."			
	dated October 11, 2	terly Minimum Data Set (MDS 2017, revealed the following: ctive Diagnoses included	5)	3211.5 Nursing Facilities 1. Nursing hours of 4.1 per patient day	2/2/18
	Hypertension, Diab Anxiety Disorder, a	etes Mellitus, Seizure Disorde	r, , .	was not met on the day of review. 2. There were no untoward effects on the residents.	2/2/18
	required extensive	unctional Status - the resident assistance with bed mobility, otally dependent on staff for to	•	3. The Director of Human Resources and the Director of Nurses have increased the attention on the hiring and retention of licensed nurses and certified nursing assistants. The facility has been working	
	During a face-to-face January 26, 2018, a acknowledged the	ce interview conducted on at 2:00 PM with Employee #6, findings.	he	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	!
L 056	provide a minimum	1, 2012, each facility shall daily average of four and one	L 056	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	3/9/18
	per day, of which a	f direct nursing care per reside It least six tenths (0.6) hours s advanced practice registered I nurse, which shall be in addit	hall ·	basis. 4. The results of these monitoring efforts along with any plans of action for	
	to any coverage re	quired by subsection 3211.4.		improvement will be presented by the Director of Human Resources and the Director of Nurses to the Quality Assuran Quality Improvement Committee which meets monthly and is chaired by the	3/9/18
	This Statute is no	t met as evidenced by:	Composition .	Administrator.	
	Based on record re	eview and staff interview durin direct care per resident day	ga		

Health Re	egulation & Licensing	Administration				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIE		(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAN O	F CORRECTION	IDENTIFICATION N	UMBEK:	A. BUILDING:		
		HFD02-0020		B. WING		02/02/2018
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INAROTT	ONO FILALITICATION		WASHING	TON, DC 200		-071011
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIE T BE PRECEDED BY FULL R ENTIFYING INFORMATION)	S EGULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SI- CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE COMPLETE
L 056	Continued From page	ge 13	450000	L 056		
	meet four and one t care per resident da accordance with Tit	mined that the facility enth (4.1) hours of d ay for11 of 22 days ro le 22 DCMR Section and Required Staffin	irect nursing eviewed, in 3211,			
	Findings include:					
	A review of Nurse S Staffing Coordinato approximately 11:0	Staffing was conductor on February 02 at 0AM.	ed with the	;		
	According to the Di- Regulations for Nur	strict of Columbia's N sing Facilities 3211.	<i>I</i> lunicipal 5:			
	provide a minimum	1, 2012, each facility daily average of fou direct nursing care p	r and one			
	per day hours dete failed to meet the re hours of direct nurs	lirect nursing care pe rmined that the staffi equired four and one sing care per residen ed. The staffing for	ng levels tenth (4.1) t day on 11			
	January 11, 20 January 12, 20 January 13, 20 January 14, 20 January 16, 20 January 20, 20 January 22, 20 January 25, 20	018 = 3.95 018 = 3.6 018 = 3.4 018 = 3.77 018 = 4.0 018 = 4.0 018 = 4.0				
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Health Re	equiation & Licensing	Administration				
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TRANSIT	IONS HEALTHCARE C	APITOL CITY				
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1.050	Cartinuad Erom nas	mo 14	L 056		i I	
L 056	Continued From pag	ge 14				
	January 27, 201		1			
	January 28, 201					
	February01, 20	18 = 4.0			•	
!						
	8	be facility foiled to comply with	î i			
;	As outlined above if	he facility failed to comply with he District of Columbia's	}			
	Municipal Population	n; Title 22 DCMR Section 3211	}		+	
	Nursing Porsonnel	and Required Staffing Levels	1.1			
	which stinulates tha	it, "each facility shall provide a			·	
	minimum daily aver	age of four and one tenth (4.1)			4	
	hours of direct nursi	ing care per resident per day.				
	Tiodio or an oot traile.					
	The finding was ack	knowledged by Employee #29 a	ıt İ	3220.2 Nursing Facilities		
	the time of the revie	eW.	į	1. Temperatures taken at the resider	nts did	
			1	not meet standards.		
				2. Temperatures in the kitchen and		
			1.400	serving lines in the dining rooms we	re in	
L 108	3220,2 Nursing Fac	cilities	L 108	excess of the standard but regrettab	ly the	
	·····	I de ada aball not ayaaad	\$ \$	temperatures fell at the point of deliv	ery to	
	Ine temperature ro	r cold foods shall not exceed 45°F) Fahrenheit, and for hot		the residents. 3. Dining Services is now calling ear	ah unit	
	foods shall be above	e one hundred and forty		as the trays are ready to be rolled or		
	degrees (140°F) Fa	hrenheit at the point of delivery	.	unit to ensure the quick delivery of f		
	to the resident.	in criment at the power in the inch		the proper temperatures. Additional		
				residents are being encouraged to t		
	This Statute is not	: met as evidenced by:		their lunch and dinner in the dining r		
		ons during a test tray		for quickness of services, maintenal		
		uary 30, 2018, at approximately	v i	of appropriate temperatures and		
	1:15 PM, it was dete	ermined that hot foods		socialization. CNAs and nurses		
	temperatures were	not maintained at the point of		have been inserviced about the nee		
		m temperature of 140 degrees		quickly deliver trays to the residents		
	Fahrenheit (F) as re	equired.		ensure proper temperatures. The		
			i.	Director of Dining Services and the	;	
				Nursing QI Team will monitor food	:	
	Findings included		1	temperatures on a routine basis.	offorts	
				4. The results of these monitoring will be presented by the Director of	Dining 3/10/18	
		ANAD 2000 0 UThe temperature	ĺ	Services to the QAPI Committee wh	nich is	
		MR 3220.2, "The temperature		chaired by the Administrator.		

Health Regulation & Licensing Administration STATE FORM

Health Regulation & Licensing Administration (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: ___ B. WING 02/02/2018 HFD02-0020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2425 25TH STREET SE TRANSITIONS HEALTHCARE CAPITOL CITY WASHINGTON, DC 20020 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) L 108 Continued From page 15 L 108 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 128 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

Health Regulation & Licensing Administration

STATE FORM

Health Regulation & Licensing Administration						(VO) DATE C:	IDVEV I
	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		-R· I		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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L 128	Continued From pag	ge 16		L 128	_		
:	sufficient detail to er and	nable an accurate recond	ciliation;				
	an account of all commaintained and peri	rug records are in order a ntrolled substances is odically reconciled. met as evidenced by:	and that				
	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		the ng ality as		 Resident #179 The narcotic book was signed important to the involved nurse given education on the correct proto 	was	1/29/18
	medications for one (1) resident. Residents' #179. Findings included			signing for the administration of Co Substances. 2. A review of all of the Narcotic Bo performed and all were in complian 3. Licensed nurses were inserviced		ntrolled oks was ce.	: 1/29/18
	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's, e on on I with ved a dent		The policy of signing off on Narcotic The Nursing Quality Improvement T monitor for compliance monthly. To their monitoring efforts will be forwat to the Director of Nurses for his and 4. The Director of Nurses will prese analysis of these monitoring efforts action plans for improvement to the Quality Assurance/Quality Improver Committee which meet monthly and chaired by the Administrator	tic Logs Team will The results varded nalysis. sent his s with any ne ement	3/10/18
	#179. At the time of #179's individual content showed a pill count 5/325 mg (milligram the blister pack content to	of the observation, Residentrolled substance recording of 19 for Oxycodone/AF also [RX #24417636]. How taining the medication Tab 5/325 mg showed a	dent d AP/ Tab vever,				

Health Re	egulation & Licensing	Administration	,			
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		\$\$AOTIII*C	STON, DC 20	· · · · · · · · · · · · · · · · · · ·	/V6)	
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	Manual Ma	ALLES OF THE STATE				
L 128	Continued From pag	ne 17	L 128			
L 120	Continuou i rom pa	5 .				
	D. C. Salaranders	with Employee #24 Pegistered				
	During an interview	with Employee #24, Registered not sign for the medication can				
	I sign it out now. I a	ave it already, I forgot to sign."	1			
	Employee #24, Clin	ical Nurse Manager, stated,			· ·	
	"You were suppose	d to sign it before now."	•		:	
					•	
	Facility staff failed to	o document the administration of	T ;			
	to Resident#179 in	ter administering the medication accordance with acceptable	•			
	standards of clincal	practice.				
	Starigards of clinical	praedice.				
	Employees #7 and	#24 acknowledged the finding at				
	the time of the obse	ervation.		•		
	!			3245.10 Nursing Facilities		
			ļ			
1 306	3245.10 Nursing Fa	acilities	L 306	4 Desident #12		
2 000	02,0,10,144,011.19		,	 Resident #12 The call light was re-positioned u 	pon 1/29/18	
	. A call system that n	neets the following requirements	i	discovery.	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
	shall be provided:		•	2. All other call lights were reviewed	and	
	() D			Corrections made whenever necessa	ary. 1/29/18	
	(a)Be accessible to	each resident, indicating signals tion, toilet room, and bath or		3. Nursing staff were inserviced on	the	
	shower room and o	ther rooms used by residents;	!	need to have the call light always visi	ible 3/10/18	
				and within reach. The Nursing Improvement Team will monitor call I	iaht ·	
	(b)In new facilities	or when major renovations are		placement, visibility and response tin	ne on	
	made to existing fa	cilities, be of type in which the	í	a monthly basis and report their findi	ngs	
	1	ninated only in the resident's		to the Director of Nurses.	į	
	room;			4. The Director of Nurses will prese	nt his	
	: (c)Be of a quality w	hich is, at the time of installation	.	findings and any action plans for	; 20/	
	consistent with cur	ent technology; and	' [improvement to the Quality Assurance Quality Improvement Committee whi		
				meets monthly and is chaired by the	•	
	(d)Be in good work	ing order at all times.		Administrator.		
		1 t ::dame th:::	i			
	This Statute is no	t met as evidenced by:	:			
					:	
1	!		{			
	Based on observat	ions, resident and staff				

Health R	Health Regulation & Licensing Administration							
		(X1) PROVIDER/SUPPLIE IDENTIFICATION N		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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more large of the barriers	10110 IP & FUO A PE O	A DITOL OITV	2425 25TH	STREET SE				
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L 306	Continued From pag	ge 18		L 306				
	interviews, the facilif (1) resident's call sy three (3) of six (6) ca tested.	stem was within rea	ch, and					
	Findings included					i :		
	On January 29, 2 during a face-to-face the call bell was not	e interview with Resi	dent #12,			1		
	When Employee #8 of the resident's call room and found the curtains in the room	call light behind the	ound the					
	The resident's Quarterly Minimum Data Set (MDS) dated October 11, 2017, showed the following:					i		
	Under Section I-Act Failure, Hypertensic Mellitus, Hyperlipide		etes			† ! !		
		unctional Status - the assistance with bed t tally dependent on s	mobility,			: : :		
	The facility staff fails within reach for Resthe the staff.	ed to ensure the call sident #12 to facilitat	bell was e contacting					
	During a face-to-fac January 29, 2018, a	e interview with Em t approximately 2:10	oloyee #8 on) PM,					

Health Re	Health Regulation & Licensing Administration							
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED			
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IKANSIII	TRANSITIONS HEALTHCARE CAPITOL CITY WASHINGTON, DC 20020							
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L 306	Continued From pag	ge 19	L 306		:			
	she acknowledged t	he findings.	:	D : 1 1 D : #2124 and 2504	261			
	5110 4011110 1110 1110			2. Resident Rooms #212A and 359A, Shower Room	, SIV			
			i :	Maintenance staff repaired the cite	ed 2/1/18			
	2 Observations on	January 31, 2018, between		call bells immediately upon discovery				
	11:45 AM and 4:00	PM and February 1, 2018,	:	2. Call bells throughout the facility we	ere			
	between 9:20 AM at	nd 11:30 AM, showed three (3)	ļ	checked and repairs provided if nece	essary. : 2/2/18			
	call bells failed to al	arm when activated as follows:		All call bells were in compliance. 3. The Maintenance staff was inservi				
	A Two (2) resident	room call lights in Rooms #212A	•	the repair and upkeep of the call bell				
	and 359A	room dan ngma m ribama na kasa	o .	and continue to monitor them				
			ì	in resident rooms every day. Resultheir monitoring efforts are brought to	ts of the :			
) call bells in the 3 North shower		Director of Facilities for his review.	3 (110			
	room			4. The Director of Facilities will prese	ent			
	The observations m	ade, in the presence of		his findings and any action plans for	nce/ 3/16/18			
	Employee #15, wer	e acknowledged.		improvements to the Quality Assurar Quality Improvement Committee whi				
				meets monthly and is chaired by the				
			1	Administrator.	1			
L 359	3250.1 Nursing Fac	cilities	L 359	0050 4 Manualina Facilitian	:			
			1	3250.1 Nursing Facilities				
	Each food service a	areas shall be planned, rated in accordance with Title 23	į	1. The plastic debris inside the ice so	oop 1/25/18			
	DCMR Chapter 22	, 23 and 24, and with all other		holder and the grease found on the ou	itside of			
	applicable District la	aws and regulations.		the fryer were taken care of immediate discovery.	ery upon			
İ	:	met as evidenced by:			4/05/49			
	Based on observati	ons made in the kitchen on	;	2. All other areas of the kitchen were compliance.	e in			
	January 25, 2018, a	at approximately 9:30 AM, the pare and distribute foods under		3. These cited areas were added to	the			
	sanitary conditions	as evidenced by plastic debris	:	cooks' walk through protocol to ensu	ure 2/15/18			
	inside the ice scoop	holder and two (2) of two (2)	į	on-going compliance. Any areas of	concern			
	soiled grease fryers		***************************************	are forwarded to the Director of Dini Services for his analysis	ng			
				4. The Director of Dining Services w	ill 3/16/18			
	Findings included			present his analysis of these monitor	ing efforts			
	, , idingo moidaod	•		with any action plans for improveme	ent to the			
				Quality Assurance/Quality Improven	nent Lie			
		c debris observed inside the ice		Committee which meet monthly and chaired by the Administrator	10			
	scoop holder.		į	chaned by the Administrator				

Health Regulation & Licensing Administration								
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLI	E CONSTRUCTION	(X3) DATÉ SURVEY COMPLETED			
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		JOOWITE			
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		STREET AND	DRESS, CITY, ST	ATE ZIP CODE				
NAME OF PE	ROVIDER OR SUPPLIER		STREET SE					
TRANSIT	ONS HEALTHCARE C	APITOL CITY	STON, DC 2					
	CULDIA DV OT	The state of the s		PROVIDER'S PLAN OF CORRECTIO	N	(X5)		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES I BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	COMPLETE DATE		
L 359	Continued From pag	ge 20	L 359					
	` '			3256.4 Nursing Facilities				
		grease fryers soiled on the		ozoo. Tyvaromig Fasimise				
	outside with grease	stants.	1	1. Surge Protector				
	The observations m	ade in the presence of	•	1. The noted surge protector was se	cured 2	2/1/18		
	Employee #11 were			immediately upon discovery.	aronorli.	2/1/18		
				2. All other surge protectors were procured	лорену	2/1/10		
L 413	3256.4 Nursing Fac	ilities	L 413	secured. 3. The securing of surge protectors	was :			
2 110	OZOO, 4 Ivalonig I do			Inserviced to the Maintenance Staff		/16/18		
	Each housekeeping	employee shall keep the facility	<u>}</u>	The Maintenance Quality Improvem	ent			
		odor accumulation of dirt,		Team will inspect/monitor the surge i		3		
	rubbish, dust, and h		- 1 - 1	monthly. The results of these monito				
		met as evidenced by:		efforts will be brought to the Director of Facilities for his review.				
	Based on observation	ons made during an		4. The Director of Facilities will pres	ent			
	environmental tour o	of the facility on , facility failed to nent that is free from accident		his findings and any action plans for				
	hazards.	Hera mat is nee nom doordon	!	improvements to the Quality Assura	ince/ 3	3/16/18		
	nazaras.			Quality Improvement Committee wh				
				meets monthly and is chaired by the	9			
	Findings included		į	Administrator.	:			
	Ob	nuary 21 2019 hatuaan 11:45		2. Call bell cords				
	Observations on Ja	nuary 31, 2018, between 11:45 nd on February 1, 2018, betweer	; 1	2. Gall bell colds				
	9.20 AM and 11.30	AM showed potential accident	•	1. The noted call bell cords were re	placed 2	2/1/18		
	hazards as follows:	0,,40. pota	1	immediately upon discovery.				
			•	2. All other call bell cords were insp	ected 2	2/1/18		
	1. A surge protector	r in use, unsecured, on the floor		and all were in compliance.	dood on			
		of one (1) resident in one (1) of		3. The Maintenance staff was insertite inspection and replacement of control of the inspection and replacement of control of the inspection and replacement of control of the inspection and replacement of control of the inspection and replacement of control of the inspection and replacement of control of the inspection and replacement of the ins				
	53 resident rooms.			cords.	an ben	2/16/18		
	2 Call helle corde fi	rayed in two (2) of 53 resident	j	The Maintenance Quality Improvem				
1	rooms including Ro	oms #121 (Beds A and B) and		will inspect the call bell cords				
	132 (Bed A).	,,,		monthly. The results of these monit	Its of these monitoring			
		_	-	efforts will be brought to the				
		nade in the presence of		Director of Facilities for his review.		3/16/18		
	Employee #15 were	e acknowledged.		4. The Director of Facilities will preshis findings and any action plans fo				
				improvement will be presented to the	ne			
				Quality Assurance/Quality Improver	nent			
				Committee which meets monthly an	d is			

Health Regulation & Licensing Administration STATE FORM

chaired by the Administrator.