### STRENTY REPORT OF CORRECTION MAKE OF PROVIDER OR SUPPLIER STREET ACCRESS, CITY, STATE, ZP CODE	Health R	Regulation & Licensing	Administration				
SERENTY REHABILITATION AND HEALTH COMPANDATION COMPANDAT				1 ` '			
SERENTY REHABILITATION AND HEALTH 1380 SOUTHERN AVE SE WASHINGTON, DC 20032 20032			HFD02-0011	B. WING		09/0	3/2019
CALID CALI	NAME OF P	ROVIDER OR SUPPLIER			·		_
PREFIX TAG L 000 Initial Comments An unannounced Licensure Survey was conducted at Serenity Rehabilitation and Health Center from August 26, 2019, through September 3, 2019. 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 BIP - Blood Pressure cm - Centimeters CMS - Centiers for Medicare and Medicaid Services CNA- Certified Nurse Aide CPR- Cardiopulmonary Resuscitation CRF - Community Residential Facility D.C. District of Columbia Municipal Regulations DC Discontinue DI - Deciliter DMH - Department of Mental Health EKG - 12 lead Electrocardiogram EMS - Emergency Medical Services (911) G-tube Gastrostomy tube HSC Health Service Center HWAC - Heating ventilation/Air conditioning ID - Interliectual disability IDT - Interdisciplinary team	SERENIT	Y REHABILITATION A	ND HEALTH				
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		An unannounced Licat Serenity Rehabilith August 26, 2019, the Survey activities coresampled residents. based on observation interviews. The following is a disacronyms that may be activitied activities. The following is a disacronyms that may be activitied. ARD - Assessing BID - Twice-B/P - Blood cm - Centimete CMS - Centers Services CNA- Certified National CRF - Community CRF - Certified National CRF - Community CRF - Community CRF - Community CRF - Certified National CRF - Community CRF - Community CRF - Certified National CRF - Cer	ration and Health Center from rough September 3, 2019. Insisted of a review of 70. The following deficiencies are on, record review and staff or rectory of abbreviations and/or be utilized in the report: Mental Status ment reference date a-day I Pressure ers of for Medicare and Medicaid lurse Aide apulmonary Resuscitation munity Residential Facility of Columbia of Columbia Municipal ment of Mental Health de Electrocardiogram cy Medical Services (911) ostomy tube th Service Center ventilation/Air conditioning		Facility submits this plan of correction procedures established by the Department's directive to change C which the Department alleges are dunder state Regulations Relating to term care. This should not be const either a waiver of the Facility's right appeal and to challenge the accuracy severity of the alleged Deficiencies	on under artment se onditions deficient long rued as to cy or	11/22/19

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE



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PRINTED: 10/08/2019 FORM APPROVED Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED BUILDING: В. B. WING HFD02-0011 09/03/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1380 SOUTHERN AVE SE SERENITY REHABILITATION AND HEALTH WASHINGTON, DC 20032 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX (X5) COMPLETE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (EACH CORRECTIVE ACTION SHOULD BE PREFIX OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) L 000 Continued From page 1 L 000 11/22/19 Lbs -Pounds (unit of mass) Medication Administration Record MAR -**Medical Doctor** MD-MDS -Minimum Data Set Mg milligrams (metric system unit of mass) milliliters (metric system measure of mL volume) mg/dl milligrams per deciliter mm/Hg ~ millimeters of mercury MN midnight Neuro -Neurological NP -**Nurse Practitioner** PASRR - Preadmission screen and Resident Peg tube - Percutaneous Endoscopic Gastrostomy

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PO-

POS -

Prn -

Pt -

Q-

QIS -

SCC

Sol-

TAR -

Trach-

following:

L 051 3210.4 Nursing Facilities

Rp, R/P -

by mouth

Every

Solution

required nursing intervention;

accuracy in the transcription of

physician 's order sheet

Quality Indicator Survey

Treatment Administration Record

Special Care Center

As needed

Responsible party

Patient

Tracheostomy

A charge nurse shall be responsible for the

(a)Making daily resident visits to assess physical and emotional status and implementing any

(b)Reviewing medication records for completeness,

2MU711

L 051

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(Sertraline).

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L 051	Resident #95 was ac 10, 2018, with diagnal Immunodeficiency V Gastroesophageal R Vascular Disease, Anemia, Os Anxiety, and Major D A review of of the Qu (MDS) completed Ju Interview for Mental which is an indication moderately impaired make decisions. Review of the Phys 7/15/19 "Lovenox so	the resident care plans failed to the use of an Antidepressant lew was conducted with ugust 29, 2019, at PM. The employee reviewed owledged that the care plan for sant was never developed. Bed to develop plan of care for of anticoagulant. Idmitted to the facility on Janual oses which included Human lirus Disease, Reflux Disease, Peripheral Chronic Obstructive Pulmonaristeoarthritis, Neuropathic pain,	y	Monitoring Corrective Action: Assistant Director of Nursing/ Designation complete house wide assessment /au residents to identify potential resident facility staff failed to develop compreherson centered care plans weekly till then monthly times 3 months. Findings will be reported to the Quality Assurance Performance Improveme Committee monthly for the next 3 months.	udit of is that nensive, mes 4, iy nt	11/22/19

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GT site care.

acknowledged the findings.

A face-to-face interview was conducted with Employee #18 [Nurse Manager] on August 30, 2019, at approximately 9:55 AM. She

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thin liquids

Review of the care plan showed, "Focus: Resident has a history of Dementia. Interventions: monitor weight, PO (by mouth) intake, skin integrity, labs, provide mechanical soft diet with chopped meats.

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This Statute is not met as evidenced by:

Based on record review and staff interview, during a review of staffing [direct care and advanced practiced registered nurse per Resident per day hours], it was determined that facility failed to provide a minimum daily average of six tenths (0.6) hours of advanced practice registered nurse or registered nurse per resident per day for two (2) of twenty-six (26) days reviewed in accordance with Title 22 DCMR Section 3211, Nursing Personnel and Required Staffing Levels.

ensure that the facility has adequate staffing by regulatory requirement. The facility is actively recruiting nursing staff and new hire orientation monthly and as needed.

The facility will initiate a staff retention program including incentive and sign on bonuses for licensed nursing staff. The affected Resident suffered no negative outcome.

Identification of others with the Potential to be Affected:

All residents residing in the facility have the potential to be affected. Human Resources and Staffing Coordinator will complete house wide

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registered nurse per resident at a rate of 0.5 hours.

A face-to-face interview conducted with the Staffing Coordinator at the time of the staffing review and

she acknowledged the findings.

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L 067	Continued From pag	e 10	L 067	L067		11/22/19
L 067	3214.1 Nursing Faci		L 067	Corrective Action for the Residents Affected:		
	program shall be pro include training on the	a-going in-service education ovided by the facility and shall ne provision of resident care. met as evidenced by:		The facility cannot retroactively co this deficiency. The staff developn was educated on importance of er that annual in-services sheets rec	nent nsuring	
	facility's staff failed to sheets failed to reco training, the subject,	iew and staff interview, the o ensure annual in-services rd the mandatory 12 hours of the date, the time/duration, the		mandatory 12 hours of training, the the date, the time/duration, the pull and/or who Conducted the training	e subject rpose,	
	(4) of four (4) in-serv	conducted the training in four rice(s) reviewed.		Health Care Academy was contact correct the error on their competer	ncies	
	Findings included			from credits to contact hours for C competencies/Training	NA	
	in-service records or	e staff annual/mandatory n 09/03/19 at 1:00 PM showed education on four (4) topics, as		The affected Residents suffered n negative outcome.		
	Abuse Training - 01/ 01/31/19, 02/02/19,	26/19, 01/27/19, 01/30/19, and 02/03/19:		Identification of others wit Potential to be Affected:	h the	
	Dementia/Alzheimer Podiatry/Geriatric Fo 04/19/19; and	e's - 02/04/19 and 05/09/19; oot Care - 04/17/19 and e, and Neglect - 05/09/19.		All residents residing in the facility the potential to be affected. The Director of Staff Development Designee will complete house wid	nt/	
	training documents in "In-Service Training the following:	the previously mentioned revealed twenty-seven (27) Sign-in Sheets" that showed		Assessment/ Audit to identify pote annual in-services sheets that failed record the mandatory 12 hours of tr the subject, the date, the time/durat the purpose, and/or who conducted	d to aining, ion,	
	documented evidend	sign-in sheets lacked ce of the amount of in-service ceived from the previously e training.		training. Any issue found during this audit was corrected.		
		sign-in sheets lacked ce of the subject, the date,		Measures to prevent recur The Director of Nursing/Designee		

PRINTED: 10/08/2019 FORM APPROVED Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ HFD02-0011 09/03/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1380 SOUTHERN AVE SE SERENITY REHABILITATION AND HEALTH WASHINGTON, DC 20032 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (EACH CORRECTIVE ACTION SHOULD BE PREFIX OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) L 067 Continued From page 11 L 067 11/22/19 provide education to the Staff Development the time, the purpose, and who conducted the on importance of ensuring that annual training. The only information on the two (2) sing-in sheets were 41 employee signatures. in-services sheets record the mandatory 12 hours of training, the subject, the date. 3. One (1) of the 27 sign-in sheets lacked the time/duration, the purpose, and/or who documented evidence of the subject, the date, the conducted the training. time, the purpose, and who conducted the training. The one (1) sign-in sheet, however, did have the **Monitoring Corrective Action:** name of the person who conducted the training and The Director of Staff Development/ twenty-five employee signatures. Designee will complete house wide Assessment/ Audit to identify potential 4. Sixteen (16) of the 27 sign-in sheets lacked annual in-services sheets that failed to documented evidence of the time the training was record the mandatory 12 hours of training. provided. the subject, the date, the time/duration, the purpose, and/or who conducted the During a face-to-face interview on 09/02/19, at 2:45 training weekly times 4 then, monthly times PM, the Employee # Staff Educator 3 months. acknowledged the findings. Findings will be reported to the Quality Assurance Performance Improvement Committee monthly for the next 3 months L 088 3217.3 Nursing Facilities L 088 L088 The Infection Control Committee shall establish Corrective Action for the written infection control policies and procedures for at least the following: Residents Affected: The facility cannot retroactively correct (a)Investigating, controlling, and preventing this deficiency. infections in the facility; Facility staff was in-serviced on importance of developing a system of surveillance to (b)Handling food; identify infections or communicable diseases and corrective action taken to minimize the (c)Processing laundry; spread of the infection. The affected Residents suffered no (d)Disposing of environmental and human wastes; negative outcome .Identification of others with the (e)Controlling pests and vermin;

(f) The prevention of spread of infection:

Potential to be Affected:

the potential to be affected.

. All residents residing in the facility have

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STAT	EMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE (SURVEY PLETED
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	088	related to infections; (h)Nondiscrimination treatment of persons virus or who have a This Statute is not assed on record reversely facility failed to developed identify infections or census on the first described included to identify infections. Review of the facility logs showed the following showed the following include chin absorbed include value included incontinent of include value included value included value included value included value included value included incontinent included value	nts and corrective actions and in admission, retention, and swho are infected with the HIV diagnosis of AIDS. met as evidenced by: iew and staff interview the alop a system of surveillance to communicable diseases. The ay of survey was 175. evelop a system of surveillance or communicable diseases. d's Infection Control Surveillance owing: e 25 facility-acquired infections ess, vaginitis, boil at right chest, y tract infections related to E. lation for urinary tract infection, and of the eyelid, fungal irritation, ince, and pneumonia. The 23 facility-acquired infections poil at right chest, conjunctivitis, and fungal irritation - no	L 088	Assistant Director of Nursing/ De will complete house wide assessing Audit to identify potential resident facility staff failed to develop a system surveillance to identify infections of communicable diseases. Assistant Director of Nursing/ Deswill complete house wide assessing Audit to identify potential resident facility staff failed to show how correction is taken to help minimize the of the infection. Any issue found during this audit with corrected. Measures to prevent recur Staff Development will provide ed to the facility staff on importance of developing a system of surveillance identify infections or communicable diseases; and corrective action take minimize the spread of the infection Monitoring Corrective Action Assistant Director of Nursing/ Dewill complete house wide assessing Audit to identify potential resident facility staff failed to develop a system surveillance to identify infections or communicable diseases weekly time then, monthly times 3 months. Assistant Director of Nursing/ Dewill complete house wide assessing Audit to identify potential resident facility staff failed to show how correction is taken to help minimize the of the infection weekly times 4 then times 3 months. Findings will be reported to the Continuous will be rep	nent/ that stem of or signee nent/ that ective spread II be rence: ucation f to ion: signee nent/ that em of es 4 signee nent/ that ective spread , monthly uality ement	11/22/19

Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ HFD02-0011 09/03/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1380 SOUTHERN AVE SE SERENITY REHABILITATION AND HEALTH WASHINGTON, DC 20032 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) L 088 Continued From page 13 L 088 L091 11/22/19 conjunctivitis. Corrective Action for the Residents Affected: The facility cannot retroactively correct Based on the surveillance data, facility staff failed to this deficiency. show how corrective action taken to help minimize The soiled ice machine on One (1) of the spread of the infection (e.g., staff education and three (3) residents care units was cleaned on competency assessment). 9/27/19 The facility staff will be in-serviced on During a face-to-face interview on August 29, 2019 importance of maintaining a safe, sanitary at approximately 11:30 AM, Employee # 27 environment. acknowledged the findings. The affected Residents suffered no negative outcome. L 091 3217.6 Nursing Facilities L 091 The Infection Control Committee shall ensure that Identification of others with the infection control policies and procedures are Potential to be Affected: implemented and shall ensure that environmental .All residents residing in the facility have services, including housekeeping, pest control, the potential to be affected. laundry, and linen supply are in accordance with the requirements of this chapter. Assistant Director of Nursing/ Designee This Statute is not met as evidenced by: will complete house wide assessment/ Based on observations and staff interview, facility Audit to identify potential soiled Ice staff failed to maintain a safe, sanitary environment machine that facility staff failed to maintain as evidenced by a soiled ice machine on one (1) of in a safe sanitary condition. three (3) resident care units. Any issue found during this audit will be corrected. Findings included ... Measures to prevent recurrence: During an environmental walkthrough of the facility . Facility staff will be in-serviced on on August 27, 2019, between 10:30 AM and 3:00 importance of maintaining a safe, sanitary PM, the access door to one (1) of one (1) ice environment. machine located on the third floor pantry was soiled on the inside. **Monitoring Corrective Action:** This deficient practice could potentially contaminate .Assistant Director of Nursing/ Designee beverages consumed by residents or staff. will complete house wide assessment/ Employee #8 acknowledged the above findings Audit to identify potential soiled Ice machine that facility staff failed to maintain in a safe sanitary condition weekly times 4

then, monthly times 3 months.

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at approximately 3:00 PM.

Employee #19 acknowledged the above findings

during a face-to-face interview on August 27, 2019

addressed.

that is less than 135 degrees Fahrenheit Any issues found during the audit will be

Measures to prevent recurrence: 1.Staff Development will provide education to the Food and Nutrition Services staff on the importance of preparing and serving

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STATE FORM

3/4/29- 130#

4/3/19- 136# 5/2/19- 135# 6/3/19-136#

7/1/19- 136#

8/1/19- 128 #

During an interview on 8/28/19 at 10:00 AM

outcome.

Identification of others with the

.All residents residing in the facility have

The Dietitian/Designee will complete house wide assessment/audit of residents

Potential to be Affected:

the potential to be affected.

Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING HFD02-0011 09/03/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1380 SOUTHERN AVE SE SERENITY REHABILITATION AND HEALTH WASHINGTON, DC 20032 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY L 109 Continued From page 16 L 109 to identify potential residents that facility staff failed to provide evidence of resident was asked have you lost weight. The monitoring or modifying interventions resident responded "yes, I don't like the food here." consistent with resident needs and goals to maintain acceptable parameters of 11/22/19 Review of the meal log showed resident refused one or more meals for the month of August and or nutritional status. consumed 51-75% of meals. Any issued found during the assessment /audit will be corrected. Further review of the medical record showed the following entries: Measures to prevent recurrence: Staff Development will provide education Nurse practitioner noted dated 7/31/19 "resident to the facility staff on importance of wanted to change his diet to regular, resident stated Providing evidence of monitoring or I want to have corn meat and hot dog." modifying interventions consistent with resident needs and goals to maintain Nurse practitioner note dated 8/2/19: "resident wanted to talk to again for changing his diet, acceptable parameters of nutritional status. resident agreed to continue his cardiac diet again." **Monitoring Corrective Action:** Review of the medical record showed an The Dietitian/ Designee will complete house interdisciplinary team meeting was held on 8/6/19 wide assessment /audit of residents to identify and the resident's documented weight loss of 8 lbs. potential residents that the facility staff failed nutritional issues were not addressed. to provide evidence of monitoring or modifying interventions consistent with resident needs Dietary note dated 8/7/19: "pt. does not like the food and goals to maintain acceptable parameters of and has been complaining of diet, registered nutritional status weekly times 4, then monthly times 3 months. dietician explained to patient that preference for fried foods can be detrimental to his health and that Findings will be reported to the Quality the patient can have fried foods no more than once Assurance Performance Improvement a week due to complaints of possible weight loss, Committee monthly for the next 3 months. continue current diet and Boost BID supplement." Nurse supervisor note dated 8/22/19 "resident lost 8 lbs within a month, he had a reweigh and the reweigh remain the same." Significant weight change note by registered dietician dates 8/21/19 "PO intake is 50-100 %

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Nursing Services;

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

STATE FORM

Re-assessed on 9/3/19. The Consultant

recommendations to correct the insulin

.The affected Resident suffered no

Pharmacist was educated on the importance of identifying and making

dosage.

2MU711

negative outcome.

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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L 128	(b) Submit a written the status of the phaperformances, at least (c) Provide a minimu per year to all nursing session that includes and possible side efficient medications; (d) Establish a system disposition of all condetail to enable an account of all commaintained and period This Statute is not assed on observation interview for one (1) consultant pharmaci recommendations to one resident. Reside Findings include	report to the Administrator on irmaceutical services and staff ist quarterly; m of two (2) in-service sessions ig employees, including one (1) is indications, contraindications fects of commonly used m of records of receipt and trolled substances in sufficient ccurate reconciliation; and uig records are in order and that introlled substances is odically reconciled, met as evidenced by: on, record review and staff of 70 sampled residents, the st failed to identify and make correct the Insulin dosage for	L 128	Identification of others with Potential to be Affected: All residents residing in the facility the potential to be affected. Assistant Director of Nursing/ Dewill complete house wide assessmof residents to identify potential rethe consultant pharmacist failed to it and make recommendations to combination dosage. Any issues found during the audit addressed. Measures to prevent recure Staff Development will provide edute to the Consultant Pharmacist on the importance of identifying and make recommendations to correct the Institutional Complete house wide assessifications and the complete house wide assessification of the importance of identify and make recommendation to identify potential complete house wide assessification in the consultant Pharmaciled to identify and make recommendation to correct the Insulin dosage weekly then monthly times 3 months. Findings will be reported to the Quality Assurance Performance Improvement Committee monthly for the next 3 months.	signee nent/audit sidents dentify ect the will be rence: ucation ne ulin on: signee ment / cial macist endations times 4, ty	

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consultant pharmacist on September 03, 2019 at approximately 12:30 PM. After reviewing the orders in the computer he acknowledged the finding and stated that he would implement an audit system

to ensure that this problem will not reoccur.

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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L 161	3227.12 Nursing Fa Each expired medicusage. This Statute is not Based on review of three (3) medication approximately 12:30 floor failed to date through the containers accessed; medication for one (cart on the second for the containers lacked initially accessed. Ferrous Sulfate 16 of Expiration date 01/20 Ranitidine 300 ml be Expiration 4/1/20 Manantine 150ml be Keppra 16 oz. bottled date 03/22 Ferrous Sulfate 16 of date 01/20 Chlorhexidine Gluc.	cilities ation shall be removed from met as evidenced by: medications stored on one (1) of carts on August 29, 2019 at DPM the facility staff on the first ne labels of seven (7) of 12 dication containers when they and to remove an expired 1) resident from a medication loor. edications were opened. All of the dates on which they were	L 161	Corrective Action for the Reside Affected: The facility cannot retroactively contained this deficiency. A. All medications in the medication without date on the labels of vials/medication containers when the were first accessed were removed for medication cart. Reordered and data when first accessed. B. The expired medication was remined at the labels of the potential to be Affected: A. Assistant Director of Nursing/ E. Will complete house wide assessing audit of medications to identify pormedications that the facility staff fadate the labels of vials/medication containers when they were first accessing the same of the potential to be affected. B. Assistant Director of Nursing/ E. Will complete house wide assessing audit of medications to identify pormedications when they were first accessing the same of the potential to the same of the potential to the facility staff fadate the labels of vials/medication containers when they were first accessing audit of medications to identify potential to medications to identify potential to remove from the medication and successing audit of medications that the facility failed to remove from the medication and decreased.	ey rom the ed moved /19. o h the y have Designee nent/ tential iled to essed. Designee nent/ tential y staff n cart.	11/22/19

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MARE OF PROVIDER OR SUPPLIER SERENTY REHABILITATION AND HEALTH (A4) D PREFIX TAG (CA4) D CONTINUED From page 21 Docusate Sodium 16 oz. bottle/15 oz. left Expiration date 1/21. B. Facility staff failed to remove one (1) expired medication from the medication care. Labetelol 100mg six (6) tables with a "Use by date" of 6/0/11/9 was observed on the medication orders revealed that the Labetelol was prescribed for the resident on June 27, 2018. The prescriber worde "Labetalol HCL Tablet 100mg pive 1 tablet crailly two times a day for HTN [Hypertension] hold if SBP [Systolic Blood Pressure <110 [less than] nor HR [Heart Rate] <60 [less than]. The medication was discontinued on July 31, 2018. Further review of the Physician's order and the MAR failed to reveal a current order for the Labetelol. A face-to-face interview was conducted with Employee #17 at approximately 3.00 PM on August 29, 2019. During the interview the employee stated that the resident was no longer taking the medication should have been removed from the medication cart. A face-to-face interview was conducted with Employee #4 Manager at approximately 3.00 PM on August 29, 2019. During the interview the employee at Manager at approximately 3.00 PM on August 29, 2019. During the interview was conducted with Employee # Manager at approximately 3.00 PM on August 29, 2019. During the interview was conducted with Employee # Manager at approximately 3.00 PM on August 29, 2019. During the interview was conducted with Employee # Manager at approximately 3.00 PM on August 29, 2019. During the interview was conducted with Employee # Manager at approximately 3.00 PM on August 29, 2019. During the interview was conducted with Employee # Manager at approximately 3.00 PM on August 29, 2019. During the interview the employee and the MAR part of the Category of the Categor	, ,						
1380 SOUTHERN AVE SE WASHINGTON, DC 20032 PROVIDERS PLAN OF CORRECTION CASHINGTON, DC 20032 PROVIDERS PLAN OF CASHINGTON, DC 2004 PROVIDERS PLAN OF CASHINGTON, DC 2	HFD02-0011			B. WING		09/03/2019	
WASHINGTON, DC PROVIDER'S PLAN OF CORRECTION PREPIX TAGS PROVIDER'S PLAN OF CORRECTION	NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	ATE, ZIP CODE		
EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY TAG CRISCIDENT PYING INFORMATION) L 161 Continued From page 21 Docusale Sodium 16 oz. bottle/15 oz. left Expiration date 1/21. B. Facility staff failed to remove one (1) expired medication from the medication care. Labetelol 100mg six (6) tablets with a "Use by date " of 6/01/19 was observed on the medication cart during review of medication storage on August 29, 2019 at approximately 1:00 PM. Review of the resident's medication orders revealed that the Labetelol was prescribed for the resident on June 27, 2018. The prescriber wrote "Labetalol HCL Tablet 100mg give 1 tablet orally two times a day for HTN [Hypertension] hold if SBP [Systolic Blood Pressure <110 [Jess than] or HR [Heart Rate] < 40 [Jess than] in The medication was discontinued on July 31, 2018. Further review of the Physician's order and the MAR failed to reveal a current order for the Labetelol. A face-to-face interview was conducted with Employee #17 at approximately 3:00 PM on August 29, 2019. During the interview the employee stated that the resident was no longer taking the medication and acknowledged that the expired medication and acknowledged	SERENIT	Y REHABILITATION A	ND HEALTH				
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employee stated that the resident was no longer taking the medication and acknowledged that the expired medication should have been removed from	L 161	Docusate Sodium 16 date 1/21. B. Facility staff fails medication from the 100mg six (6) tablets 6/01/19 was observer review of medication approximately 1:00 for the Labetelol way June 27, 2018. The HCL Tablet 100mg of day for HTN [Hypert Blood Pressure <11 le <60 [less than]. The on July 31, 2018. For der and the MAR for the Labetelol. A face-to-face intervent Employee #17 at ap 29, 2019. During the stated that the reside medication and acknowledge medication should her medication cart. A face-to-face intervent Employee # Manage August 29, 2019. Employee stated that that ing the medication and acknowledge with the medication stated that the reside medication cart.	ed to remove one (1) expired medication care. Labetelol with a "Use by date " of ed on the medication cart during storage on August 29, 2019 at PM. The second of the resident on a prescribed for the resident on a prescriber wrote "Labetalol give 1 tablet orally two times a rension] hold if SBP [Systolic D [less than] or HR [Heart Rate] a medication was discontinued further review of the Physician's ailed to reveal a current order review as no longer taking the nowledged that the expired have been removed from the resident was no longer the tresident was no longer in and acknowledged that the tresident was no longer in and acknowledged that the	L 161	A.Staff Development will provide to the facility licensed nurses on importance of labeling of vials/med containers when they are first acces. B.Staff Development will provide to the facility licensed nurses on importance of removing expired medications from the medication ca. Monitoring Corrective Acti. A. Assistant Director of Nursing/ E. will complete house wide assess audit of residents to identify poten medications that the facility staff fadate the labels of vials/medication containers when they were first ac weekly times 4, then monthly time 3 months. B. Assistant Director of Nursing/ E. will complete house wide assessmand audit of medications to identify potential complete house wide assessmandit of medications to identify potential complete house wide assessmandit of medications that the facility failed to remove from the medication weekly times 4, then monthly times 3. Findings will be reported to the Quality Assurance Performance Improvement	education ication ssed. education art. on: oesignee ment / tial ailed to ccessed. s oesignee nent/ tential / staff n cart months y	

Health Regulation & Licensing Administration						
	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
HFD02-0011			B. WING		09/03/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, ST	ATE ZIP CODE		
		1380 9011	THERN AVE	·	•	
SERENIT	Y REHABILITATION A	NIJAFALIH	TON, DC 2			
(X4) ID PREFIX TAG	(EACH DEFIC!ENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
L 306	shall be provided: (a)Be accessible to a from each bed locati shower room and oth (b)In new facilities or made to existing faci call bell can be termi room; (c)Be of a quality wh consistent with curre (d)Be in good working the from the consistent with curre (d)Be in good working the from the consistent with curre (d)Be in good working the from the curre (d)Be in good working the consistent with curre (d)Be in good working the curre (d)Be in good working the curre (d)Be in good working the current (d)Be in good working (d)Be in good working the current (d)Be in good working (d)Be in good workin	each resident, indicating signals on, toilet room, and bath or ner rooms used by residents; when major renovations are lities, be of type in which the nated only in the resident's ich is, at the time of installation, nt technology; and	L 306	L306 Corrective Action for the Residents Affected: The facility cannot retroactively cothis deficiency. The affected call bells in resident at #209B, #241A and #309A were recons/27/19. The affected residents suffered not negative outcome Identification of others with Potential to be Affected: All residents residing in the facility the potential to be affected. The Director of Maintenance/ Desivill complete house wide Assessm Audit to identify potential resident that facility staff failed to maintain bell system in good working conditions.	rooms' placed h the y have gnee nent/ room the call	
	staff failed to maintai working condition as three (3) of 38 reside audio or visual alarm. Findings included During an environme on August 27, 2019, PM, call bells in resident's rooms.	ental walkthrough of the facility between 10:30 AM and 3:00 dent rooms #209B, #241A and when tested , three (3) of 38 d prevent or delay care to		Any issue found during this audit v corrected. Measures to prevent recur Staff Development will provide edu to the facility staff on importance of maintaining the call bell system in go working condition. Monitoring Corrective Acti The Director of Maintenance/ Deswill complete house wide Assessm Audit to identify potential resident that facility staff failed to maintain the bell system in good working condition weekly times 4 then, monthly times 3 months.	rence: cation cod on: signee nent/ rooms e call	

Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ HFD02-0011 B. WING_ 09/03/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1380 SOUTHERN AVE SE SERENITY REHABILITATION AND HEALTH WASHINGTON, DC 20032 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PRÉFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) L 306 Continued From page 23 L 306 Findings will be reported to the Quality 11/22/19 Assurance Performance Improvement Employee #8 acknowledged the above findings during a face-to-face interview on August 27, 2019 Committee monthly for the next 3 months. at approximately 3:00 PM.

Health Regulation & Licensing Administration