Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0005	A. BUILDING: _____ B. WING _____	02/26/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WASHINGTON HOME	3720 UPTON STREET NW WASHINGTON, DC 20016

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L 000	Initial Comments A Licensure Survey was conducted on February 22, 2016 through February 26, 2016. The following deficiencies are based on observations, record review, resident and staff interviews for 17 sampled residents and 43 supplemental records reviewed. On September 15, 2015 the Skilled Nursing facility announced that it will be closing. The anticipated closure date is December 2016. The following is a directory of abbreviations and/or acronyms that may be utilized in the report: Abbreviations AMS - Altered Mental Status g-tube- Gastrostomy tube EKG - 12 lead Electrocardiogram NP - Nurse Practitioner BID - Twice- a-day EMS - emergency medical services (911) EMAR- electronic medication administration record EXP- expiration HVAC - Heating ventilation/Air conditioning Neuro - Neurological B/P - Blood Pressure CRF - Community Residential Facility CNA- Certified Nurse Aide DMH - Department of Mental Health Peg tube - Percutaneous Endoscopic Gastrostomy NP - Nurse Practitioner L - Liter Dl - deciliter	L 000	The Washington Home makes its best effort to operate in substantial compliance with both the Federal and State law. Submission of this Plan of Correction (POC) does not Constitute an admission or agreement by any party, its board, officers, directors, employees or agents as to the truth of the facts alleged or the validity of the conditions set forth on the Statement of Deficiencies. The following plan of correction constitutes the faciliities written credible allegation of compliance. It is prepared and/or executed solely because it is required by Federal and State law.	

Health Regulation & Licensing Administration

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

D.O.N | 3/28/16

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L 000	Continued From page 1 CMS - Centers for Medicare and Medicaid Services Lbs - pounds (unit of mass) MAR - Medication Administration Record MD- Medical Doctor MDS - Minimum Data Set Mg - milligrams (metric system unit of mass) mL - milliliters (metric system measure of volume) mg/dl - milligrams per deciliter mm/Hg - millimeters of mercury POS - physician ' s order sheet Prn - As needed Pt- Patient TAR - Treatment Administration Record PASRR - Preadmission screen and Resident Review ARD - assessment reference date IDT - Interdisciplinary team ID - Intellectual disability QIS - Quality Indicator Survey D.C. - District of Columbia D/C- Discontinue Rp, R/P- Responsible Party PO- By Mouth	L 000		
L 035	3207.10 Nursing Facilities Dated orders and dated progress notes in the resident's medical record shall be used to document medical supervision at the time of each visit and shall be signed and dated by the resident's physician or the resident's nurse practitioner or physician assistant, with countersignature by the resident's physician. This Statute is not met as evidenced by: Based on observations, record review and interview for one (1) of 17 stage 2 sampled residents, it was determined the physician failed	L 035	L035 1.Resident #69-Therapy attempted screen of 2/26- resident refused therapy intervention 2.Audit current psychiatric consults to identify needed recommendations- no concerns identified 3. Designated clipboard placed on Units for MD to review consults prior to filing within the chart to ensure recommendations are seen. 4.Unit manager or designee to audit psychiatric consults weekly x 3 then monthly x 3 to evaluate recommendations. Any identified trends will be reported to the QAPI committee monthly Compliance Date	4/9/16

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L 035	Continued From page 2 to review the total program of care for Resident #69 as evidenced by a failure to act on a consulting specialists ' recommendation to initiate rehabilitation services. The findings include: Random observations of Resident #69 during the survey period, February 22 through 26, 2016 revealed the resident stayed mostly in his/her room in the bed. The resident was interviewed during the Stage I phase of the survey process and verbalized he/she was able to make his/her needs known. During the interview, he/she stated that staff would assist him/her to get out of bed when he/she wanted; however had no desire to get out of bed at the time of the interview on February 23, 2016 at approximately 1:00 PM. According to the physician ' s progress note dated November 24, 2105, Resident #69 ' s diagnoses included Schizophrenia, Depression, Cerebrovascular Disease, status post Cerebrovascular accident with right sided weakness. A psychiatric follow up note dated February 9, 2016 included the following: " [Resident named] ...has noted recently that [he/she] has spent more time in [his/her] room than usual. While [he/she] will say that [he/she] goes out " once a day " the staff reports that [he/she] is resistant to get dressed and go outside of [his/her] room despite many invitations and encouragements. [Resident] denies being depressed ...[he/she] is pleasant most of the time but that [he/she] does not like to change [his/her] routine ....recommendations ...if available, would restart the physical therapy with [Resident] as [he/she] will otherwise develop muscle weakness ... "	L 035		

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L 035	Continued From page 3 A review of physician progress notes and physician orders lacked evidence that the physician/medical team acted on the psychiatrists ' recommendation to initiate rehabilitation [rehab] services for Resident #69. There was no documentation by the physician/medical to indicate that he/she was aware of the recommendation or that he/she disagreed with the recommendation. A face-to-face interview was conducted with Employee #19 on February 25, 2016 at approximately 3:00 PM. In response to a query regarding rehabilitative services for Resident #69, he/she stated that physical, occupational and speech therapy services are available but that he/she had not received a request or referral for rehab services for the resident. A face-to-face interview was conducted with Employee #4 on February 25, 2016 at approximately 12:30 PM. The employee stated that he/she was unaware of a request for rehab services for Resident #69 but advised that he/she would inquire with the physician regarding rehab. The record was reviewed February 25, 2016.	L 035		
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	L 051	L051 1.Resident # 20,24,37,56,62,69,84,88 and 112- Discharge care plans initiated. 2.Current resident records audited to identify needs for discharge care plan -identified concerns corrected 3.Re-educate Social service department related to the need for discharge care plans and timely documentation of resident and family meetings related to discharge process. 4.Director of Social services or designee to audit upcoming discharge charts weekly x 4 then monthly x 3. Any identified trends will be reported to the QAPI committee monthly. Compliance Date	4/9/16

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L 051	Continued From page 4 physician orders, and adherences to stop-order policies; (c)Reviewing residents' plans of care for appropriate goals and approaches, and revising them as needed; (d)Delegating responsibility to the nursing staff for direct resident nursing care of specific residents; (e)Supervising and evaluating each nursing employee on the unit; and (f)Keeping the Director of Nursing Services or his or her designee informed about the status of residents. This Statute is not met as evidenced by: Based on record review and staff interview for nine (9) of 17 Stage 2 sampled residents and three (3) supplemental residents, it was determined that facility staff failed to develop comprehensive care plans with measurable goals, timetables and specific interventions to manage the discharge needs of residents. Residents' #20, 24, 37, 56, 62, 69, 84, 88, and 112. The findings include: The provider ' s ' Notice of Closure ' A review of the facility ' s documents revealed the facility provided a "Notice of Closure" letter signed by the Chief Executive Officer and dated November 3, 2015 addressed to all residents [and/or responsible parties] residing in the facility that read: "This letter serves each of you as your official notice of closure and the need to transfer or discharge to another location. Final closure will be December 15, 2016...We will assure the continuity of services by providing the receiving	L 051		

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L 051	Continued From page 5 facility with assessment and care plan, and for discharge, by arranging for those services required by the post discharge plan..." Pursuant to The District of Columbia ' s Transfer/Discharge statute - D.C. Law 6-108, the Nursing Home and Community Residence Facilities Protections Act, DC Code 44-1003.01 " ...Residents residing at the facility will undergo involuntary discharge as follows: Chapter 10. Nursing Homes and Community Residence Facilities Protections. Subchapter III. Discharge, Transfer, and relocation of residents. § 44-1003.01. Grounds for involuntary discharge, transfer, or relocation by facility. (a) Unless a resident and his or her representative consent otherwise, a facility may discharge the resident, transfer the resident to another facility, or relocate the resident from one part or room of the facility to another only:...(5) If the facility is closing or officially reducing its licensed capacity ... " 1. Facility staff failed to develop a discharge plan of care for Resident #20. A review of Resident #20's clinical record revealed a social service progress note dated September 18, 2015 at 3:21 PM that read , " Spoke with [family member] about the closing of [facility]. S/he is interested in working with [family member] to find a place for [him/her] to live ....SE [southeast], NE [northeast] are a possibility. Also [local facility] is an option. Will continue to work with them to explore a safe discharge plan. " A social service progress note dated November 9, 2015 at 4:37 PM read, "The formal letter to resident notifying [gender] of closure of [name of	L 051		

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L 051	Continued From page 6 facility] in December 2016, has been placed in the chart. This letter has also been mailed to the resident's responsible representative." The interdisciplinary team last updated Resident #20 ' s comprehensive care plan on January 22, 2016. However, there was no evidence of a care plan that reflected problem identification, goals and approaches to address the resident ' s impending involuntary discharge. A face-to-face interview was conducted with Employee #10 on February 26, 2016 at approximately 3:30 PM regarding the aforementioned findings. He/she acknowledged there was no discharge plan. The record was reviewed February 26, 2016. 2. Facility staff failed to develop a discharge plan of care for Resident #24. A review of social work progress notes revealed the following: January 7, 2016 at 2:38 PM " Have been speaking with [family members named]. They have begun to look into facilities. The requested a referral to go to [facility named]. Called that facility and had Medical records send them a packet. The family is to visit other facilities ...but does not want referrals sent to them as yet ... " January 14, 2016 at 4:09 PM " [family members named] are now actively working on placement. They visited [facility named] and felt that this was an acceptable place to transfer the resident ...spoke with admission coordinator and they don ' t have any LTC [long term care] beds. As asked, will check back ... "	L 051		

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L 051	Continued From page 7 The interdisciplinary team last updated Resident #24 ' s comprehensive care plan on November 17, 2015. However, there was no evidence of a care plan that reflected problem identification, goals and approaches to address the resident ' s impending involuntary discharge. A face-to-face interview was conducted with Employee #10 on February 26, 2016 at approximately 3:30 PM regarding the aforementioned findings. He/she acknowledged there was no discharge plan. The record was reviewed February 26, 2016. 3. Facility staff failed to develop a discharge plan of care for Resident #37. A review of Resident #37 's clinical record revealed the following Social Service progress note dated and timed 12:42 PM February 24, 2016; " On January 1/14/2016, [attendees named including responsible party(s)] met for the individualized discharge planning meeting. The resident had been denied by [Facility name] for admittance, so family had many questions about the reason. Per [responsible party] it was because of " aggressive behavior " so [attendee named] reviewed the resident ' s chart and spoke with the psychiatrist about behaviors. SW [social worker] explained the process of finding, applying, and being transferred to another facility. It was decided, after reviewing the facility ' s lists, that resident ' s [responsible party] was going to explore some out of state facilities. " The interdisciplinary team last updated Resident #37 ' s comprehensive care plan on February 20,	L 051		

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L 051	Continued From page 8 2016. However, there was no evidence of a care plan that reflected problem identification, goals and approaches to address the resident ' s impending involuntary discharge. A face-to-face interview was conducted with Employee #10 on February 26, 2016 at approximately 3:30 PM regarding the aforementioned findings. He/she acknowledged there was no discharge plan. The record was reviewed February 26, 2016. 4. Facility staff failed to develop a discharge plan of care for Resident #56. A review of Resident #56 ' s clinical record revealed the following Social Services progress notes: " October 26, 2015 11:26 AM: Care conference / discharge planning on10/14/15: The interdisciplinary team met with the resident and [his/her] RP [Responsible Party]. Care plans and medications were reviewed....RP is pleased with [his/her] family members care ...RP has visited nursing homes but has not made a decision where to apply. " " December 17, 2015 15:32[3:32PM] Length of Stay discharge planning comment= Residents RP, has had many conversations with the social worker regarding [his/her] family member. RP feels that as long as [resident] is receiving good care, [he/she] will remain at [Name of facility]. SW [Social Worker] gave RP the list of DC [District of Columbia] nursing homes, which [she/he] used when [he/she] visited them ... RP told SW that [he/she] was not impressed with any of the homes. RP stated that [he/she] was instead	L 051		

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L 051	Continued From page 9 working on getting extension until 6/2017 [June 2017]. " " December 30, 2015 16:21 [4:21PM] Length of Stay discharge planning comments= On 12/30/15[at] 3:00 PM, the SW [social worker], SW Director, RP [responsible party] and [family member] met for a discharge assessment meeting. RP was given the Maryland and DC lists of nursing homes and a source book ..." The interdisciplinary team last updated Resident #56 ' s comprehensive care plan on January 31, 2016. However, there was no evidence of a care plan that reflected problem identification, goals and approaches to address the resident ' s impending involuntary discharge. A face-to-face interview was conducted with Employee #10 on February 26, 2016 at approximately 3:30 PM regarding the aforementioned findings. He/she acknowledged there was no discharge plan. The record was reviewed February 26, 2016. 5. Facility staff failed to develop a discharge plan of care for Resident #62. A review of Resident #62 ' s clinical record revealed the following Social Services progress notes: " November 9, 2015 16:54 [4:54PM] General Social Services Comments = The formal letter to the resident notifying [him/her] of the closure of [Facility Name] in December 2016, has been placed in the chart. The letter has also been mailed to the resident's responsible	L 051		

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L 051	Continued From page 10 representative. " " December 18, 2015 14:38 [2:38PM] General Social Services Comments = Speak regularly to [family member]. [His/her] first choice had been for [facility name] for transfer ...Discussed with the [family member]. Explained that other options needed to be explored ...Will continue to follow and assist with planning ... " February 26, 2016 at 14:35 [2:35 PM] " Formal discharge planning meeting was held on 2/4/16 ...[attendees listed, including family member] ...[family member] made it clear that [he/she felt that the only comparable transfer location for [Resident] would be [facility named] ...SW [social worker] offered to continue to have follow up informal and formal meetings ....[family member] said [he/she] would like to continue to meet .... " The interdisciplinary team last updated Resident #62 ' s comprehensive care plan on December 15, 2015. However, there was no evidence of a care plan that reflected problem identification, goals and approaches to address the resident ' s impending involuntary discharge. A face-to-face interview was conducted with Employee #10 on February 26, 2016 at approximately 3:30 PM regarding the aforementioned findings. He/she acknowledged there was no discharge plan. The record was reviewed February 26, 2016. 6. Facility staff failed to develop a discharge plan of care for Resident #69. A review of social worker progress notes dated February 3, 2016 revealed a care conference was	L 051		

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L 051	Continued From page 11 conducted on February 3, 2016 to address the resident's continuing care needs and discharge planning. The resident and family member was in attendance. The interdisciplinary team last updated Resident #69 ' s comprehensive care plan on November 29, 2015. However, there was no evidence of a care plan that reflected problem identification, goals and approaches to address the resident ' s impending involuntary discharge. A face-to-face interview was conducted with Employee #10 on February 26, 2016 at approximately 3:30 PM regarding the aforementioned findings. He/she acknowledged there was no discharge plan. The record was reviewed February 26, 2016. 7. Facility staff failed to develop a discharge plan of care for Resident #84. A review of Resident #84 ' s clinical record revealed the following Social Services progress notes: November 12, 2015 at 17:31 [5:31PM]; " The RP [responsible party] has submitted [his/her] preferences. Medical records has sent records to [facility names] ...Will continue to follow for discharge plans. " November 13, 2015 at 17:31 [5:31PM]; " The formal letter to the resident notifying [gender] of closure of [name of facility] in December 2016, was given and read to the resident. A copy has been placed in the chart. This letter has also been mailed to the resident ' s responsible representative. "	L 051		

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L 051	Continued From page 12 December 1, 2015 at 13:33 [1:33PM]; " RP has released medical records to [names of facilities] No bed matches yet ...SW to continue to follow for discharge planning ... " The interdisciplinary team last updated Resident #84 ' s comprehensive care plan on February 1, 2016. However, there was no evidence of a care plan that reflected problem identification, goals and approaches to address the resident ' s impending involuntary discharge. A face-to-face interview was conducted with Employee #10 on February 26, 2016 at approximately 3:30 PM regarding the aforementioned findings. He/she acknowledged there was no discharge plan. The record was reviewed February 26, 2016. 8. Facility staff failed to develop a discharge plan of care for Resident #88. A review of Resident #88 ' s clinical record revealed the following Social Services progress notes: November 9, 2015 at 16:50 [5:50PM]; " The formal letter to resident notifying [gender] of closure of [name of facility] in December 2016, has been placed in the chart. This letter has also been mailed to the resident's responsible representative. " November 20, 2015 at 16:07 [4:07PM]; " Left message for RP [responsible party] on this date, to discuss discharge planning. Await call back. "	L 051		

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L 051	Continued From page 13 January 18, 2016 at 15:37 [3:37 PM]; " Placed follow up call to [RP name] ...Awaiting call back to discuss transition planning. " The interdisciplinary team last updated Resident #88 ' s comprehensive care plan on December 5, 2015. However, there was no evidence of a care plan that reflected problem identification, goals and approaches to address the resident ' s impending involuntary discharge. A face-to-face interview was conducted with Employee #10 on February 26, 2016 at approximately 3:30 PM regarding the aforementioned findings. He/she acknowledged there was no discharge plan. The record was reviewed February 26, 2016. 9. Facility staff failed to develop a discharge plan of care for Resident #112. A review of Resident #112 ' s clinical record revealed the following Social Services progress note dated and timed November 11, 2015 at 12:49; " On November 6, 2015, the social worker hand delivered and read to the resident the official letter of closure of [name of facility]. " The interdisciplinary team last updated Resident #112 ' s comprehensive care plan on November 17, 2015. However, there was no evidence of a care plan that reflected problem identification, goals and approaches to address the resident ' s impending involuntary discharge. A face-to-face interview was conducted with Employee #10 on February 26, 2016 at approximately 3:30 PM regarding the aforementioned findings. He/she acknowledged	L 051		

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L 051	Continued From page 14 there was no discharge plan. The record was reviewed February 26, 2016.	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 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	L 052	L052 1. Resident #54 returned from hospital, assessed and monitored x 72 hours with no negative outcomes 2.Reviewed all residents with fall with injury in the last 30 days to identify concerns related to hazards in the environment-no identified concerns, areas noted to be free of safety hazards 3.All resident rooms will be inspected during weekly Maintenance Rounds to identify any concerns. Maintenance technicians re-educated on identifying areas of concern related to safety hazards -loose carpet, exposed electrical wiring, surge protectors unmounted 4. Plant operations Director or designee will review weekly Maintenance rounds checklists and report any identified trends to the QAPI committee Monthly 5.Compliance Date	4/9/16

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L 052	Continued From page 15 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. This Statute is not met as evidenced by: A. Based on observations, record review and staff interview for one (1) of 17 sampled residents, it was determined that sufficient nursing time was not provided to ensure that the resident environment remained as free from accident hazards as is possible and that adequate supervision was provided in order to enhance safety and reduce the risk of an accident as evidenced by one (1) resident who sustained a fall with injury. Resident #54 The findings include: On February 26, 2016 at approximately 9:00 AM, Employee #2 informed the survey team that Resident #54 sustained a fall with injury " this morning " and was sent to a local hospital for emergency treatment via ambulance. A review of the facility ' s incident report titled, " Incident Details, " documented by nursing staff, dated February 26, 2016 at 4:48 AM read as follows: " Around 2:48 AM there was a sound from resident ' s room, writer and the assigned CNA [certified nursing assistant] rushed to the room where resident was found on the floor in sitting position leaned on [his/her] right side noted	L 052	L052 cont. 2. Surge protectors in rooms 208 and 323 re- mounted 3. Carpet in hall of blue pod-tightened 4.Call light replaced in room 104 2.Evaluated other resident rooms with no identified concerns of exposed electrical wiring/surge protectors not mounted and loose carpeting 3.All resident rooms will be inspected During weekly Maintenance Rounds to identify any concerns. Maintenance technicians re-educated on identifying areas of concern related to safety hazards -loose carpet, exposed electrical wiring, surge protectors unmounted 4. Plant operations Director or designee will review weekly Maintenance rounds checklists and report any identified trends to the QAPI committee Monthly 5.Compliance Date	4/9/16

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L 052	Continued From page 16 with blood all over [his/her] face. Resident alert and oriented x3 [person, place, time], resident stated to writer [he/she] fell from chair and hit [his/her] head on the floor. Supervisor made aware and came to the unit. Resident noted with laceration on [his/her] forehead ...and laceration on left eyebrow ....pressure dressing applied to the sites. Resident denied back and neck pain at this time, pupils react to light equal. Active and passive ROM [range of motion] with normal limit to all extremities. Dr [named] notified and new order received to transfer resident to hospital ER [emergency room ' for further evaluation and treatment. 911 [emergency medical services] called and resident was transferred to hospital [named] ER at around 3:25 AM ... " {SIC} On February 26, 2016 at approximately 9:30 AM, an observation was conducted of Resident #54 ' s room. The room was observed cluttered. Multiple items were noted scattered along the floor surface and the bed was covered with personal belongings. For example the observations included but was not limited to the following: A dining tray was noted lying upside down on the floor proximal to the room entrance, blocks of wood, long rolls of paper, plastic containers, cans, a towel and a blow dryer were observed on the floor surface posing a potential trip hazard and an unsafe environment. The room had three (3) free-standing garment racks, three (3) stationary chairs, one (1) wheelchair and a rolling cart similar to a shopping cart filled with items. Resting atop the rolling cart was a carpenter-style hand saw approximately 15 - 18 inches in length readily accessible to anyone entering the room. The private bathroom was filled with clutter including large plastic bags and plastic containers. The toilet and sink were not accessible because the entryway and space was	L 052		

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L 052	Continued From page 17 blocked with items. On February 26, 2016 at approximately 10:15 AM, during the observation of Resident #54 ' s room, the resident appeared in the doorway lying on a stretcher accompanied with private ambulance transporters. A gauze bandage was observed on his/her forehead and alongside the left eyebrow. He/she stated " what ' s going on ...why are you in my room, get out of my room. " When greeted, Resident #54 responded in the affirmative to his/her name and stated " fine " in response to the query, " How are you? " The resident was advised regarding the survey process and the purpose for observing his/her room. The resident further verbalized " take me to my room, my room is fine. " A review of the quarterly Minimum Data Set [MDS] dated November 26, 2015 [assessment reference date (ARD) 11/19 - 26/2015] under Section I, Active Diagnoses revealed Resident #54 ' s diagnoses included Hypertension, Peripheral Vascular Disease, Cerebrovascular Accident, Neuralgia and Depression. Section G, Functional Status was coded as the resident utilized a wheelchair for mobility, required limited assistance for transfer between bed and chair, supervision for locomotion and limited assistance for toilet use; G0400, Functional Limitation in Range of Motion was coded as " B1, " indicative of impairment on one side of the lower extremity. Section C, Cognitive Patterns revealed the resident was moderately cognitively impaired with a score of " 9 " in the Brief Interview for Mental Status. Section E, Behavior was coded as Delusions, verbal behavioral symptoms directed toward others occurred 4 to 6 days out of seven days and rejection of care occurred daily.	L 052		

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L 052	Continued From page 18 A review of the most recent psychiatric consultation dated December 22, 2015 revealed Resident #54 ' s mental health diagnoses included Major Depression and severe Obsessive Compulsive Disorder with significant Hoarding. The psychiatric follow up note dated December 22, 2015 included: " [Resident named] has a long history of depression and obsessive compulsive disorder. There has been a history of agitation with both verbal and physical aggressiveness, particularly when [Resident] is confronted about [his/her] hoarding or any of [his/her] habits. Staff has spent a great deal of time developing a treatment plan for [Resident] trying to accommodate [his/her] whishes while also making sure that [his/her] room was safe ...of note is that while [his/her] room is quite cluttered with unnecessary paraphernalia, the room in passable and safe for easy entry and exit (a difference from the past) ... " A review of the comprehensive care plan for Resident #54 revealed the interdisciplinary team [IDT] updated the plan on November 17, 2015 and updated the problem area related to " Falls " on February 26, 2016. The following problem areas [including but not limited to] were identified by the IDT: " Problem: Falls - potential for falls related to history of falls. Goals: resident will have no injury related to falls in the next 90 days. Approaches: give resident verbal reminders to ask or call for assistance when [he/she] needs it ...have staff clear bed each evening of all belongings, if [he/she] will permit it to allow resident choice of sleeping in bed or chair. This may prevent [him/her] from falling from chair when [he/she] is sleeping .... " Under the evaluation section dated 9/14/15 " had a fall from wheelchair; abrasion	L 052		

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L 052	Continued From page 19 noted on LUA [left upper arm]. Bacitracin ordered till healed. Probably fell asleep in chair, where [he/she] sleeps most of the time. Clutters bed so that [he/she] can ' t go to bed and sleep. This is [his/her] normal routine sitting up in chair and sleeping. Refuses to go to his bed even when offered to remove clutter from bed ... " " Problem: Behavior problem - Resident displays inappropriate behavior when [he/she] is asked to make [his/her] room more tidy, to remove excess items from room and when [he/she] is denied access to things [he/she] wants to do; resident exhibits inappropriate behavior toward staff as evidenced by verbal and physical abuse when asked to tidy up room or does not get [his/her] way; pillaging and hoarding. Goals: resident will decrease episode of inappropriate behavior ...will not display verbal and/or physical abuse towards staff ...pillaging and hoarding will not negatively impact self or others through next review. Approaches: allow resident to be aware of the harmful items that will be removed ...check for harmful items weekly and remove from room, report the resident informed refusal of having the harmful items removed to the family members. Evaluation: continues to have verbally abusive outbursts ...refuses psyche meds [psychotherapeutic medications] as well as other meds at times, still gets upset and agitated at times especially when it comes to referencing room cleaning ...Still gets very angry and agitated at times when staff tell [him/her] [he/she] can ' t do certain things ... " " Problem: Noncompliance to calling for assistance with transfers and ADLs [activities of daily living]. Goal: resident will adhere to calling for assistance when needed with transfers and ADLs. Approaches: praise resident for	L 052		

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L 052	Continued From page 20 demonstrating desired behavior, discuss with resident implications of not complying with therapeutic regime Evaluation: remains non-adherent to calling for assistance with transfers and ADLs. Attempts to do things for [him/herself] but not able to, so when staff see [him/her] struggling, they assist ... " " Problem: Mood State, resident continues to hoard and store too much in room, causing safety issues. Goal: room will be tidy and less congested. Approaches: monitor room for tidiness ...solicit friends or family to help [him/her] pare down [his/her] belongings. Evaluation: limits have been placed on [him/her] to remove the trash and clean up the room. [He/she] straightens it up a little and before many hours have passes the room looks horrible ... " A review of the behavior monitoring records for the period of January 1, 2016 to February 26, 2016 revealed that nursing staff documented three times daily regarding the occasions that Resident #54 exhibited combativeness and/or medication non-compliance. The records revealed " no problem behaviors noted " for the review period with the exception of January 16, 2016 at 6:43 AM when the resident exhibited an episode of screaming when he/she wanted a drink from the refrigerator. A review of nursing notes for February 25 and 26, 2016 (the day prior to and of the fall incident) read as follows: February 25, 2015 at 7:53 AM " resident remain alert and verbally responsive, no complain of pain or any discomfort, status post [S/P] ABT [antibiotic medication] ...no adverse reaction noted. Will continue with plan of care. "	L 052		

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L 052	Continued From page 21 February 25, 2016 at 18:07 [6:07 PM] " S/P ABT for [diagnosis recorded]. No adverse reactions noted PO [oral] fluids encouraged. Resident refused both breast to be assessed, MA [physician] aware. Denied any pain/discomfort. No concern verbalized. " {SIC}. February 25, 2016 at 19:29 [7:29 PM] " Patient had quiet evening. ADLs [activities of daily living] provided. Patient tolerated due medication and feeding well. No acute distress noted. Post ABT therapy. " February 26, 2016 at 00:38 [12:38 AM] " Resident remain alert and stable, status post ABT ...no adverse reaction noted. " February 26, 2016 at 03:37 [3:37 AM] " Transfer to emergency department 2/26/16 03:35 [3:25 AM]. Fall related minor injury ... " A review of the facility ' s document detailing " Resident Rights " included in the admission packet included but was not limited to the following: " Your rights as a resident ...you have the right to exercise you rights as a resident of this facility and as a citizen or resident of the United States ...you have the right to retain and use personal possessions including some furnishings, and appropriate clothing as space permits, unless to do so would infringe upon the rights or health and safety of other residents. A face-to-face interview was conducted with Employee # 25 on February 26, 2016 at approximately 10:45 AM. He/she stated that Resident #54 had a long history of hoarding behaviors and that it was challenging to get him/her to be compliant. He/she was seen by the	L 052		

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L 052	Continued From page 22 psychiatrist recently. The family, facility administration and the Long Term Care [LTC] Ombudsman have participated in meetings involving concerns with this resident and related behaviors. A face-to-face interview was conducted with Employee #26 on February 26, 2016 at approximately 11:00 AM. He/she stated that Resident #54 most often sleeps in the chair. That is his/her preference. He/she does not like people to change his/her room and prefers his/her bed cluttered. He/she verbalized that Resident #54 had a long history of challenging behaviors and that the facility administration was directly involved with managing his needs. A face-to-face interview was conducted with Employee #1 on February 26, 2016 at approximately 1:00 PM. He/she was aware of the hoarding behaviors of Resident #54 and that the facility was trying to balance the rights of the resident and safety of the resident and others. He/she stated that dangerous items such as an electric drill and lumbar have been removed from the resident ' s possession. He/she was unaware that Resident #54 had a hand saw in his/her room. Resident #54 had a documented history of behavioral challenges and hoarding practices that the interdisciplinary team identified and recommended approaches for managing. The IDT identified an approach to " have staff clear bed each evening of all belongings, if [he/she] will permit it to allow resident choice of sleeping in bed or chair. This may prevent [him/her] from falling from chair when [he/she] is sleeping " There was no evidence that staff implemented measures to clear the resident ' s bed so that	L 052		

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L 052	Continued From page 23 he/she may sleep in it on February 26, 2016. The resident reportedly fell from sleeping in a chair and sustained lacerations to the head and face. There was no evidence in the behavior monitoring records and/or nursing notes that Resident #54 exhibited noncompliance and/or refusals on or about February 26, 2016, the day of the fall with injury. There was no evidence that the resident ' s bed was cleared so that he/she could sleep in it. Additionally, observations of the resident ' s room during the period that he/she was out of the facility obtaining medical treatment at a local emergency department on February 26, 2016, revealed that the resident ' s bed surface was filled with clutter, the room floor had items scattered across the surface posing a trip hazard and a hand saw was readily accessible to whomever entered which posed a potential accident hazard. Facility staff failed to ensure that Resident #54 ' s room was free from accident hazards and that the resident, who was assessed as moderately cognitively impaired, was adequately supervised as to prevent accidents. The record was reviewed February 26, 2016. B. Based on record review and staff interview for two (2) of 17 stage 2 sampled residents, it was determined that sufficient nursing time was not provided to ensure residents attain or maintain the highest practicable state of well-being as evidenced by failure to perform pain assessments and re-assessments prior to and after the administration of " as needed " [prn] pain medication and failed to clarify physician ' s orders for the prescribed indication for use of	L 052		

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L 052	Continued From page 24 Morphine [analgesic medication] for one (1) resident; and failed to administer a pneumococcal vaccine and follow through with timeliness on a physician ' s order for a speech evaluation for one (1) resident. Resident ' s #24, and #92. The findings include: 1. Facility staff failed to perform pain assessments prior to and following the administration of " as needed " [prn] pain medication [Morphine - an Opioid analgesic medication.] and failed to clarify physician ' s orders for the prescribed 'indication for use' of Morphine. A.. Facility staff failed to conduct pain assessments prior to and following the administration of " prn " Morphine. A review of the facility policy titled, " Pain Management " Revised July, 2015 states under the section titled ' Purpose, ' " To relieve or decrease the level of the resident ' s/patient ' s pain. 1). Pain assessment ...3) pain evaluation ... " In section ' II ' titled ' Pain Assessment - Administration of Pain Medications. ' a. Prior to administration of PRN [as needed] medications for pain, the licensed nurse must assess the resident ' s/patient level of pain using a quantitative scale ...A Progress Note with the quantitative pain measurement documented in the note, must be entered in the EMR [electronic medical record] under the category of Pain management. One hour (or earlier if the resident/patient voices concern) following the administration of the PRN pain medication the licensed nurse must re-assess the resident '	L 052	L052 cont. 1.Resident # 24-order for morphine clarified 2/25/16 to be for dyspnea/pain. 2. Audit conducted 3/10/16 of prn medications to identify appropriate indication- no other concerns identified Audit completed 3/3/16 to identify any residents requesting pneumonia vaccine-identified concerns corrected 3. Re-educate Licensed nursing staff on medication indications and pain assessment 4. Unit Manager or designee to audit prn medication administration and pre and post pain assessment weekly x4 then monthly x 3 and report any identified trends to the QAPI committee monthly 5.Compliance Date	4/9/16

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L 052	Continued From page 25 s/patient ' s level of pain using the quantitative scale ... " A review of the clinical record revealed that Resident #24 ' s diagnoses included Metastatic Colon Cancer. A Physician's progress note dated January 27, 2016 revealed, " ...Pain 2/2 [secondary to] Cancer: well controlled w/ [with] methadone [narcotic pain medication] and PRN [as needed] morphine [narcotic pain medication]. " The " Physician's Order Sheet " dated February 1, 2016 directed the administration of Morphine Sulfate solution, " give 60mg (milligrams) under the tongue as needed, every hour for dyspnea " [shortness of breath]. On February 24, 2016 at approximately 2:10PM, a face-to-face interview was conducted with Employee #11, the nurse for Resident #24. When asked why Resident #24 was receiving Morphine, Employee #11 stated, "The resident receives Morphine for pain. Morphine was typically given prior to wound care." The employee was asked how pain was assessed for Resident #24. Employee #11 stated, "When the resident is in pain, I see it on [his/her] face. " When asked where the effectiveness of the medication is documented, Employee #11 stated, " We do not always document the effectiveness. " A review of the " Electronic Medication Administration Record (EMAR) " for February 2016 revealed the following: Morphine was administered on February 14, 2016 at 11:00AM for pain. The result was documented as " Effective. "	L 052		

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L 052	Continued From page 26 Morphine was administered on February 23, 2016 at 11:42 AM for pain. The result is documented as " effective. " Morphine was administered on February 24, 2016 at 10:42 AM, however the reason documented was "Given as ordered." The result was documented as "effective no pain" A review of the nursing notes and the pain management notes lacked documented evidence that pain assessments were performed prior to, and after the administration of PRN (as needed) pain medication. On February 25, 2016 at approximately 4:45 PM, a face-to-face interview was conducted with Employee #4. He/she acknowledged the aforementioned findings. The record was reviewed on February 24, 2016. B. Facility staff failed to clarify the prescribed ' indication for use ' of Morphine an Opioid analgesic medication. A review a physician ' s progress note signed and dated November 24, 2015, in the section titled HPI (history and physical information) revealed, " ...prn [as needed] morphine sulfate for dyspnea, for pain uses [approximately] 4 [times] a month usually [with] dressing [changes] ... " A Physicians progress note dated January 27, 2016 revealed, " ...Pain 2/2 [secondary to] Cancer: well controlled w/ [with] methadone and PRN [as needed] morphine [narcotic pain medication]. "	L 052		

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L 052	Continued From page 27 The " Physician Order Sheet " dated February 1, 2016 directed that the resident was prescribed Morphine Sulfate solution, " give 60mg (milligrams) under the tongue as needed, every hour for dyspnea. " The order was initially ordered July 8, 2015. On February 24, 2016 at approximately 2:10PM, a face-to-face interview was conducted with Employee #11, the nurse for Resident #24. When asked why Resident #24 was receiving Morphine, Employee #11 stated that the resident received Morphine for pain. The physician ' s order lacked evidence that the Morphine was to be administered as needed for pain. Facility staff failed to clarify the prescribed indication for use for ' as needed ' Morphine. On February 25, 2016 at approximately 4:45 PM, a face-to-face interview was conducted with Employee #4. He/she acknowledged the aforementioned findings. The record was reviewed on February 24, 2016. 2. Facility staff failed to administer Resident #92's pneumococcal vaccine in accordance with physician's orders and failed to follow through with timeliness on a physician 's order for a speech evaluation. A. Facility staff failed to administer Resident #92's pneumococcal vaccine in accordance with physician's orders. A " Physician ' s Order Sheet " dated February 5, 2016 directed, " Pneumovax 23 (Pneumococcal 23-Valps Vaccine), Injectable, 25mcg (micrograms) /05ml (milliliters): Inject 0.5 ml	L 052	L052 cont. 1.Resident # 92 discharged from facility 2. Resident # 92 seen by ST on 2/26/16. To be followed to determine appropriateness of diet upgrade. 2. Audit conducted of current orders for ST-no other concerns noted 3.Re-educate Licensed Nursing staff on 24 hour chart check policy and procedure 4. 11-7 Supervisor to audit new written orders nightly to identify appropriate follow through. Audits to be forwarded to the Unit Managers for review. Any identified trends will be reported to the QAPI committee monthly 5. Compliance date	4/9/16

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L 052	Continued From page 28 Intramuscular as needed for immunization. A review of the Medication Administration Record (MAR) for February 1-26, 2016 revealed the Pneumovax was not administered. It was further determined through review of the electronic clinical record and the immunization history form that Resident #92 was not administered the pneumococcal vaccine. There was no evidence that facility staff offered and/or administered the Pneumovax to Resident #92 in accordance with physician's orders. A face-to-face interview was conducted with Employee #4 and Employee #8 on February 24, 2016 at approximately 11:00 AM. Both acknowledged the aforementioned finding. The clinical record was reviewed on February 24, 2016. B. Facility staff failed to follow through with timeliness on a physician's order for a speech evaluation for Resident #92. An " Interim Order Form " dated January 8, 2016 at 11:30AM directed, " Speech screen for upgrade in diet consistency, especially the meat items per resident ' s request. " A review of the speech section of the clinical record revealed the most recent speech screen/evaluation was October 1, 2015. The clinical record lacked evidence of a speech evaluation subsequent to October 1, 2015. A face-to-face interview was conducted with Employee#4 on February 25, 2016 at 3:00 PM. He/she acknowledged that the speech therapist	L 052		

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L 052	Continued From page 29 had not seen the resident. A follow-up interview was conducted with Employee #19 on February 24, 2016 at approximately 3:30 PM regarding the aforementioned order. He/she acknowledged the finding and further stated, " I never received the consult for an evaluation. However, I will follow-up. " Facility staff failed to follow through with timeliness on a speech evaluation, until brought to their attention during the survey process. A period of 30 days lapsed before the evaluation occurred. There was no evidence that the resident exhibited any nutritional status deficits secondary to the delay. The clinical record was reviewed on February 24, 2016.	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 hours], it was determined that the Nursing Facility failed to meet the 0.6 [six tenths] hour for Registered Nurses/Advanced Practice Registered	L 056	L056 1.No residents directly affected 2.No residents directly affected 3.New calculation tool implemented - educated staffing coordinator and nursing administration on the daily needs of the facility Over scheduling by 1 RN to accommodate call outs if needed. 4.DON to monitor daily schedules and report any identified concerns to the QAPI monthly committee. Compliance Date	4/9/16

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L 056	Continued From page 30 Nurse hours on one (1) of the 14 days reviewed, in accordance with Title 22 DCMR Section 3211, Nursing Personnel and Required Staffing Levels. The findings include: A review of Nurse Staffing was conducted on February 26, 2015 at approximately 11:00 AM. A review of the daily average of nursing hours per resident per day was conducted for the 2-week period of February 12 - 26, 2016. According to the District of Columbia Municipal Regulations for Nursing Facilities: 3211.5 "Beginning January 1, 2012, each facility shall provide a minimum daily average of four and one tenth (4.1) hours of direct nursing care per resident per day, of which at least six tenth (0.6) hour 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." The facility failed to meet the 0.6 [six tenth] hour of direct nursing care per resident day for Registered Nurse/Advanced Practice Registered Nurse for one (1) of 14 days reviewed as outlined below. The calculated nursing coverage rate for Saturday, February 13, 2016 was determined to be provided at a rate of 0.56 as opposed to the required 0.6 hours. A face-to-face interview/review was conducted with Employee # 2 on February 26, 2016 at approximately 11:00 PM. He/she acknowledged the findings.	L 056		

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L 091	Continued From page 31	L 091		
L 091	3217.6 Nursing Facilities The Infection Control Committee shall ensure that infection control policies and procedures are implemented and shall ensure that environmental services, including housekeeping, pest control, laundry, and linen supply are in accordance with the requirements of this chapter. This Statute is not met as evidenced by: Based on observation and staff interview for one (1) of 17 sampled residents it was determined that facility staff failed to manage wound treatment supplies in a manner equipment as to reduce and/or prevent the potential for cross contamination during a wound treatment; and facility staff failed to ensure that the Infection Control Program included a consistent and systematic collection, analysis, interpretation and dissemination of data to identify infections and infection risks in the facility. The findings include: 1. Facility staff failed to manage wound treatment supplies in a manner as to reduce and /or prevent the potential for cross contamination during wound care for Resident #24. On February 26, 2016 at approximately 10:15AM, a wound care observation was conducted. During this time Employee #12 removed clean uncovered/unwrapped cotton tipped applicators from a package and placed them uncovered into a cardboard box containing "Non-Woven Sponges." The clean tips of the applicators were touching the inside surface of the box. When Employee #12 started to perform the dressing change to the resident ' s right hip, he/she removed the cotton tip applicators from the box and placed them on an open, clean gauze pad	L 091	L091 1.No actual harm to the resident # 24 2. No resident directly affected 2.Re-educate license nurses on wound management and dressing change technique 2.Re-educate Unit Managers on infection control monitoring 3.Unit Managers to perform (1 or 10% of current wounds)random dressing change audit weekly to identify trends. Any identified trends will be reported to the QAPI committee monthly Unit Managers to complete infection control surveillance sheets weekly and forward to the QAPI department. 4.QA/ED to audit ABT/infection usage weekly and report any identified trends to QAPI committee monthly Compliance Date	4/9/16

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L 091	Continued From page 32 wrapper. The employee then applied Skin integrity Hydrogel dressing (a gel that is used to maintain a moist wound environment) to the wound on the resident's right hip. He/she then used the cotton tip applicator to spread the gel around the wound. On February 26, 2016 at approximately 11:00AM a face-to-face interview was conducted with Employee #12 regarding clean technique and the potential for cross contamination. He/she acknowledged the findings and stated that the cotton tipped applicators should have been placed on the clean gauze when removed from the package. Facility staff failed to manage wound treatment supplies in a manner as to reduce and/or prevent the potential for cross contamination during wound care. 2. Facility staff failed to ensure the implementation of an infection control program that included a consistent and systematic collection, analysis, interpretation and dissemination of data to identify infections and infection risks in the facility. A review of the November 2015 surveillance forms lacked evidence of consistent tracking and trending such as: The "Most recent Admit or Readmit Date " was not recorded for nine (9) of nine (9) residents listed; The "Infection Site" was not recorded for one (1) of nine (9) residents listed; The onset date of the infection was not recorded	L 091		

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L 091	Continued From page 33 for nine (9) of nine (9) residents listed; The infection was " in-house acquired " was not recorded for two (2) of nine (9) residents listed " Present on Admission " was not recorded for two (2) of nine (9) residents listed " Antibiotic " the strength of the antibiotic and duration of use was not record for two (2) of nine (9) residents listed. The date the antibiotic was initiated and completed was not recorded for four (4) of nine (9) residents listed A review of the December 2015 surveillance forms lacked evidence of consistent tracking and treading such as: The " Most recent Admit or Readmit Date " was not recorded for nine (9) of 10 residents listed; The onset date of the infection was not recorded for five (5) of 10 residents listed; The infection was " in-house acquired " was not recorded for two (2) of 10 residents listed " Present on Admission " was not recorded for four (4) of 10 residents listed " Antibiotic " the strength of the antibiotic and duration of use was not recorded for one (1) of 10 residents listed. The date the antibiotic was initiated and completed was not recorded for nine (9) of 10 residents listed A review of the January 2015 surveillance forms	L 091		

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L 091	Continued From page 34 lacked evidence of consistent tracking and treading such as: The " Most recent Admit or Readmit Date " was not recorded for five (5) of 10 residents listed; The " Infection Site " was not recorded for one (1) of 10 residents listed; The onset date of the infection was not recorded for six (6) of 10 residents listed; The infection was " in-house acquired " was not recorded for three (3) of 10 residents listed The " infection site " was not recorded for four (4) of 10 residents listed " Present on Admission " was not record for two (2) of 10 residents listed " Antibiotic " the strength of the antibiotic and duration of use was not recorded for two (2) of 10 residents listed. The date the antibiotic was initiated and completed was not recorded for seven (7) of 10 residents listed There was no evidence that the facility ' s Infection Control Program included a consistent and systematic collection, analysis, interpretation and dissemination of data to identify infections and infection risks in the facility. In addition, at the time of this review the facility had no residents on transmission based precautions and no evidence of outbreaks of communicable disease. A face-to-face interview was conducted with Employee # 3 on February 23, 2016 at 3:16 PM.	L 091		

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L 091	Continued From page 35 He/she acknowledged the findings and stated, " I have implemented a new surveillance sheet."	L 091	L099 1.No residents directly affected 1.Food items undated were discarded 2. Steam table steam wells have been corrected and properly cleaned. 3. Fryers properly cleaned 4. Water inlet valve to juice machine properly reported to Maintenance, machine has since been taken out of service as it is no longer needed for service. 5. Tilt Skilled lid handle properly reported to Maintenance, equipment taken out of service until properly repaired 6. Plastic cover to sugar storage bin replaced. 3/3/16 7. On/off control valve of tilt skilled properly reported to Maintenance, equipment taken out of service until properly repaired. 8. Storage scoops properly cleaned for sugar and flour bins 9. Convection Ovens cleaned of food debris 3. Opening and closing checklist to be completed daily and forwards to the Dining Services Director for review. On the spot corrections to be completed as appropriate. 1.Addressed proper labeling and dating procedures with all team associates by conducting the following: Completed 2/23/16 ▪ All staff mandatory in-service on "Labeling & Dating Procedures" on 2/23/16. ▪ Instituted department Opening and Closing checklists with emphasis on inspecting all food products with proper label & date.	
L 099	3219.1 Nursing Facilities Food and drink shall be clean, wholesome, free from spoilage, safe for human consumption, and served in accordance with the requirements set forth in Title 23, Subtitle B, D. C. Municipal Regulations (DCMR), Chapter 24 through 40. This Statute is not met as evidenced by: Based on observations that were made during a tour of the dietary services on February 22, 2016 at approximately 9:45 AM, it was determined that the facility failed to store, prepare and serve food under sanitary conditions as evidenced by nine (9) of nine (9) plates of chicken salad, one (1) of one (1) tray of macaroni salad, a quarter pan of cooked broccoli and one whole pan of cooked chicken breast that were not dated , eight (8) of eight (8) steam wells and two (2) of two (2) grease fryers that were soiled, a leaking inlet valve to one (1) of one (1) juice machine, a leaking control valve to one (1) of one (1) tilt skillet, a missing handle to one (1) of one (1) tilt skillet and a broken plastic cover to one (1) of one (1) sugar storage bin. The findings include: 1. Nine (9) of nine (9) plates of chicken salad with tomatoes and crackers, stored in refrigerator box #7 were not dated. 2. One (1) of one (1) tray of macaroni salad, a quarter pan of cooked broccoli and one whole pan of cooked chicken breast stored in the walk-in refrigerator were not dated.	L 099		

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L 099	Continued From page 36 3. Eight (8) of eight (8) steam wells from two (2) of two (2) steam tables were soiled with food residue. 4. Two (2) of two (2) grease fryers were soiled with leftover fried food residue. 5. The water inlet valve to one (1) of one (1) juice machine was leaking. 6. The on/off control valve to one (1) of one (1) tilt skillet was leaking. 7. The handle from the lid cover to one (1) of one (1) tilt skillet was missing. 8. One (1) of two (2) plastic covers to one (1) of one (1) sugar storage bin was broken and a piece of that cover was missing. 9. Two (2) of two (2) scoop storage containers were soiled at the bottom with excess sugar and flour. 10. Two (2) of two (2) convection ovens were soiled with burnt food deposits. These observations were made in the presence of Employee #20 and Employee #21 who acknowledged the findings.	L 099	L099 cont. ▪ Implemented closing check out procedures for each team member. All staff will be properly checked out by a Manager or Supervisor in their respective area to ensure that all products is properly labeled and dated before end of shift. 2.The following procedures have been implemented addressing this area: Steam table cleaning 2/29/16 ▪ Daily clean-up of steam wells after each meal service updated in position job flow. ▪ Supervisor and Management inspection taking place after each meal period and end of shift. 3.Manager reviewed proper procedures for cleaning fryers with staff for cleaning and maintaining. Completed 3/1/16 4. Water inlet valve to juice machine properly reported to Maintenance, machine has since been taken out of service as it is no longer needed for service. 5. Tilt Skilled lid handle properly reported to Maintenance, equipment taken out of service until properly repaired 6. Plastic cover to sugar storage bin replaced. 3/3/16 7. On/off control valve of tilt skilled properly reported to Maintenance, equipment taken out of service until properly repaired 8. Storage scoops placed on weekly cleaning rotation in sanitation schedule. Completed 3/1/16	
L 199	3231.10 Nursing Facilities Each medical record shall document the course of the resident's condition and treatment and serve as a basis for review, and evaluation of the care given to the resident. This Statute is not met as evidenced by:	L 199		

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L 199	Continued From page 37 Based on observation, record review and staff interview for three (3) of 17 sampled residents and three (3) supplemental residents, it was determined that facility staff failed to ensure that a hospice discharge note was readily available in the active clinical record for Resident #24 and that the clinical record included documented evidence of discharge planning activities for two (2) residents. Additionally, facility staff failed to ensure that eight (8) of eight (8) glucometers [a medical device for measuring blood glucose] were set with the current date(s) and time. Resident's #20, 24 and 88. The findings include: 1. Facility staff failed to document evidence of measures related to facilitating Resident #20 ' s involuntary discharge from the facility. A review of the facility ' s documents revealed the facility provided a "Notice of Closure" letter signed by the Chief Executive Officer and dated November 3, 2015 (original notification was September 15, 2015) addressed to all residents [and/or responsible parties] residing in the facility that read: "This letter serves each of you as your official notice of closure and the need to transfer or discharge to another location. Final closure will be December 15, 2016...We will assure the continuity of services by providing the receiving facility with assessment and care plan, and for discharge, by arranging for those services required by the post discharge plan..." A social service progress note dated September 18, 2015 at 3:21 PM read, " Spoke with [family	L 199	L099 cont 9.Convection Ovens placed on weekly and monthly cleaning & sanitation schedules. Completed 3/1/16 4.Dining Services Director will review Daily Checklist inspections weekly and report any identified trends to the QAPI committee monthly 5. Compliance Date L199 1. Resident # 88,and # 20-Social services progress notes updated in regards to discharge planning 2.Audited current residents Social Services progress notes to identify needed documentation related to discharge planning-identified areas corrected 3.Re-educate Social Services department related to the need for ongoing and timely documentation related to discharge planning. 4. Director of Social Services or designee to audit Social Services progress notes weekly x 4 then monthly x 3. Any identified trends to be reported the QAP I committee monthly. Compliance Date	4/9/16 4/9/16

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L 199	Continued From page 38 member] about the closing of [Facility named]. S/he is interested in working with [family member] to find a place for [him/her] to live ....SE [southeast], NE [northeast] are a possibility. Also [local facility] is an option. Will continue to work with them to explore a safe discharge plan. " A social service progress note dated November 9, 2015 at 4:37 PM read, " The formal letter to resident notifying [gender] of closure of [name of facility] in December 2016, has been placed in the chart. This letter has also been mailed to the resident's responsible representative. " The clinical record lacked documented evidence of measures implemented by the social work staff subsequent to September 2015, as it relates to facilitating Resident #20 ' s involuntary discharge from the facility. A face-to-face interview was conducted with Employee #10 on February 26, 2016 at approximately 3:30 PM who acknowledged the findings. The record was reviewed February 26, 2016. 2. Facility staff failed to ensure that a hospice discharge note was readily available in Resident #24 ' s active clinical record. A review of a physician order dated October 29, 2015 directed, "discharge from hospice on 11/3/15 ... " A review of a Community Hospices note dated November 3, 2015 read: " ...Swer [social worker] discussed with pt [patient] discharge from	L 199	L199 cont 2.NP reviewed resident chart and completed a late entry related to hospice discharge 2.No other hospice clients at this time 3. UM to audit any residents on hospice caseload for appropriate documentation relating to admission and or discharge from services 4. Any identified trend will be reported to the monthly QAPI committee meeting. 5. Compliance Date 3. No resident adversely affected 2. Glucometer reset to correct time and date 3. 3-11 Supervisors to audit glucometers weekly to check for appropriate date and time. 4. Any identified trend will be reported to the monthly QAPI committee meeting. 5. Compliance Date	4/9/16 4/9/16

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L 199	Continued From page 39 hospice ... " A review of the clinical record lacked documented evidence of a hospice discharge note. On February 25, 2016 at approximately 9:45 AM a face-to-face interview was conducted with Employee #14 regarding the process of discharging a resident from hospice. He/she stated that the hospice staff will review the care plan to see if it has been adjusted, and a discharge note is placed in the chart. When asked where the discharge summary from hospice is found in the chart, Employee #14 stated that [vendor named] is the electronic medical record ssytem that is used by hospice and that the information is typically placed in the hospice section of the active clinical record. Employee #14 acknowledged that the hospice discharge summary was not in Resident #24 ' s clinical record. The record was reviewed February 24, 2016. 3. Facility staff failed to document evidence of measures related to facilitating Resident #88 ' s involuntary discharge from the facility. A review of the facility ' s documents revealed the facility provided a "Notice of Closure" letter signed by the Chief Executive Officer and dated November 3, 2015 (initial notification was September 15, 2015) addressed to all residents [and/or responsible parties] residing in the facility that read: "This letter serves each of you as your official notice of closure and the need to transfer or discharge to another location. Final closure will be December 15, 2016...We will assure the continuity of services by providing the receiving facility with assessment and care plan, and for	L 199		

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L 199	Continued From page 40 discharge, by arranging for those services required by the post discharge plan..." A review of Resident #88 ' s clinical record revealed the following Social Services progress notes: November 9, 2015 at 16:50 [5:50PM]; " The formal letter to resident notifying [gender] of closure of [name of facility] in December 2016, has been placed in the chart. This letter has also been mailed to the resident's responsible representative. " November 20, 2015 at 16:07 [4:07PM]; " Left message for RP [responsible party] on this date, to discuss discharge planning. Await call back. " January 18, 2016 at 15:37 [3:37 PM]; " Placed follow up call to [RP name] ...Awaiting call back to discuss transition planning. " A review of the facility ' s social work discharge planning tracking document(s) revealed that Resident #88 ' s primary representative [family] was contacted via teleconference on February 9, 2016. A discussion was held regarding " discharge options. " There was no evidence of documentation related to the February 9, 2016 teleconference regarding " discharge options. " A review of social service progress notes lacked documented evidence of measures implemented to facilitate Resident #20 ' s involuntary discharge from the facility. A face-to-face interview was conducted with Employee #10 on February 26, 2016 at approximately 3:30 PM regarding the aforementioned findings. He/she acknowledged	L 199		

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L 199	Continued From page 41 the social service notes were not current.. The record was reviewed February 26, 2016. 4. Facility staff failed to ensure that eight (8) of eight (8) glucometers were set with the current date(s) and time. An observation of eight (8) of eight (8) glucometers (on Unit 1A, 2A, 2B, 3A) revealed that the current date and time was not set on the devices/machines; and the dates and times of the blood glucose results registered in the device did not reconcile with the dates and times recorded in the electronic medical record for the respective resident(s). A face-to-face interview was conducted on February 22, 2016 at approximately11:25AM with Employees #4, #5, #6 and #7. They verified that the glucometers were not calibrated yearly for accuracy, they are used until they are unable to be turned on then they would be discarded and be replaced with new ones. There was no evidence that the glucometers machines were being checked by the facility to make sure the correct dates and times were set. A face-to-face interview was conducted with the Employee #24 on February 22, 2016 at approximately 12:05PM. He/she acknowledged findings. This record was reviewed February 22, 2016.	L 199		

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L 214	Continued From page 42	L 214	L214	
L 214	3234.1 Nursing Facilities Each facility shall be designed, constructed, located, equipped, and maintained to provide a functional, healthful, safe, comfortable, and supportive environment for each resident, employee and the visiting public. This Statute is not met as evidenced by: Based on observations made on February 22, 2016 between 11:30 AM and 3:00 PM, it was determined that the facility failed to provide an environment that is free from accident hazards as evidenced by surge protectors that were not mounted in two (2) of 38 resident rooms, a loose carpet on one (1) of three (3) pods on the third floor and a cluttered resident room was observed with a hand saw. The findings include: 1. The surge protector was not properly mounted and was observed on the floor in two (2) of 38 resident rooms. (#208 and #323). 2. The carpet in the hallway of unit 3A (blue pod) was loose and presented a tripping hazard. 3. Resident room #323 was cluttered with numerous items such as nails, screws, pieces of wood and metal that were scattered throughout and presented an accident hazard to the resident, staff and visitors, one (1) of 38 rooms surveyed. 4. The call bell in one (1) of 38 resident rooms surveyed was torn (#104) exposing the electrical wiring. These observations were made in the presence of Employee #22 and Employee #23 who acknowledged the findings. An isolated observation conducted on February 26, 2016 at approximatley 10:00 AM revealed that	L 214	1. Resident #54 returned from hospital, assessed and monitored x 72 hours with no negative outcomes 2.Reviewed all residents with fall with injury in the last 30 days to identify concerns related to hazards in the e nvironment-no identified concerns, areas noted to be free of safety hazards 3.All resident rooms will be inspected During weekly Maintenance Rounds to identify any concerns. Maintenance technicians re-educated on identifying areas of concern related to safety hazards -loose carpet, exposed electrical wiring, surge protectors unmounted 4. Plant operations Director or designee will review weekly Maintenance rounds checklists and report any identified trends to the QAPI committee Monthly 5.Compliance Date	4/9/16

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L 214	Continued From page 43 a carpenter-style hand saw approximately 15 - 18 inches in length was observed in one (1) resident room, resting atop a push cart readily accessible to anyone entering the room which posed a potential accident hazard. The findings were acknowledged by Employee #26 at approximately 10:05 AM on February 26, 2016.	L 214	L214 cont. 2. Surge protectors in rooms 208 and 323 re- mounted 3. Carpet in hall of blue pod-tightened 4.Call light replaced in room 104 2.Evaluated other resident rooms with no identified concerns of exposed electrical wiring/surge protectors not mounted and loose carpeting 3.All resident rooms will be inspected During weekly Maintenance Rounds to identify any concerns. Maintenance technicians re-educated on identifying areas of concern related to safety hazards -loose carpet, exposed electrical wiring, surge protectors unmounted 4. Plant operations Director or designee will review weekly Maintenance rounds checklists and report any identified trends to the QAPI committee Monthly 5.Compliance Date	4/9/16
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 made on February 22, 2016 between 11:30 AM and 3:00 PM, it was determined that the facility failed to maintain resident call systems as evidenced by inoperative call bells in two (2) of 13 resident rooms. The findings include: Call bells did not function as intended in two (2) of	L 306		

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L 306	Continued From page 44 38 resident rooms (#115 and #127). These observations were made in the presence of Employee #22 and Employee #23 who acknowledged the findings.	L 306	L306 1.Call lights in 115 and 127 replaced 2. Audited all call lights- no identified concerns noted 3.Resident rooms will be inspected During weekly Maintenance Rounds to identify any concerns. Maintenance technicians re-educated on identifying areas of concern 4. Plant operations Director or designee will review weekly Maintenance rounds checklists and report any identified trends to the QAPI committee Monthly 5.Compliance Date	4/9/16
L 410	3256.1 Nursing Facilities Each facility shall provide housekeeping and maintenance services necessary to maintain the exterior and the interior of the facility in a safe, sanitary, orderly, comfortable and attractive manner. This Statute is not met as evidenced by: Based on observations made on February 22, 2016 between 11:30 AM and 3:00 PM, it was determined the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior as evidenced by loose wallpaper on two (2) of five (5) resident care units, soiled bathroom vents in three (3) of 38 resident rooms, a loose cove base in one (1) of 38 resident rooms and marred walls in three (3) of 38 resident rooms. The findings include: 1. The wall paper was loose, unglued from the walls in unit 2b across from rooms #203 and #204, between rooms #207 and #208, on unit 2a between rooms #237 and #238 and next to room #247. 2. Bathroom vents were soiled on the inside and outside in three (3) of 38 resident rooms. (#123, #207 and #212). 3. The cove base close to the bathroom was	L 410		

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L 410	Continued From page 45 hanging loose and needed to be secured in one (1) of 38 resident rooms (#208). 4.Walls were marred in three (3) of 38 resident rooms (#207, #212, #255). These observations were made in the presence of Employee #22 and Employee #23 who acknowledged the findings.	L 410	L410 1.Loose wallpaper removed from walls between room 203/204 and 207/208 2.BR vents cleaned in rooms 123,207,212 3. Rooms 207,212,255 inspected by maintenance and marred walls repaired 4. Cover base in room 208 repaired 2.Maintence evaluated all other rooms to identify areas needing repair (loose wallpaper, soiled BR vents, Marred walls, loose cove base) areas of concerns repaired 3.Resident rooms will be inspected During weekly Maintenance Rounds to identify any concerns. Maintenance technicians re-educated on identifying areas of concern of loose wallpaper, soiled BR vents, marred walls, loose cove base. 4. Plant operations Director or designee will review weekly Maintenance rounds checklists and report any identified trends to the QAPI committee Monthly 5.Compliance Date	4/9/16
L 537	3270.2b Nursing Facilities (b) If the resident is likely to be discharged within six (6) months after the discharge assessment, a discharge plan. This Statute is not met as evidenced by: Based on record review and staff interview for seven (7) of seven (7) discharged sampled residents, it was determined that facility staff failed to develop a post-discharge plan of care to ensure the individual ' s needs will be met after discharge from the facility into the community. Residents ' #12, #40, #96, #100, #101, #107, and #118 The findings include: A letter sent to the residents from the Chief Executive Officer and Administrator of the facility dated November 3, 2015, regarding the facility ' s closure stipulated; " This letter is to establish the next steps as required by the District of Columbia Model Resident Transfer and Discharge Plan for Nursing homes .... When you and your representative are ready to move, we will provide you with the following information: A written statement of the medical assessment and evaluation, and post-discharge plan of care ... "	L 537		

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L 537	Continued From page 46 A review of the District of Columbia official Code 2001 Edition, Division VIII. General Laws Title 44. Charitable and Curative Institutions. Subtitle I. Health Related institutions. Chapter 10. Nursing Homes and Community Residence Facilities Protections. Subchapter III. Discharge, Transfer and Relocation of Residents. §44-1003.04 Discussion and Counseling "Before a resident is voluntarily or involuntarily discharged, transferred to another facility or reacted within a facility, a facility representative shall discuss the reasons for the move with the resident and his or her representative and shall answer any questions they must have about the move or the written notice they received pursuant to §44-1003.02 (a). The contents of the discussion shall be summarized in writing, include the names of the individuals involved in the discussion and be made a part of the resident ' s clinical record. In addition, the facility representative shall strongly recommend and offer to provide counseling services to the resident and his or her representative before the move. If the resident has requested a hearing pursuant to §44-1003.03 (a), facility staff shall attempt to prepare the resident for the possibility of having to move on 3-day (for an intra-facility relocation) or 5-day (for a discharge or transfer to another facility) notice should the hearing decision not be in his or her favor." 1. Facility staff failed to develop a post discharge plan of care for Resident #12. A review of Resident #12 ' s closed record revealed that the resident was admitted to the facility on April 2, 2013 and was discharged to	L 537	L537 1.Resident #12,40,96,100,101,107 and 118- previously discharged 2. Audited current resident records to identify the need for Discharge Plan of Care-identified concerns corrected 3.New Interdisciplinary Discharge plan of Care form implemented. Educate IDT on completion of Discharge Plan of Care 4.Director of Social services or designee to audit upcoming discharge charts weekly x 4 then monthly x 3. Any identified trends will be reported to the QAPI committee monthly. 5.Compliance Date	4/9/16

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L 537	Continued From page 47 another facility on December 22, 2015. There was no evidence that facility staff developed a post discharge plan to assess Resident #12 ' s continued care needs and developed a plan of care designed to ensure the individual ' s needs would be met after discharge from the facility. A face-to-face interview was conducted with Employee #10 on February 26, 2016 at approximately 1:00 PM regarding the aforementioned findings. He/she acknowledged there was no post discharge plan. The record was reviewed February 26, 2016. 2. Facility staff failed to develop a post discharge plan of care for Resident #40. A review of Resident #40 ' s closed record revealed that the resident was admitted to the facility on January 14, 2015 and was discharged to another facility on November 23, 2015. There was no evidence that facility staff developed a post discharge plan to assess Resident #40 ' s continued care needs and developed a plan of care designed to ensure the individual ' s needs would be met after discharge from the facility. A face-to-face interview was conducted with Employee #10 on February 26, 2016 at approximately 1:00 PM regarding the aforementioned findings. He/she acknowledged there was no post discharge plan. The record was reviewed February 26, 2016. 3. Facility staff failed to develop a post discharge plan of care for Resident #96.	L 537		

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L 537	Continued From page 48 A review of Resident #96 ' s closed record revealed that the resident was admitted to the facility on February 5, 2014 and was discharged to another facility on February 5, 2016. There was no evidence that facility staff developed a post discharge plan to assess Resident #96 ' s continued care needs and developed a plan of care designed to ensure the individual ' s needs would be met after discharge from the facility. A face-to-face interview was conducted with Employee #10 on February 26, 2016 at approximately 1:00 PM regarding the aforementioned findings. He/she acknowledged there was no post discharge plan. The record was reviewed February 26, 2016. 4. Facility staff failed to develop a post discharge plan of care for Resident #100. A review of Resident #100 ' s closed record revealed that the resident was admitted to the facility on December 3, 2013 and was discharged to another facility on December 11, 2015. There was no evidence that facility staff developed a post discharge plan to assess Resident #100 ' s continued care needs and developed a plan of care designed to ensure the individual ' s needs would be met after discharge from the facility. 5. Facility staff failed to develop a post discharge plan of care for Resident #101. A review of Resident #101' s closed record	L 537		

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L 537	Continued From page 49 revealed that the resident was admitted to the facility on December 27, 2013 and was discharged to another facility on February 26, 2016. There was no evidence that facility staff developed a post discharge plan to assess Resident #101 ' s continued care needs and developed a plan of care designed to ensure the individual ' s needs would be met after discharge from the facility. 6. Facility staff failed to develop a post discharge plan for Resident #107. A review of Resident #107 ' s closed record revealed that the resident was admitted to the facility on July 22, 2014 and was discharged to another facility on October 12, 2015. The resident ' s discharge date was prior to the facility ' s closure letter sent to the residents. However, there was no evidence that facility staff developed a post discharge plan to assess Resident #96 ' s continued care needs and developed a plan designed to ensure the individual ' s needs would be met after discharge from the facility. A face-to-face interview was conducted with Employee #10 on February 26, 2016 at approximately 1:00 PM. He/she acknowledged that there was no post discharge plan. The record was reviewed February 26, 2016. 7. Facility staff failed to develop a post discharge plan for Resident #118. A review of Resident #118' s closed record revealed that the resident was admitted to the	L 537		

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L 537	Continued From page 50 facility on June 19, 2015 and was discharged to another facility on December 6, 2015. The resident ' s discharge date was prior to the facility ' s closure letter sent to the residents. However, there was no evidence that facility staff developed a post discharge plan to assess Resident #118's continued care needs and developed a plan designed to ensure the individual ' s needs would be met after discharge from the facility. A face-to-face interview was conducted with Employee #10 on February 26, 2016 at approximately 1:00 PM. He/she acknowledged that there was no post discharge plan. The record was reviewed February 26, 2016.	L 537		