STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095021	A. BUILDING _____ B. WING _____	07/10/2015

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HEALTH & REHABILITATION CENTER AT THOMAS CIRCLE	1330 MASSACHUSETTS AVENUE NW WASHINGTON, DC 20005

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F 000	INITIAL COMMENTS A recertification Quality Indicator Survey was conducted July 7 through 10, 2015. The following deficiencies are based on observation, record review, resident and staff interview for 19 sampled residents. The following is a directory of abbreviations and/or acronyms that may be utilized in the report: Abbreviations AMS - Altered Mental Status ARD - assessment reference date BID - Twice- a-day B/P - Blood Pressure cm - Centimeters CMS - Centers for Medicare and Medicaid Services CNA- Certified Nurse Aide CRF - Community Residential Facility D.C. - District of Columbia DCMR- District of Columbia Municipal Regulations D/C Discontinue Dl - deciliter DMH - Department of Mental Health EKG - 12 lead Electrocardiogram EMS - Emergency Medical Services (911) G-tube Gastrostomy tube HSC Health Service Center HVAC - Heating ventilation/Air conditioning ID - Intellectual disability IDT - interdisciplinary team L - Liter Lbs - Pounds (unit of mass) MAR - Medication Administration Record MD- Medical Doctor MDS - Minimum Data Set	F 000	The Residences at Thomas Circle files this Plan of Correction for the purposes of regulatory compliance. The facility is submitting this document to comply with applicable law and not as an admission or statement of agreement of deficient practices herein.	

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

NHA Executive Director 8/18/15 Revised

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

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F 000	Continued From page 1 Mg - milligrams (metric system unit of mass) mL - milliliters (metric system measure of volume) mg/dl - milligrams per deciliter mm/Hg - millimeters of mercury MN midnight Neuro - Neurological NP - Nurse Practitioner PASRR - Preadmission screen and Resident Review Peg tube - Percutaneous Endoscopic Gastrostomy PO- by mouth POS - physician ' s order sheet Prn - As needed Pt - Patient Q- Every QIS - Quality Indicator Survey Rp, R/P - Responsible party SCC Special Care Center Sol- Solution TAR - Treatment Administration Record	F 000		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns;	F 272	**F272** **What corrective action will be accomplished for those residents found to be affected by the deficient practice?** Resident Number 18 still resides in the facility and the MDS correction was completed on 7/112015. However, it was determined that there was no impact on resident care as all appropriate and necessary care plans were in place. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** All hospice residents have the potential to be affected by the alleged deficient practice. DON, or designee, will audit all current residents on hospice to ensure that Section J is complete and accurate. Any assessment found with an incomplete Section J will be corrected immediately.	

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F 272	Continued From page 2 Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interviews for one (1) of 19 sampled residents, it was determined that the facility staff failed to accurately code the quarterly minimum data set [MDS] Section J 1400: Prognosis. Resident's #18. The findings include: Facility staff failed to accurately code Resident #18's quarterly MDS Section J 1400 for prognosis.	F 272	**What measures will be put into place or what systematic changes will be made to insure that the deficient practice does not recur?** To assure that the alleged deficient process will not recur, all IDT staff will be in-serviced on accurate coding of the J section for Hospice residents. Additionally, the MDS for all hospice residents will be reviewed at by the ADON, or designee, at the residents quarterly Care Plan Meeting. **How will the corrective action be monitored to insure the deficient practice will not recur, and what QA practice will be put into place?** All completed hospice MDS submissions will be audited by the DON, or designee, weekly x 4 weeks, bi weekly x 1 month, and monthly x 3 months. Any assessment found with an incomplete Section J will be corrected immediately and reported to the Administrator. These audits will be verified by the IDT at the monthly QA meeting.	

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F 272	Continued From page 3 A review of the resident ' s quarterly MDS with an Assessment Reference Date (ARD) of May 11, 2015 revealed that Section J Health Conditions: Other Health conditions J1400 Prognosis : does the resident have a condition or chronic disease that may result in a life expectancy of less than 6 months? (requires physician documentation.) was not coded. A review of the Interim Order Form Signed and dated February 24, 2014 revealed the physician referred the to Hospice Care. Late entry February 25, 2014 admit to [hospice named] with diagnosis of Dementia and CHF [Congestive Heart Failure] and prognosis less than 6 months. A face-to-face interview was conducted with Employee #2 on July 10, 2015 at approximately 3:30 PM after review of the aforementioned he/she acknowledged the findings. The record was reviewed on July 10, 2015.	F 272	F273 **What corrective action will be accomplished for those residents found to be affected by the deficient practice?** Resident #22 no longer resides in the facility. The MDS was completed on 7/11/2015.	
F 273 SS=D	483.20(b)(2)(i) COMPREHENSIVE ASSESSMENT 14 DAYS AFTER ADMIT A facility must conduct a comprehensive assessment of a resident within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or for therapeutic leave.) This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 19 sampled residents, it was	F 273	**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** All residents have the potential to be affected by the alleged deficient practice. All current residents admitted/re-admitted in the facility will be audited for completion and accuracy. Any MDS found to be incomplete will be completed immediately. All IDT staff will be in-serviced on accurate and timely submission of the MDS for each resident.	

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F 273	Continued From page 4 determined that facility staff failed to conduct the required admissions RAI (Resident Assessment Instrument) for Resident #22. The findings include: According to the Centers for Medicare and Medicaid Services, Long-Term Care Facility Resident Assessment Instrument User ' s Manual Version 3.0 February 5, 2015, pages 2-19: stipulates : " 01. Admission Assessment (A0310A=1). The Admission assessment is a comprehensive assessment for a new resident and, under some circumstances, a returning resident that must be completed by the end of day 14, counting the date of admission to the nursing home as day 1 if: this resident is the resident ' s first time in this facility, the resident has been admitted to this facility and was discharged return not anticipated, OR, the resident has been admitted to this facility and was discharged returned anticipated and did not return within 30 days of discharge. " A review of the clinical records revealed that Resident #22 was admitted to the facility June 22, 2015. According to the MDS (Minimum Data Set) tracking records, Resident #22 had an MDS (Minimum Data Set), Entry tracking record, which revealed under Section A1600- Entry date: June 22, 2015 and Under Section A1700: Type of Entry- Admission.	F 273	**What measures will be put into place or what systematic changes will be made to insure that the deficient practice does not recur?** The ADON, or designee, will utilize the MDS tracker and communicate all MDS due dates for new admissions at daily stand-up meeting to IDT members to ensure timely completion. **How will the corrective action be monitored to insure the deficient practice will not recur, and what QA practice will be put into place?** To assure that MDS are complete on all residents, all MDS will be audited by DON, or designee, weekly x 4 weeks, bi weekly x 1 month and monthly x 3 months. This will ensure that all admission assessments are completed within 14 calendar days of admission to the facility. Any MDS found to be incomplete will be corrected immediately and reported to the Administrator. These audits will be verified by the IDT at the monthly QA meeting.	

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F 273	Continued From page 5 The resident was in the facility from June 22, 2014 until July 10, 2015 (19 days) without an Admissions MDS. A face-to-face interview was conducted with Employee #2 on July 10, 2015 at approximately 11:00 AM regarding the aforementioned findings. After a review of the resident ' s clinical record and Minimum Data Set(s), he/she acknowledged the findings. The clinical record was reviewed on July 10, 2015.	F 273	**F281** **What corrective action will be accomplished for those residents found to be affected by the deficient practice?** Resident #27 no longer resides in the facility and therefore no corrective action could be taken retrospectively. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.**	8/24/15
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 19 sampled residents it was determined that facility staff failed to consistently assess and document the status of Resident #27 ' s pressure ulcer(s) in accordance with accepted standards of practice. Resident #27 The findings include: According to the National Pressure Ulcer Advisory Panel, " Staging " is an assessment system that classifies pressure ulcers based on anatomic depth of soft tissue damage. The characteristics of a pressure ulcer includes the following: Location; Staging; Size [length, width, depth, presence of undermining or tunneling]; Color; Odor; Exudate (if present); Wound bed	F 281	All residents have the potential to be affected by the alleged deficient practice. All residents currently on wound rounds will be assessed to ensure that the current wound sheets are reflective of wound status. Any variations or updates will be noted in the Medical Record. Additionally, all licensed nurses will be in serviced on proper and accurate assessment and documentation on pressure ulcers by date 8/15/2015. **What measures will be put into place or what systematic changes will be made to insure that the deficient practice does not recur?** The ADON, or designee, will review skin sheets on a weekly basis. Any blanks or discrepancies from the prior week will be investigated and addressed as appropriate to ensure complete and accurate documentation.	

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F 281	Continued From page 6 [granulation tissue, slough or escar]; Description of wound edges [rolled edges, redness, maceration] and the presence of Pain. Research has revealed that wounds do not heal in a reverse sequence, that is the body does not replace types and layers of tissue that was lost during the ulcer development [such as muscle, subcutaneous fat or dermis]. Reverse staging is not recommended to describe improvement of an ulcer. For example, a Stage IV Pressure Ulcer does not become a Stage III and so on. When a Stage IV Pressure Ulcer has healed, it should be classified as a healed Stage IV, not a Stage 0. A review of the clinical record for Resident #27 revealed that facility staff failed to accurately and consistently assess the status of the resident ' s pressure ulcer. The facility ' s " Wound Review " forms are documented on a weekly basis to record the status of a wound. Resident #27 was admitted to the facility on March 25, 2015 with a Stage I pressure ulcer of the sacrum. A review of wound notes read as follows: March 25, 2015 - Wound site: sacrum; Wound type: reddened area; Stage of wound: 1; Length and Width [remained blank, no data assessed]; Wound review: sacral redness with skin intact. May 6, 2015 - Wound Site: sacrum; Wound type: reddened area; Stage of Wound: 1; Length and Width [remained blank, no data assessed]; Wound review: Sacral redness, red and intact. May 13, 2015 - Wound Site: sacrum; Wound	F 281	**How will the corrective action be monitored to insure the deficient practice will not recur, and what QA practice will be put into place?** To assure that the alleged deficient practice will not recur, all pressure ulcer documentation will be audited by DON, or designee, for accurate assessment and consistent documentation. Audits will occur weekly x 1 month, bi-weekly x 1 month, and monthly x 3 months. Any skin sheet found to be incomplete will be addressed immediately as appropriate and reported to the Administrator. This POC will be audited by IDT members at the monthly QA meeting.	

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F 281	Continued From page 7 type: reddened area; Stage of Wound: 1; Length: 4.0 cm and Width: 4.0 cm; Wound review: Sacral redness, red and intact. June 3, 2015 - Wound Site: sacrum; Wound type: reddened area; Stage of Wound: not applicable; Length and Width [remained blank, no data assessed]; Wound review: sacral redness June 10, 2015 - Wound Site: buttock; Wound type: open lesion, cut, laceration or skin tear; Stage of Wound: 2; Length: 0.2 cm and Width: 0.2 cm; Wound review: redness to sacral area with open area to right buttock. June 17, 2015 - Wound Site: buttock; Wound type: open lesion, cut, laceration or skin tear; Stage of Wound: " not applicable; " Length: 0.2 cm and Width: 0.2 cm; Wound review: Open area to right buttock with erythema June 24, 2015 - Wound Site: buttock; Wound type: open lesion, cut, laceration or skin tear; Stage of Wound: 2; Length: 1.0 cm and Width: 0.3 cm; Wound review: Right buttock open area surrounded by erythema. July 1, 2015 - Wound Site: buttock; Wound type: open lesion, cut, laceration or skin tear; Stage of Wound: 1; Length: 0.5 cm and Width: 0.5 cm; Wound review: Right buttock 0.5x0.5 cm. In summary, the wound assessments sheets detailed above lacked evidence that staff assessed Resident #27 ' s pressure ulcer(s) in accordance with accepted standards of practice. The assessments were incomplete and inconsistently characterized. The length and width was not assessed in 3 of 8 skin sheets listed	F 281		

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F 281	Continued From page 8 above. The staging of the wound varied from " not applicable " to Stage I, II and then reverse Staging I. When staff identified a second wound, Stage 2 of the buttocks; it is evident that assessments related to the Stage 1 sacral wound were no longer apparent. Facility staff failed to accurately and consistently assess the status of Resident #27 ' s pressure ulcer(s) in accordance with accepted standards of practice. A face-to-face interview was conducted with Employee #2 who acknowledged the findings on July 9, 2015 at approximately 3 PM. Cross referenced to 483.25	F 281	F314 **What corrective action will be accomplished for those residents found to be affected by the deficient practice?** Resident #27 no longer resides in the facility and therefore no corrective action could be taken retrospectively. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** All residents have the potential to be affected by the alleged deficient practice. All residents currently on wound rounds will be assessed to ensure that the current wound sheets are reflective of wound status. Any variations or updates will be noted in the Medical Record. Additionally, all licensed nurses will be in serviced on proper and accurate assessment and documentation on pressure ulcers by date 8/15/2015. **What measures will be put into place or what systematic changes will be made to insure that the deficient practice does not recur?** The ADON, or designee, will review skin sheets on a weekly basis. Any blanks or discrepancies from the prior week will be investigated and addressed as appropriate to ensure complete and accurate documentation.	
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 19 sampled residents it was determined that facility staff failed to consistently assess and document the status of Resident #27 ' s pressure ulcer(s). Resident #27	F 314		

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F 314	Continued From page 9 The findings include: According to the National Pressure Ulcer Advisory Panel, " Staging " is an assessment system that classifies pressure ulcers based on anatomic depth of soft tissue damage. The characteristics of a pressure ulcer includes the following: Location; Staging; Size [length, width, depth, presence of undermining or tunneling]; Color; Odor; Exudate (if present); Wound bed [granulation tissue, slough or escar]; Description of wound edges [rolled edges, redness, maceration] and the presence of Pain. Research has revealed that wounds do not heal in a reverse sequence, that is the body does not replace types and layers of tissue that was lost during the ulcer development [such as muscle, subcutaneous fat or dermis]. Reverse staging is not recommended to describe improvement of an ulcer. For example, a Stage IV Pressure Ulcer does not become a Stage III and so on. When a Stage IV Pressure Ulcer has healed, it should be classified as a healed Stage IV, not a Stage 0. A review of the clinical record for Resident #27 revealed that facility staff failed to accurately and consistently assess the status of the resident ' s pressure ulcer. The facility ' s " Wound Review " forms are documented on a weekly basis to record the status of a wound. Resident #27 was admitted to the facility on March 25, 2015 with a Stage I pressure ulcer of the sacrum. A review of wound notes read as follows: March 25, 2015 - Wound site: sacrum; Wound	F 314	**How will the corrective action be monitored to insure the deficient practice will not recur, and what QA practice will be put into place?** To assure that the alleged deficient practice will not recur, all pressure ulcer documentation will be audited by DON, or designee, for accurate assessment and consistent documentation. Audits will occur weekly x 1 month, bi-weekly x 1 month, and monthly x 3 months. Any skin sheet found to be incomplete will be addressed immediately as appropriate and reported to the Administrator. This POC will be audited by IDT members at the monthly QA meeting.	

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F 314	Continued From page 10 type: reddened area; Stage of wound: 1; Length and Width [remained blank, no data assessed]; Wound review: sacral redness with skin intact. May 6, 2015 - Wound Site: sacrum; Wound type: reddened area; Stage of Wound: 1; Length and Width [remained blank, no data assessed]; Wound review: Sacral redness, red and intact. May 13, 2015 - Wound Site: sacrum; Wound type: reddened area; Stage of Wound: 1; Length: 4.0 cm and Width: 4.0 cm; Wound review: Sacral redness, red and intact. June 3, 2015 - Wound Site: sacrum; Wound type: reddened area; Stage of Wound: not applicable; Length and Width [remained blank, no data assessed]; Wound review: sacral redness June 10, 2015 - Wound Site: buttock; Wound type: open lesion, cut, laceration or skin tear; Stage of Wound: 2; Length: 0.2 cm and Width: 0.2 cm; Wound review: redness to sacral area with open area to right buttock. June 17, 2015 - Wound Site: buttock; Wound type: open lesion, cut, laceration or skin tear; Stage of Wound: " not applicable; " Length: 0.2 cm and Width: 0.2 cm; Wound review: Open area to right buttock with erythema June 24, 2015 - Wound Site: buttock; Wound type: open lesion, cut, laceration or skin tear; Stage of Wound: 2; Length: 1.0 cm and Width: 0.3 cm; Wound review: Right buttock open area surrounded by erythema. July 1, 2015 - Wound Site: buttock; Wound type:	F 314		

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F 314	Continued From page 11 open lesion, cut, laceration or skin tear; Stage of Wound: 1; Length: 0.5 cm and Width: 0.5 cm; Wound review: Right buttock 0.5x0.5 cm. In summary, the wound assessments sheets detailed above lacked evidence that staff assessed Resident #27 ' s pressure ulcer(s) in accordance with accepted standards of practice. The assessments were incomplete and inconsistently characterized. The length and width was not assessed in 3 of 8 skin sheets listed above. The staging of the wound varied from " not applicable " to Stage I, II and then reverse Staging I. When staff identified a second wound, Stage 2 of the buttocks; it is evident that assessments related to the Stage 1 sacral wound were no longer apparent. Facility staff failed to accurately and consistently assess the status of pressure ulcer(s) for Resident #27. A face-to-face interview was conducted with Employee #2 who acknowledged the findings on July 9, 2015 at approximately 3 PM.	F 314	**F323** **What corrective action will be accomplished for those residents found to be affected by the deficient practice?**	8/24/15
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced	F 323	1. Upon discovery, the extension cord/power strip was removed from the resident room and a new piece of furniture was utilized to reposition the electronic device closer to an outlet. 2. No corrective action could be taken retrospectively related to the lack of hydrocullator temperatures. However, since December 6, 2014, the hydrocullator temperatures had been recorded on a daily basis.	

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F 323	Continued From page 12 by: A. Based on observations and staff interviews, it was determined that the facility failed to ensure that the environment was free of accident hazards as evidenced by one (1) of one (1) extension cord, which posed a trip hazard that could result in an accident, was observed on the floor of one (1) of 19 resident ' s rooms. The findings include: The following observations were made on July 7, 2015 at 3:45 PM and July 10, 2015 at 10:20 AM: One (1) of one (1) extension cords were in use and observed on the floor of one (1) of 19 residents ' rooms (room #210). These observations were made in the presence of Employees #37 who acknowledged the findings. B. Based on observation, record review and staff interview, it was determined that facility staff failed to ensure residents' were free of potential accident hazards, as evidenced by staff not consistently monitoring and documenting the hydrocollator pack [moist heat] water temperatures in one (1) of one (1) hydrocollator unit.	F 323	**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** 1. On 7/10/15 all resident rooms were inspected and no other extension cords/power strips were found. Thus only one additional resident had the potential to be affected by this alleged deficient practice, as this is a "double occupancy" room (210). Again the extension cord/power strip was removed. 2. All residents utilizing therapy services have the potential to be affected by this alleged deficient practice. Again, hydrocullator temperatures have been recorded on a daily basis, and in accordance with regulatory requirements, since December 6, 2014. **What measures will be put into place or what systematic changes will be made to insure that the deficient practice does not recur?** 1. In conjunction with the PM Program, specific resident rooms will be inspected by the Plant Supervisor, or designee, within 72-hours of new admissions to ensure that no extension cords/power strips are in use. In the event that an extension cord/power strip is identified, it will promptly be removed and be reported to the Plant Operations Director for appropriate follow through. Additionally, staff will be in-serviced on what to do if they see an extension cord/power strip in use in a resident room.	

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F 323	Continued From page 13 The findings include: According to the facility ' s policy, " Rehab Care Clinical Practice Guidelines, Issue: 2.04, dated September 23, 2014 stipulates; " Hydrocollator Unit Maintenance -... The unit water temperature should be checked and recorded on a daily basis. " During an environmental tour of the Rehabilitation Department with Employee #19 on July 10, 2015 at approximately 10:30 AM, One (1) hydrocollator machine was in use. Upon review of the " Monthly Hydrocollator, Cold Packs and Paraffin Tank Temperature Log " it was noted the staff failed to consistently monitor and document the hydrocollator water temperatures on a daily basis. The " Monthly Hydrocollator, Cold Packs and Paraffin Tank Temperature Log " was used to document the hydrocollator packs water temperatures. The documentation recorded in the first (1st) column of the log was representative of the hydrocollator pack temperature prior to providing moist heat to residents as directed by a physician ' s order . A review of the Hydrocollator Temperature Log sheets for the period of October 2014 through July 2015 revealed the following: October 14-17, 2014- No temperatures documented	F 323	2. The Program Director, or designee, will review the temperature log weekly to ensure compliance with the daily documentation requirement. **How will the corrective action be monitored to insure the deficient practice will not recur, and what QA practice will be put into place?** 1. The Plant Director, or designee, will conduct room inspections weekly x 4 weeks, bi-weekly x 1 month and monthly x 3 months to ensure that this practice does not recur. In the event that an extension cord/power strip is identified it will promptly be removed and be reported to the Administrator. Any findings related to the admission room inspections and/or other room inspections will be reported to the IDT members at the monthly QA meeting. 2. The Associate Administrator, or designee, will audit the hydrocullator logs weekly x 4 weeks and monthly x 3 months to ensure compliance with the daily documentation requirement. Any instances of non-compliance shall be addressed and reported to the Administrator. Results of the audit will be reported to the IDT members at the monthly QA meeting.	

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F 323	Continued From page 14 October 20-24, 2014- No temperatures documented October 27-31, 2014- No temperatures documented December 1-5, 2014 - No temperatures documented A face-to-face interview was conducted with Employee #19 on July 10, 2015 at approximately 11:00 AM regarding the aforementioned findings. He/she acknowledged that the temperatures were not consistently monitored and documented.	F 323	**F371** **What corrective action will be accomplished for those residents found to be affected by the deficient practice?** 1. Upon discovery, the grill, burners and hot food transporters were cleaned by cooks and utility staff. 2. No corrective action could be taken retrospectively related to the lack of dish machine temperatures prior to March 1, 2015. However, since March 1, 2015, the dish machine temperatures had been recorded on a daily basis.	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations made in the main kitchen on July 7, 2015 at approximately 9:00 AM, it was determined that the facility failed to prepare and serve food under sanitary conditions as evidenced by one (1) of (1) soiled grill, eight (8) of eight (8) soiled burners from the gas stove and three (3) of three (3) hot food transporters that	F 371	**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** 1. All residents have the potential of being affected by this alleged deficient practice. Again, the grill, burners and hot food transporters were cleaned by cooks and utility staff upon discovery. 2. All residents have the potential to be affected by this alleged deficient practice. Again, dish machine temperatures have been recorded on a daily basis, and in accordance with regulatory requirements, since March 1, 2015. **What measures will be put into place or what systematic changes will be made to insure that the deficient practice does not recur?**	

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F 371	Continued From page 15 were dirty on the outside. The findings include: 1. One (1) of one (1) grill was soiled with burnt food deposits. 2. Eight (8) of eight (8) burners from the gas stove were soiled with leftover and spilled food particles. 3. Three (3) of three (3) hot food transporters were soiled on the outside. These observations were made in the presence of Employee #34 who acknowledged the findings. B. Based on record review and staff interview, it was determined that the facility staff failed to maintain dish machine temperature records on file for one (1) year. The findings include: A tour of the kitchen was conducted on July 10, 2015 at approximately 9:45 AM with Employee #35. A query was made to review the dish machine temperature records for the past twelve months. Employee #35 was able to produce March 2015 through July 10, 2015. Facility staff failed to maintain a file on dish machine temperature records for 1 year. The record was reviewed on July 10, 2015.	F 371	1. A cleaning checklist will be completed on a daily basis by the Executive Chef, or designee, to ensure that the grill, burners and hot food transporters are clean and ready for use. The Executive Chef, or designee, will in-service all food production staff on proper cleaning procedures related to the grill, burners and food transporters. 2. The Executive Chef, or designee, will review the temperature log weekly x 4 weeks to ensure compliance with the daily documentation requirement. In-service will also be provided to utility staff on the procedure of documenting daily temperatures for the dish machine. **How will the corrective action be monitored to insure the deficient practice will not recur and what QA practice will be put into place?** 1. The Food & Beverage Director, or designee, will conduct kitchen inspections weekly x 4 weeks and monthly x 3 months and quarterly thereafter to ensure that this practice does not recur. In the event that the grill, burners or food transporters are soiled, they will promptly be cleaned and be reported to the Administrator. Any findings related to the inspections will be reported to the IDT members at the monthly QA meeting. 2. The Food & Beverage Director, or designee, will audit the dish machine logs weekly x 4 weeks and monthly x 3 months to ensure compliance with the daily documentation requirement. Any instances of non-compliance shall be addressed and reported to the Administrator. All will be kept on file in the	
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an	F 441		

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F 441	Continued From page 16 Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for 7	F 441	Food & Beverage Office for a period of one-year. Results of the audit will be reported to the IDT members at the monthly QA meeting. **F441** **What corrective action will be accomplished for those residents found to be affected by the deficient practice?** HR has completed an audit of all employee files to 1.) Ensure all current employees have an annual TB screen on record and 2.) Identify individuals with a history of positive PPD TB skin test and ensure these individuals are certified free of communicable diseases by a physician. Audit effective completion date is 8/10/2015. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** All residents have the potential to be negatively Effected by the alleged deficient practice. Effective 7/27//2015 we have created and implemented an updated Employee Health Screening form that meets all applicable Federal and/or state/District of Columbia guidelines. Completion of this form will be required upon hire for new employees and to be renewed on an annual basis for every employee. Additionally, Health Wellness Event will be scheduled no later than August 30th where the community will have our in-house medical providers see and complete each employee clearance form. Any	8/24/15

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F 441	Continued From page 17 of 34 personnel records reviewed, it was determined that the facility failed to implement measures to prevent the spread of infection as evidenced by failure to verify freedom of communicable disease for employees by way of annual TB screening (i.e. symptom screen). (Personnel records # 2, 4, 8, 9, 10, 11 and 12). (Personnel records # 2, 4, 8, 9, 10, 11 and 12). The findings include: Centers for Disease Control (CDC's) Prevention Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis (TB) in Health Care Setting, 2005. Morbidity and Mortality Weekly Reports (MMWR) 2005:54(RR17); 1-141 stipulates: "TB Screening Procedures ... all HCWs (health care workers) should receive baseline screening upon hire .....HCWs should receive TB screening annually (i.e., symptom screen) for all HCWs and testing for infection with M. tuberculosis for HCWs with baseline negative test results...HCWs with a baseline positive or newly positive...should receive one chest radiograph result to exclude TB disease. Instead of participating in serial testing, HCWs should receive a symptom screen annually". The facility's Policy titled " Employee Physical Examination" on pages 22 and 23 of the Employee Handbook revised April 2013 stipulates: "Your offer of employment is conditional upon a successful physical examination. The examination will assure that you are free from communicable diseases or any other health	F 441	in the scheduled wellness event will be sent a certified letter stating that they have the option to see their own personal medical provider in order to complete the clearance of a free communicable disease form. Once completed by their provider, they must present proof of this clearance and fit for work document no later than September 10, 2015. **How will the corrective action be monitored to insure the deficient practice will not recur, and what QA practice will be put into place?** Administrator and/or the Executive Director, will audit all employee health records no later than September 14, 2015 to ensure 100% compliance with this plan of correction. **How will the corrective action be monitored to insure the deficient practice will not recur, and what QA practice will be put into place?** Following this initial compliance audit, Associate Administrator or designee will complete an audit of all new hires bi-weekly x 2 months, and monthly x 3 months to assure continued compliance. Results of all audits will be reviewed at the monthly QA meeting.	

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F 441	Continued From page 18 condition, which would endanger the health and welfare of the residents or your fellow employees. This physical examination will be performed according to Federal and/or state/District of Columbia guidelines, including the Americans with Disabilities Act... The nature and the extent of the physical examination will be determined by The [Facility ' s name] The examination will be performed by The [Facility ' s name] examining physician and/or nurses and will be paid by The [Facility ' s name]. The3is physical examination will include a mandatory two step Mantoux test (which test for tuberculosis). If the outcome of the Mantoux test is positive, you will be required to have a chest x-ray. The charge for this x-ray will be paid for by The [Facility ' s name]... After the initial employment physical examination, you may be required to have additional examination as a condition of continued employment... State/District of Columbia regulations may prohibit certain Employment at The [Facility ' s name] if you have a communicable disease. If you feel you have contacted a communicable disease, you need to report that information to your department head immediately. A doctor ' s certificate documenting that you are free of communicable disease will be required in order to report back to work. " A review of personnel records revealed seven (7) clinical personnel were determined to have a	F 441		

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F 441	Continued From page 19 documented history of positive Purified Protein Derivative (PPD) Mycobacterium Tuberculosis (TB) skin test. Their personnel records lacked documented evidence that they were certified free of communicable disease. According to the Human Resources Director, the TB symptoms screen form was completed, signed and dated by the individuals themselves for six (6) employees. One (1) of the seven employees did not have an annual TB screen on record. (Personnel # 2, 4, 8, 9, 10, 11 and 12). 1. The facility failed to ensure that Personnel # 2 ' s Mycobacterium Tuberculosis symptom screen complied with the afore-stated regulations and guidelines. A review of Personnel # 2's health record conducted on July 8, 2015 revealed the following: (i). A " PA [posterior/anterior] and Lateral Chest X-ray " form dated July 11, 2013. The form noted: " INDICATION: Positive [Purified Protein Derivative]. Findings: " Lungs are free of infiltrate or effusion pubis no evidence of active granulomatous disease " . (ii). The facility ' s form titled " Mandatory Tuberculosis Screening Form" signed and dated May 25, 2015. The screening form included " Symptoms /Health Checklist " . The " Symptoms /Health Checklist " lacked a health care provider certification that Personnel # 2 is "free of	F 441		

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F 441	Continued From page 20 communicable disease". The freedom of communicable disease form was completed by Personnel #2 him/herself. 2. The facility failed to ensure that Personnel # 4 ' s Mycobacterium Tuberculosis symptom screen complied with the afore-stated regulations and guidelines. A review of Personnel # 4 ' s health record conducted on July 8, 2015 revealed the following: (i). A " Tuberculosis Control Program " form dated August 13, 2012. The form noted: " Lungs are free of active Tuberculosis Disease " . (ii). The facility ' s form titled " Mandatory Tuberculosis Screening Form" dated January 12, 2015. The screening form included a " Symptoms /Health Checklist " . The " Symptoms /Health Checklist " lacked a health care provider certification that Personnel # 4 is "free of communicable disease". The freedom of communicable disease form was completed by Personnel #4 him/herself. 3. The facility failed to ensure that Personnel # 8 ' s Mycobacterium Tuberculosis symptoms screen complied with the afore-stated regulations and guidelines. A review of Personnel # 8 ' s health record conducted on July 8, 2015 revealed the following:	F 441		

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F 441	Continued From page 21 (i). An " Internal Medicine/Primary Care " form dated December 20, 2011. The form noted that Personnel # 8 ' s Chest X-ray performed on February 7, 2011 was normal. (ii). The facility ' s form titled " Mandatory Tuberculosis Screening Form" dated August 18, (year illegible). The screening form included a " Symptoms /Health Checklist " . The " Symptoms /Health Checklist " lacked a health care provider certification that Personnel # 8 is "free of communicable disease". The freedom of communicable disease form was completed by Personnel #8 him/herself. 4. The facility failed to ensure that Personnel # 8 ' s Mycobacterium Tuberculosis symptoms screen complied with the afore-stated regulations and guidelines. A review of Personnel # 9's personnel record conducted on July 8, 2015 revealed the following: (i). A " Department of Imaging Services " report dated March 9, 2012. The report noted a normal exam of the chest. (ii). The facility ' s form titled " Mandatory Tuberculosis Screening Form" dated August 18, The screening form included a Symptoms /Health Checklist " . The " Symptoms /Health Checklist " lacked a health care provider certification that Personnel # 9 is "free of communicable disease". The freedom of communicable disease form was completed by Personnel #9 him/herself.	F 441		

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5. The facility failed to ensure that Personnel # 10 ' s Mycobacterium Tuberculosis symptoms screen complied with the afore-stated regulations and guidelines.

A review of Personnel # 10's health record conducted on July 8, 2015 revealed the following:

(i). A " Radiology " report dated June 16, 2011. The report noted: " INDICATION: Positive [Purified Protein Derivative]. Findings: ...Lungs are clear ...Impression: No evidence of pulmonary tuberculosis. "

(ii). The facility ' s form titled " Mandatory Tuberculosis Screening Form" dated August 18, 2014. The form included a " Symptoms /Health Checklist " . The " Symptoms /Health Checklist " lacked a health care provider certification that Personnel # 10 is "free of communicable disease". The freedom of communicable disease form was completed by Personnel #10 him/herself.

6. The facility failed to ensure that Personnel # 11 ' s Mycobacterium Tuberculosis symptoms screen complied with the afore-stated regulations and guidelines.

A review of Personnel # 11's health record conducted on July 8, 2015 revealed the following:

(i). An " Immunization / Screening Test Record "

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F 441	Continued From page 23 form signed and dated January 31, 2014. The test record noted: " ...Positive [Purified Protein Derivative] [skin test]: Chest X-ray 10/26/2010 [negative] " . (ii). The facility ' s form titled " Mandatory Tuberculosis Screening Form" dated June 22, 2015. The screening form included " Symptoms / Health Checklist " . The " Symptoms /Health Checklist " lacked a health care provider certification that Personnel # 11 is "free of communicable disease". The freedom of communicable disease form was completed by Personnel #11 him/herself. 7. The facility failed to ensure that Personnel # 12 complied with the afore-stated regulations and guidelines. A review of Personnel # 12's health record conducted on July 8, 2015 revealed the following: A " Chest X-Ray Report " signed and dated February 10, 2012. The Chest X-Ray report noted: " Clinical Indications: New Positive [Purified Protein Derivative] [skin test]. Impressions: This chest x-ray is negative for active tuberculosis disease. " A further review of the Employee ' s personnel record lacked documented evidence of an annual symptoms screen for the employee with documented history of positive Purified Protein Derivative [tuberculosis skin test].	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095021	A. BUILDING _____ B. WING _____	07/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 441	Continued From page 24 The health facility failed to ensure that Personnel #12 underwent annual TB screening. The health facility failed to ensure that facility ' s clinical personnel, with known / documented history of positive Tuberculosis Skin Test were screened and certified "free of communicable disease". Ongoing face-to-face interviews were conducted with the Human Resources Director on July 8, 9 and 10, 2015 at approximately 10: 30 AM to 1: 30 PM. A follow-up face-to-face interview was conducted with the Facility's Administrator on July 9, 2015 at approximately 11:00 AM. After a further review of the afore-stated regulations and guidelines, they both acknowledged the findings. The records were reviewed on July 10, 2015.	F 441	F469 **What corrective action will be accomplished for those residents found to be affected by the deficient practice?** Pest Control contractor was contacted immediately upon report of sighting on 7/10/15. The Pest Control Contractor followed up and treated the area on 7/13/15. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** All residents have the potential to be affected by this alleged deficient practice. Environmental Service Director will conduct a full walk through with the Pest Control company to ensure all "hot spots" are on the routine list for treatment. Any areas with activity that are not on the routine treatment list will be added. **What measures will be put into place or what systematic changes will be made to insure that the deficient practice does not recur?**	8/24/15
F 469 SS=D	483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM The facility must maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by:	F 469	The Housekeeping Supervisor, or designee, will conduct routine rounds, not less than weekly, of the dishwasher area to ensure no new pest activity is present. If activity is noted, a call will be placed to the Pest Control company and it will be noted in the Pest Control binder on the nursing unit. Additionally, utility staff will be in serviced on proper cleaning and	

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F 469	Continued From page 25 Based on observation, and staff interview, it was determined that facility staff failed to maintain the kitchen free of crawling pest. The findings include: A tour of the kitchen was conducted on July 10, 2015 at approximately 9:45 AM. After checking the dish machine rinse cycle temperature, a crawling pest was observed on the wall behind the dish machine. The observation was made in the presents of Employee #35 who acknowledged the finding,	F 469	maintenance of the dish room to assist in the prevention of pest activity in the area. Staff will be re-educated regarding the proper protocol and follow-up for a pest control sighting which includes logging in the binder and contacting the Environmental Services director who will in turn contact the Pest Control contractor for follow up. **How will the corrective action be monitored to insure the deficient practice will not recur, and what QA practice will be put into place?** The Pest Control binders will be reviewed by the Environmental Services Director on a weekly basis to ensure sightings have been addressed by the Pest Control contractor. Any sightings noted but not addressed will be reported immediately. The number of sightings, locations and follow-up will be documented and presented at the monthly Quality Assurance Meeting.	
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 19 sampled residents, it was determined that facility staff failed to ensure that an Initial Nursing Assessment for hospice was a	F 514	**F514** **What corrective action will be accomplished for those residents found to be affected by the deficient practice?** The hospice admission assessment for resident #18 was completed but not in the patient's personal medical record. Hospice provided a copy for the facility which was placed on the chart. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.**	8/24/15

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F 514	Continued From page 26 part of the active clinical record. Resident #18 The findings include: A review of the Interim Order Form Signed and dated February 24, 2014 revealed Referral for Hospice Care...; Late entry February 25, 2014 admit to [hospice named] with diagnosis of Dementia and CHF [Congestive Heart Failure] and prognosis less than 6 months. A review of the resident's activie clincal record lacked evidence of the Initial Nursing Assessment for hospice. A face-to-face interview was conducted with Employee #34 and Employee #2 on July 10, 2015 at approximately 3:30 PM after review of the aforementioned both acknowledged the findings. The record was reviewed on July 10, 2015.	F 514	All hospice residents have the potential to be affected by this practice. The facility hospice nurse will review all records for current hospice residents to ensure that they have admission assessments as part of their personal medical record. Any resident without an assessment present will be copied and placed in the medical record immediately. **What measures will be put into place or what systematic changes will be made to insure that the deficient practice does not recur?** The ADON, or designee, will review the medical record within 72 hours of resident being admitted to hospice to ensure that admission assessment is present on file. In the event that the assessment is missing, hospice will be contacted immediately to provide a copy and the DON will be notified. **How will the corrective action be monitored to insure the deficient practice will not recur, and what QA practice will be put into place?** All new admissions to hospice will be audited by the DON, or designee, weekly x 4 weeks, bi-weekly x 1 month, and monthly x 3 months. Any assessment not found in the record will be obtained immediately and reported to the Administrator. These audits will be verified by the IDT at the monthly QA meeting	