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 _____	06/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 on June 2 through June 9, 2014. The deficiencies are based on observation, record review and interviews for 22 sampled residents. 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 EMS - Emergency Medical Services (911) NP - Nurse Practitioner BID - Twice- a-day HVAC - Heating ventilation/Air conditioning Neuro - Neurological B/P - Blood Pressure CRF - Community Residential Facility EMS - Emergency Medical Services (911) DMH - Department of Mental Health Peg tube - Percutaneous Endoscopic Gastrostomy NP - Nurse Practitioner BID - Twice- a-day B/P - Blood Pressure L - Liter Dl - deciliter CMS - Centers for Medicare and Medicaid Services Lbs - pounds (unit of mass) MAR - Medication Administration Record MDS - Minimum Data Set Mg - milligrams (metric system unit of mass) mL - milliliters (metric system measure of	F 000	**This Plan of Correction is submitted without denying or acknowledging that the cited deficiencies exist. This plan of correction is a requirement of the Department of Health.**	

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

Administrator | 8/7/14

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 volume) mg/dl - milligrams per deciliter POS - physician ' s order sheet Prn - As needed 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 mm/Hg - millimeters of mercury PICC- Peripheral Intravenous Central Catheter APRN- Advanced Practice Nurse RN- Registered Nurse QA- Quality Assurance	F 000		
F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on record review, family interview, and staff interviews for one (1) of 22 sampled residents, it was determined that the facility staff failed to resolve a grievance related to missing clothing for Resident #13. The findings include: During a family interview conducted on June 3,	F 166	**F166** **How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.** The facility has a policy of not reimbursing for lost or stolen items. The family was notified of this policy by the facility during the survey process and it was documented on a concern form on 6/30. **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** All residents and their responsible parties have the potential to be affected by the same deficient practice as all residents and their responsible parties have personal belongings. The SW will be	

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F 166	Continued From page 2 2014 at approximately 10:15 AM, the family member was asked, "Has [Resident ' s name] had any missing personal items?" He/she stated, " Yes, this has been a constant back and forth with the facility staff. A ton of my family members ' [Resident #13] stuff is missing. I filled out a complaint form at least twice, maybe three times ...have had multiple conversations and nothing has ever been done. This has been going on since the beginning of May 2014. I have spoken to the administrator, the social worker, and the laundry supervisor. There is a sign in the closet stating, ' Family will do laundry. ' They ignore the sign. My last conversation with the social worker was insulting. I was passed to housekeeping and still nothing has been resolved. No one seems to know what is going on. I just want this fixed. " The family member was asked, "Has the staff told you that they are looking for the missing items(s)?" He/she stated, "No." The ' Grievance QA [Quality Assurance] Log ' for May and June 2014 and emails [electronic mail] dated May 16, 28, 29, 2014 were reviewed on June 5, 2014. The emails revealed the facility staff were made aware of the missing clothing by the family member. A review of the facility's ' Grievance QA [Quality Assurance] Log ' revealed there was nothing documented by the facility staff addressing the family member ' s concerns regarding the resident ' s missing items; and there was no evidence of a resolution to the resident's missing property.	F 166	re-in serviced on the personal belonging and grievance policy. For a period of 3 months, all concerns and complaints will be forwarded to QA to ensure compliance with the policy. **What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur.** The SW will be in-serviced on the grievance policy. All grievances will be brought to morning meeting also for a period of 3 months, all concerns and complaints will be forwarded to QA by the SW to ensure compliance with the policy. **Indicate how you plan to monitor your performance to make sure that solutions are sustained. You must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction must be integrated into the quality assurance system.** 100% of concerns will be reported to QA by the SW and audited for a period of three months. **Include dates when corrective action will be completed.** 9/8/2014	

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F 166	Continued From page 3 A review of the facility ' s grievance log lacked evidence that a complaint/concern form was recorded and/or investigated. A face-to-face interview was conducted with Employee #13 on June 5, 2014 at approximately 2:00 PM. A query was made regarding Resident#13 ' s personal missing items. He/she stated, " I have e-mails from the family member and am aware of the concerns, but have not documented anything in the ' Grievance QA ' (Quality Assurance) log." A face-to-face interview was conducted with Employee #1 on June 6, 2014 at approximately 3:30 PM. A query was made regarding the process to resolve the grievance. He/she stated, "The grievance was investigated. " There was no evidence that facility staff implemented measures to resolve the grievance expressed by Resident #13 ' s family. The facility staff failed to ensure that a grievance expressed by the family member of Resident #13 was resolved.	F 166		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations during the survey period	F 241	**F241** **How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.** The residents shower schedule will be removed from the assignment sheets by the staffing coordinator. The drapes were fixed in the resident's room by Housekeeping. **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.**	

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F 241	Continued From page 4 of June 2, through June 5, 2014 it was determined that the facility failed to consistently maintain an environment which ensured the dignity of its residents as evidenced by the posting of personal care information on the daily staffing assignment sheet and drapes in one (1) resident ' s room held together with a large (black-colored) binder clip. Resident #53 The findings include: 1. Facility staff failed to consistently maintain an environment which ensured the dignity of its residents as evidenced by the posting of personal care information on the daily staffing assignment sheet. The initial tour was conducted on June 2, 2014 at approximately 9:00 AM. Review of the facility ' s SNF (Skilled Nursing Facility) Assignment Sheet dated June 2, 2014 indicated that the form was divided in to three (3) columns of room numbers identified as Group I, II and III, with an associated staff member for each column/group. Within the columns of room numbers, three (3) resident room numbers were listed as " shower " , to include Group I - Room 202A, Group II - Room 206b, and Group III - Room 208P [private]; and one (1) resident room number from Group II reflected " LOA " (leave of absence) for Room 207P. The sheet was posted at the Nurses ' Station in view of all staff, residents, and/or visitors.	F 241	All residents have the potential to be affected by the same deficiency. Drapes will be checked for a period of 3 months by the housekeeping supervisor or designee to ensure that they are in good working order. The residents shower schedule will be removed from the assignment sheets by the staffing coordinator. **What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur.** All nursing staff will be in-serviced on removing the residents shower schedule from the shower sheets. New drapes have been ordered and will be installed. **Indicate how you plan to monitor your performance to make sure that solutions are sustained. You must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction must be integrated into the quality assurance system.** For a period of three months, the hskpg supervisor or designee will check the drapes at least once a month to make sure the correction actions have been implemented. The staffing coordinator will check the assignment sheets to make sure the facility is in compliance. Results will be reported to QA for a period of 3 months. **Include dates when corrective action will be completed.** 9/8/2014	

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F 241	Continued From page 5 A face-to-face interview was conducted on June 2, 2014 at approximately 9:20 AM with Employee #4 relative to the assignment sheet. Employee #4 explained that the sheet allows residents and staff to see the assigned personnel for the day, and allows the staff to confirm the bathing schedule. When queried as to the listing of personal care activities on the sheet, Employee #4 responded it is the practice to add the personal care schedule to the staffing assignment list as a matter of convenience for the staff. Employee #4 did not respond when queried regarding the public's ability to view the information. At 12:30 PM it was noted during the dining observation that the personal care information had been removed. The Assignment Sheet for the evening shift of June 4, 2014 was reviewed on June 5, 2014 at approximately 7:50 AM. The bottom portion of the assignment sheet reflected showers were designated for three (3) rooms. The facility staff failed to consistently maintain an environment which ensured resident dignity. 2. Facility staff failed to ensure the dignity of Resident #53 as evidenced by using a large (black colored) binder-style clip to hold the drapes closed.	F 241		

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F 241	Continued From page 6 During a resident interview conducted on June 2, 2014 at approximately 2:20 PM, a query was made to the resident, " Do you have any problems with the temperature, lighting, noise level or anything else in the building that affects your comfort? The resident responded, "The curtains would not close. I have sun in my eyes in the morning. " A second observation of the resident's room was conducted on June 3, 2014 at approximately 10:00 AM in the presence of Employee #2 and #8. It was observed that the drapes were held together by a large (black colored) binder clip. Employee #8 removed the clip and the drapes remained in the open position. A face-to-face interview was conducted on June 5, 2014 at approximately 11:00 AM with Employee #1. A query was made regarding the failure of the drapes to properly close in Room #210. Employee #1 stated, " We just ordered new drapes for the private rooms, that included Room 210." Employee #1 did not address the use of the large black colored binder clip that held the drapes together. Facility staff failed to ensure the dignity of Resident #53 as evidenced by using a large (black colored) binder clip to hold the drapes together.	F 241		
F 244 SS=D	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the	F 244	**F244** **How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.** Resident #13 and resident #51 were both spoken to regarding their concerns and resolution was documented in the resident council minutes on 7/29. No other residents voiced similar concerns.	

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F 244	Continued From page 7 facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for two (2) of 22 sampled residents, it was determined that the facility failed to act upon grievances identified through Resident Council Review. Resident #13 and #51. The findings include: 1.Facility staff failed to act upon a grievance voiced by Resident #13. On June 4, 2014 at approximately 2:00 PM, the surveyor reviewed the Resident Council meeting minutes for the period of July 2013 through May 2014. A review of the meeting minutes revealed that Resident #13 expressed concerns regarding missing items of clothing. The meeting minutes lacked evidence that the grievance was acted upon. 2. Facility staff failed to act upon a grievance voiced by Resident #51. On June 4, 2014 at approximately 2:00 PM, the surveyor reviewed the Resident Council meeting minutes for the period July 2013 through May	F 244	**How you will 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 same deficient practice. The Activities Director will be in-serviced on documenting her follow-up with residents. The Resident Council Minutes will be reviewed in the morning meeting. The Activities Director will submit the follow-up of resident council minutes to QA for a period of 3 months. **What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur.** The Activities Director will be in-serviced on documenting her follow-up with residents. The Activities Director will submit the follow-up of resident council minutes to QA for a period of 3 months. **Indicate how you plan to monitor your performance to make sure that solutions are sustained. You must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction must be integrated into the quality assurance system.** The Activities Director will be in-serviced on documenting her follow-up with residents.	

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F 244	Continued From page 8 2014. A review of the meeting minutes revealed that Resident #51 expressed a desire for a room change. The meeting minutes lacked evidence that the grievance was acted upon. A review of the facility ' s Grievance Log was conducted on June 5, 2014 at approximately 4:20 PM. The grievance log lacked evidence of any resolution of concerns expressed in the Resident Council Meetings and/or meeting minutes. A face to face interview was conducted with Employee #14 on June 4, 2014 at approximately 3:30 PM. A query was made regarding the actions taken to resolve the residents' grievances. Employee #14 verbalized that [he/she] personally brings the resident concerns from the Council meeting to the attention of the appropriate department representatives at the conclusion of each meeting. Employee #14 also stated he/she depends on the department to subsequently communicate resolutions to the residents, and in some instances when the department representatives give feedback, he/she personally informs the residents and/or families. When queried about the documentation of interventions, updates, and/or resolutions to concerns, Employee #14 responded, " I don ' t always write down every conversation. " A face-to-face interview was conducted on June 5, 2014 at approximately 9:43 AM with Resident #16. A query was made regarding if staff responds to the resident concerns. Resident #16 stated, " I do not feel the staff responds to resident concerns or grievances. " The resident provided no further information.	F 244	The Resident Council Minutes will be reviewed in the morning meeting. The Activities Director will submit the follow-up of resident council minutes to QA for a period of 3 months. **Include dates when corrective action will be completed.** 9/8/14	

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F 244	Continued From page 9	F 244		
F 246 SS=D	Facility failed to act upon grievances identified through Resident Council Review. 483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observations made during an environmental tour, it was determined that facility staff failed to ensure that the call bell in one (1) of 10 resident bathrooms observed were accessible and able to function as intended as evidenced by the call bell wrapped around the grab in the resident ' s bathroom. The findings include: During an environmental tour conducted on June 5, 2014 at approximately 11:00 AM in Room #209 it was observed that the resident ' s bathroom call bell (pull cord) was wrapped around the grab bar, thus prohibiting the bell to alarm if triggered [pulled].	F 246	**F 246** **How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.** The call bell was removed from the residents grab bar on or around 6/6. This issue was care planned for this resident. All other resident rooms were checked and no other rooms had similar issues. **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** All residents that can self ambulate and have the physical capability to wrap a call bell around the grab bar have the potential to be affected. All other resident rooms were checked and no other rooms had similar issues. **What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur.** The issue was care planned, as the resident has dementia and wrapped the cord around the grab bar them self. The nursing staff will be in-serviced on care planning residents for these behaviors that impact their reasonable accommodation of needs.	

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F 246	Continued From page 10 These observations were made in the presence of Employees #1, #2, #6, and #7 who acknowledged the findings.	F 246	**Indicate how you plan to monitor your performance to make sure that solutions are sustained. You must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction must be integrated into the quality assurance system.** Residents rooms will be audited once a week for three months by the DON or designee and results will be reported to QA to ensure that no call bells are wrapped around grab bars and if they are that the reason has been addressed. **Include dates when corrective action will be completed.** 9/8/14 **F 253** **How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.** The wet ceiling tile was replaced and the causation for the wet tile was corrected on or around 6/6. The window blinds were repaired and are in the process of being permanently replaced. The red stain is a stain, but the floor is scheduled to be replaced. The door that was "unable to close" had a walker in the closet and in the presence of the surveyor once the walker was removed the closet door shut.	
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations made during an environmental tour of the facility on June 5, 2014 at approximately 11:00 AM, it was determined that the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior as evidenced by the observation of a stained ceiling tile noted in one (1) of four (4) rooms, one (1) window drape held together with a large black colored binder clip in one (1) of 10 rooms observed and one (1) room with a red colored stain on the carpet and closet door that remained ajar, unable to close into its frame. The findings include: 1. Ceiling tiles were observed stained in one (1) of four (4) rooms, Room 209. 2. Window drapes were observed held	F 253		

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F 253	Continued From page 11 together by a large black colored binder-style clip in room 210. 3. In Room 205B, the closet door was unable to completely close and a red colored stain was observed on the carpet. These observations were made in the presence of Employees #1, #2, #6 and #7 who acknowledged the findings.	F 253	**How you will 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. All issues have been corrected or are in the process of being corrected. Rounds will be conducted on all rooms to make sure similar items are addressed. **What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur.** All housekeeping staff will be in-serviced on looking for and reporting maintenance related issues as the do the daily cleaning of the rooms. Similar issues were looked for in 100% of rooms during survey and no similar issues were found. 100% of rooms will be checked and then room checks will be done once a week by the Administrator or their designee for 3 months and reported to the QA committee for a period of three months. **Indicate how you plan to monitor your performance to make sure that solutions are sustained. You must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction must be integrated into the quality assurance system.** Room checks will be done once a week by the Administrator or their designee for 3 months and reported to the QA committee for a period of three months.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by:	F 280		

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F 280	Continued From page 12 Based on interview, and record review for one (1) of 22 sampled residents, it was determined that the facility staff failed to review and revise cae plans to reflect goals and approaches to ensure one (1) residents dental needs after tooth extraction. Resident #13 The findings include: 1. Facility staff failed to initiate a care plan to address Resident #13 ' s dental needs after his/her teeth were extracted. A telephone interview was conducted with the [Responsible Party named] for Resident #13 on June 2, 2014 at approximately 10:45 AM. When queried, does the [Resident #13 named] have any tooth problems, gum problems, mouth sores or denture problems. He/she replied, " Yes, I have concerns about the mouth. The Dentist pulled decayed teeth in March 2014. They were supposed to be getting bottom dentures but there has been no follow up. It ' s [the dental care] just hanging out there unresolved. " A review of the care plans revealed that the dental care plan lacked revisions to include goals and interventions to manage the tooth extractions performed March 14, 2014. Dental records signed February 7, 2014 (no time indicated) revealed, "Recommendations: Extract #26 and remove root tips #29 and #2 lower partial recommended and bridge from #22-28 is also recommended. After reviewing x- rays final treatment extract remaining teeth because they are non- restorative. Lower complete denture. "	F 280	**Include dates when corrective action will be completed.**9/8/14 **F 280** **How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.** The dentist and facility contacted Resident # 13'sfamily regarding the lower dentures and explained the plan. This issue was also care planned. **How you will 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 same deficient practice. All residents charts were checked for similar issues and no similar issues were found. Charge nurses will be in-serviced regarding appropriately updating care plans for things including dental services. **What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur.** Charge nurses will be in-serviced regarding appropriately updating care plans for things including dental services. An audit of 10% of charts per month will be completed by the DON or designee to ensure that dental services has been appropriately addressed and care planned. This audit will be conducted for a period of three months.	

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F 280	Continued From page 13 Dental care notes dated February 28, 2014 (no time indicated), revealed, "...Tooth #26 was extracted. Gel form was placed in extraction site and pressure was applied. " Dental care notes dated March 14, 2014 (no time indicated), revealed " ....Tooth #28 and root tips #27 and # 29. Suture was placed to assist in healing. " The Interdisciplinary progress notes dated March 14, 2014 at 3:00 PM revealed, " Seen by dentist, tooth extraction done. " A review of the "Resident Change Evaluation" form dated March 17, 2014 revealed, "Change Noted: New order, Resident is s/p [status/ post] tooth extraction upon MD [Medical Doctor] assessment resident was noted with redness in the gum ....New order given to start resident on Penicillin VK 250 mg [milligrams] 1 [one] tablet po [by mouth] BID [twice daily] 5 [five] days for gum infection." A face-to-face interview was conducted with Employee #4 on June 6, 2014 at approximately 3:15 PM. A query was made regarding whether or not the care plan was revised after the resident's teeth were extracted on March 14,2014. He/she stated it was not done. There was no evidence the facility reviewed or revised the care plan to identify interventions to manage the resident's dental care needs after his/her teeth were extracted. Employee #4 acknowledged the findings on June 6, 2014 at approximately 3:15 PM.	F 280	**Indicate how you plan to monitor your performance to make sure that solutions are sustained. You must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction must be integrated into the quality assurance system.** An audit of 10% of charts per month will be completed to ensure that dental services has been appropriately addressed and care planned. This audit will be conducted for a period of three months by the DON or designee. **Include dates when corrective action will be completed.** 9/8/14	

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F 280	Continued From page 14 The record was reviewed June 6, 2014.	F 280	**F309** **How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.** The Rehab staff followed up on the physician orders for a consult for Resident #20. The consult was performed on 6/6/14. .	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on resident observation, record review and staff interview one (1) of 22 sampled residents, it was determined that facility staff failed to obtain physical and occupational therapy consults as prescribed for one (1) resident. Resident#20 The findings include: Facility staff failed to follow physician ' s orders to obtain a Physical and Occupational Therapy consults for Resident #20. A review of the Resident #20 ' s quarterly MDS (Minimum Data Set) with an ARD date of March 3, 2014 revealed in Section I Active Diagnoses included: Coronary Artery disease, Hypertension, Renal Insufficiency, Hyperlipidemia, Arthritis, Hip Fracture, Depression and Cataracts.	F 309	**How you will 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 deficient practice. The nursing and rehab staff will be in-serviced regarding the rehab communication book.100% of charts will be initially audited to make sure residents have current evals and screens. An audit of 25% of resident charts per month will be conducted to ensure that rehab orders are being followed-up on. This audit will occur by the Rehab Director or designee and be reported to QA over a period of 3 months. **What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur.** The nursing and rehab staff will be in-serviced regarding the rehab communication book. A monthly audit of 25% of resident charts per month will be conducted to ensure that rehab orders are being followed-up on. This audit will occur by the Rehab Director or designee and be reported to QA over a period of 3 months	

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F 309	Continued From page 15 During a resident observation conducted on June 2, 2014 at approximately 11:30 AM and 12:30 PM, Resident #20 was observed seated in a wheelchair at the dining room table with his/her torso and head leaning forward and subsequently noted with his/her head leaned forward to a resting position on the table. A review of the resident ' s medical record revealed an " Interim Order Form " dated 2/27/14 [February 27, 2014]: PT/OT [Physical Therapy/Occupational Therapy] for chair/positioning assessment. Further review of the medical record lacked evidenced of a physical and occupational therapy assessment for positioning for Resident #20. A review of the " Interdisciplinary Progress Notes " revealed February 27, 2014 12:00 PM Nursing Entry: ...New order to for PT/OT for chair positioning assessment, order noted and PT/OT made aware ... " A review of the " Interdisciplinary Care Plan " revealed February 27, 2014 PT/OT evaluation for chair positioning assessment: Discipline PT/OT. A-face-to-face interview was conducted with Employees #2 and #21 on June 5, 2014 at approximately 3:00 PM. A query was made regarding the evaluation for the February 27, 2014 assessment for Resident #20 chair/positioning. After review of the Interim Orders, Employee #21 stated " that we do not have an assessment for chair/positioning for	F 309	**Indicate how you plan to monitor your performance to make sure that solutions are sustained. You must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction must be integrated into the quality assurance system.** An audit of 25% of resident charts per month will be conducted to ensure that rehab orders are being followed-up on. This audit will occur by the Rehab Director or designee and be reported to QA over a period of 3 months. **Include dates when corrective action will be completed.** 9/8/14	

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F 309	Continued From page 16 Resident #20, " and further stated that " this current rehab company just started in February 2014. " Facility staff failed to obtain physical and occupational therapy consultations for resident #20 as prescribed by the physician to manage the resident's positioning needs. The medical record was reviewed on June 5, 2014.	F 309	**F 312** **How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.** The resident was cleaned and changed on June 5th.	
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, record review and resident, staff interviews for one (1) of 22 sampled residents, it was determined that facility staff failed to ensure activities of daily living (ADL) were provided consistent with residents' needs. Resident #13. The findings include: 1) Facility staff failed to ensure that ADL care was provided in accordance with Resident #13's needs. The resident was observed in need of personal hygiene and grooming. During a family interview when asked " Does Resident #13 receive the assistance with dressing and grooming .....that he/she needs?	F 312	**How you will 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 that are reliant on staff for ADL care. Nursing staff will be in-serviced on proper ADL care, as well as resident refusal of ADL care. All residents were checked for similar issues and no similar issues were found. **What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur.** Nursing staff will be in-serviced on proper ADL care. **Indicate how you plan to monitor your performance to make sure that solutions are sustained. You must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction must be integrated into the quality assurance system.**	

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F 312	Continued From page 17 The response was " no " ... " They could do better in this area and coax [him/her]...I have talked to them about this ...sometimes I have to clean [his/her] after two [2] weeks go by, [he/she] smells and I notice [he/she] can ' t always clean [him/herself] well after a bowel movement. On June 3, at approximately 10:00 AM Resident #13 was initially observed wearing a red jacket, red/ white stripped top and red velour pants. A second observation was conducted on June 4, at approximately 8:00 AM, the resident was observed on that day to be wearing a red jacket , red/ white stripped top and red velour pants, the same clothing noted on June 3, 2014. According to the Annual Minimum Data Set [MDS] signed May 8, 2014; Section C, Cognitive Patterns, resident was severely impaired, Section G: Functional Status, supervision with personal hygiene and bathing and Section H: Bladder/Bowel, the resident was occasionally incontinent of urine. Resident #13 was observed on June 5, 2014 at 7:55 AM lying in bed fully dressed in the same clothing he/she had been observed wearing , on June 3rd and June 4, 2014. An interview was conducted with Employee #2 at the time of the observation. He/she stated that the resident is often resistant to care. When queried, he/she stated there are staff members that resident #13 responds to better than others and acknowledged it appeared the resident had slept in the clothes he/she was currently wearing. A second and third observation of the resident at	F 312	The resident will be monitored weekly by the DON or designee for a period of three months to ensure they are receiving appropriate ADL care. Results will be submitted to QA for a period of 3 months. **Include dates when corrective action will be completed.** 9/8/14	

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F 312	Continued From page 18 on June 5 and 6, 2014 revealed the resident was walking freely on the unit in a different clothing each day and appeared to be neatly groomed. Facility staff failed to ensure that Resident #13 received personal hygiene and grooming care consistent with resident needs.	F 312	**F 371** **How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.** The servers will be in-serviced on maintaining appropriate food temperatures during the serving of food per facility and state HAACP protocols. **How you will 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 impacted by the same deficient practice. All temps are taken daily and no similar issues were found. All servers will be in-serviced regarding serving food at appropriate temperatures. Audits will be conducted once a month by the FSM or designee for 3 months to ensure food is served with appropriate temperatures. These results will be reported to QA for a period of 3 months. **What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur.** Audits will be conducted once a month for 3 months by the FSM or designee to ensure food is served with appropriate temperatures. These results will be reported to QA for a period of 3 months.	
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, record review, and staff interviews, it was determined that facility staff failed to ensure that foods were distributed in a manner to minimize the risk of food borne illness as evidenced by a failure to maintain foods at safe temperatures on the steam table and/or chilled area during distribution; hot foods at holding temperatures at or greater than 145 degrees and cold foods at holding temperatures 41 degrees or less. The findings include: During a dining observation conducted on June 2, 2014 at approximately 12:00 PM Employee	F 371		

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F 371	Continued From page 19 #28 tested food temperatures prior to serving the lunch meal at 12:00 PM. The temperatures were assessed as follows: Soup 91 - degrees Fahrenheit (F); peas and carrots 178.5 - degrees; okra 187.5 - degrees; mash potatoes 127.2 - degrees; sloppy Joe 190 - degrees; chicken 179 - degrees; fries 160.0 - degrees; mechanical chicken 196.8 - degrees; broccoli 173.6; pureed chicken 163.7 - degrees; sweet potatoes fries 146.8 - degrees; tofu 153.3 degrees. Employee #28 noted that the mashed potatoes did not reach the 145 degrees for hot foods. Employee #28 requested another serving of potatoes. At approximately 12:10 PM the temperature of the second serving of potatoes was 141.2 degrees. As a result of the above, a test tray was conducted with Employee #28. Temperatures on the test tray at approximately 12:30 PM were as follows: Soup149 - degrees; peas and carrots 122 - degrees; okra 140 - degrees; mash potatoes130 - degrees; sloppy Joe 143 - degrees; chicken 149 - degrees; fries140 - degrees; mechanical chicken 143 - degrees; broccoli 165 - degrees; pureed chicken 146 - degrees; sweet potatoes fries 125 - degrees. In a face-to-face interview with Employee #28 and Employee #5 at the time of the test tray, both acknowledged that the peas, carrots, mashed potatoes and sweet potato fries failed to maintain temperatures of 145 degrees for hot	F 371	**Indicate how you plan to monitor your performance to make sure that solutions are sustained. You must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction must be integrated into the quality assurance system.** Audits will be conducted once a month for 3 months by the FSM or designee to ensure food is served with appropriate temperatures. These results will be reported to QA for a period of 3 months. **Include dates when corrective action will be completed.** 9/8/14	

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F 371	Continued From page 20 foods. The observation was made on June 2, 2014. A face-to-face interview was conducted on June 6, 2014 at approximately 2:30 PM with Employee #29. Employee #29 offered an explanation regarding the hot foods not holding a temperature of 145 for hot foods. He/she stated " I know why the mashed potatoes were not holding the temperature". He/she then indicated that he/she reviewed with the kitchen staff step-by-step on how to make the mashed potatoes, it is very important where the milk comes from. If the milk from the walk-in- freezer is used instead of milk that is steamed, then the mashed potatoes would not be hot. We will have a temperature log that specifically identifies cooking temperatures, holding temperatures and serving temperatures. Facility staff failed to ensure foods were served at acceptable temperatures.	F 371		
F 412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced	F 412	**F 412** **How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.** The dentist came and saw Resident #13 and re-clarified with the family the dental plan including for follow-up dental care. **How you will 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 same deficient practice. Charge nurses will be in-serviced regarding appropriately updating care plans for things including dental services.	

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F 412	Continued From page 21 by: Based on record review and staff interview for one (1) of 22 sampled residents, it was determined that facility staff failed to provide follow up dental care after the resident had tooth extractions. Resident # 13 The findings include: A telephone interview was conducted June 4, 2014 at 2:00PM with Resident #13 ' s family. When asked " Does [Resident#13 named] have any tooth problems, gum problems, mouth sores or dental problems?, he/she responded " Yes ... Two months ago they had a visiting dentist who examined my (family member) and they say he/she was a candidate for new dentures...They are supposed to get his/her teeth pulled and get bottom dentures but there has been no follow up and I have no idea what is going on. " A review of Resident #13 ' s medical record revealed an initial dental evaluation was done on February 7, 2014 with recommendations " to extract #26 and remove root tips #29 and #27 ...Lower partial [dentures] recommended...Final tx [treatment] extract remaining teeth. " The resident underwent tooth extractions on February 28, 2014 and March 14, 2014." No other entries or dental visits were recorded subsequent to March 14, 2014. A face-to-face interview was conducted with Employee #4 on June 6, 2014 at 2:30 PM. He/she stated, "The dentist comes every Thursday and must have missed this resident." The record was reviewed June 6, 2014.	F 412	**What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur.** Charge nurses will be in-serviced regarding appropriately updating care plans for things including dental services. An audit of 10% of charts per month will be completed by the DON or designee to ensure that dental services has been appropriately addressed and care planned. This audit will be conducted for a period of three months. **Indicate how you plan to monitor your performance to make sure that solutions sustained. You must develop a plan for ensuring that correction is achieved and sustained. This plan must be implement and the corrective action evaluated for it effectiveness. The plan of correction mu be integrated into the quality assurance system.** An audit of 10% of charts per month will be completed to ensure that dental services ha been appropriately addressed and care planned. This audit will be conducted for a period of three months by the DON or designee. **Include dates when corrective action wil completed.** 9/8/14	

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

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F 412	Continued From page 22 Employee #2 acknowledged the findings. F 431 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS SS=D The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 412 F 431	**F 431** **How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.** Although signatures were missing, the narcotic count was correct; signatures cannot be added retroactively. No residents were affected by this deficient practice. **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** All residents that take narcotics have the potential to be affected. All Charge Nurses will be in-serviced regarding signing for narcotics. Narcotic sign-in sheets will be audited once a month for 3 months by the DON or designee and results reported to QA to ensure compliance. **What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur.** All Charge Nurses will be in-serviced regarding signing for narcotics. Narcotic sign-in sheets will be audited once a month for 3 months by the DON or designee and results reported to QA to ensure compliance	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 431	Continued From page 23 This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview, two (2) of (2) medication carts observed, it was determined that facility staff failed to consistently maintain records to account for the receipt and reconciliation of controlled medications on the second (2) floor nursing unit. The findings include: Facility staff failed to consistently maintain records to account for the receipt and reconciliation of controlled medications on both medication cart of the second (2nd) floor nursing unit. A review of the " Controlled Drug Audit (Shift to Shift Count Sheet) " used for reconciliation of controlled medications was conducted on June 5, 2014 at approximately 10:00AM on the 2nd floor. At this time it was observed that signatures to verify the reconciliation of controlled substances were either omitted or signed by the same nurse in the spaces allotted for off duty/on duty nurses for all of the following: April 19, 2014 at 7AM the off duty/on duty nurse signatures were the same on cart #1 April 21, 2014 at 7AM the off duty/on duty nurse signatures were the same on cart #1 April 22, 2014 at 3PM the off duty/on duty nurse ' s signatures were the same on cart #1 April 25, 2014 at 3PM and 11PM the off duty/on duty nurse ' s signatures were the same on cart #1 April 28, 2014 at 7AM the off duty/on duty nurse ' s signatures were the same on cart #1	F 431	**Indicate how you plan to monitor your performance to make sure that solutions are sustained. You must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction must be integrated into the quality assurance system.** Narcotic sign-in sheets will be audited once a month for 3 months by the DON or designee and results reported to QA to ensure compliance. **Include dates when corrective action will be completed.** 9/8/14	

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F 431	Continued From page 24 May 1, 2014 at 7AM the off duty/on duty nurse ' s signatures were the same and at 11PM the on duty nurse signature was omitted on cart #1. May 2, 2014 at 3:00PM the on duty nurse ' s signature was omitted on cart #1. June 5, 2014 at 7:00AM the off duty nurse ' s signature was omitted on cart #2 According to facility ' s Controlled Substances Policy revised April 2007 under " Policy Interpretation and Implementation " #9 reads: " Nursing staff must count controlled drugs at the end of each shift. The nurse coming on duty and the nurse going off duty must make the count together. They must document and report any discrepancies to the Director of Nursing Services. " There was no evidence that facility staff consistently maintained records to account for the receipt and reconciliation of controlled medications. Controlled substance reconciliation records were either blank or signed by the same nurse as ' off-going and on-coming ' [tour of duty] on the occasions delineated above. A face-to-face interview was conducted with Employees #6 and #20 on June 5, 2014 at approximately 10:35AM. After reviewing the signature sheet forms, he/she acknowledged the aforementioned findings. The observation was conducted June 5, 2014.	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and	F 441		

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F 441	Continued From page 25 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: A. Based on observations, record review and staff interview for four (4) of 22 sampled	F 441	**F441** **How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.** The residents affected by the deficient practice suffered no adverse consequences of failing to wash their hands prior to eating. Going forward, residents will be given the option of using hand sanitizer prior to eating; this process began the week of June 5th. The garbage disposals air gap was corrected per the regulatory guidelines immediately after observation by the surveyor. **How you will 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 same deficient practice. The air gap was fixed immediately after observation and residents will be given the option to use hand sanitizer to clean their hands. **What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur.** All nursing and dietary staff will be in-serviced on proper hand washing techniques. The dining room will be audited once a month for 3 months by the DON or designee and results will be reported to the QA committee to ensure compliance with the hand washing	

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F 441	Continued From page 26 residents, it was determined that the facility failed to maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of disease and infection as evidenced by failure to ensure safe hand hygiene practices during dining and feeding for four (4) residents. Resident's #6 #13 #20 and #48. The findings include: 1. Facility staff failed to ensure safe hand hygiene practices during dining and feeding for Resident #6. During a dining observation conducted on June 5, 2014 at 7:45 AM, Employee #23 was observed preparing Resident #6 for the meal. The employee was observed to touch the surfaces of the chair in which Resident #6 was seated to position the resident at the table. The employee then picked up Resident #6 ' s plated meal from the kitchen and returned to the table. Employee #23 proceeded to handle a personal handbag, and immediately proceeded to feed Resident #6. Employee #23 failed to wash hands after touching surfaces and handling personal items, prior to serving and feeding Resident #6. Employee #23 was also observed to recover spilled food from Resident #6 ' s torso and lap and place it on the plate from which Resident #6 was being fed. 2. Facility staff failed to clean Resident #13 ' s hands prior to being served the breakfast meal in the dining room on June 5, 2014.	F 441	protocols and offering of hand sanitizer. The garbage disposal will be audited once a month for 3 months by the FSM or designee and results will be reported to the QA committee to ensure compliance with having an air gap. **Indicate how you plan to monitor your performance to make sure that solutions are sustained. You must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction must be integrated into the quality assurance system.** The dining room will be audited once a month for 3 months by the DON or designee and results will be reported to the QA committee to ensure compliance with the hand washing protocols and offering of hand sanitizer. The garbage disposal will be audited once a month for 3 months by the FSM or designee and results will be reported to the QA committee to ensure compliance with having an air gap. **Include dates when corrective action will be completed.** 9/8/14	

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F 441	Continued From page 27 The breakfast meal was observed in the main dining area from 07:45 AM through 08:30 AM on June 8, 2014. Resident #13 was observed being escorted to the dining room by Employee #24 and positioned at a designated table. Resident # 13 ' s' hands were not cleaned prior to being served his/her breakfast meal. Facility staff failed to serve food in a manner so as to prevent spread of infection. A face- to- face interview was conducted with Employee #2 on June 9, 2014 at approximately 3:30 PM he /she acknowledged the findings. 3. Facility staff failed to ensure safe hand hygiene practices during dining and feeding for Resident #20. During the dining observation on June 5, 2014 at approximately 8:05 AM, Employee #25 was observed preparing Resident #20 for the meal. The employee was observed to touch the surfaces of the chair in which Resident #20 was seated to position the resident at the table. The employee then picked up Resident #20 ' s plated meal from the kitchen and returned to the table and began feeding Resident #20. Employee #25 failed to wash hands after touching chair surfaces, prior to handling and feeding the plated meal. 4. Facility staff failed to ensure safe hand hygiene practices during dining and feeding for Resident #48. A dining observation was conducted on June 2, 2014 at approximately 12:15 PM. At	F 441		

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F 441	Continued From page 28 approximately 12:30 PM Employee # 10 was observed preparing Resident #48 for the meal. Employee #10 was observed to handle leg rests of the residents ' wheel chair to facilitate positioning at the dining table. Employee #10 then picked up Resident #48 ' s plated meal from the kitchen and served Resident #48. Employee #10 failed to wash hands after handling the leg rests, prior to handling the plated meal. B. Based on observations of the kitchen and staff interview, it was determined that facility staff failed to ensure that the kitchen ice machine had an air gap to prevent backup of containminates. The findings include: During a tour of the kitchen conducted on June 2, 2014 at approximately 9:00 AM, it was observed that the pipe leading from the garbage disposal lacked an air gap as evidenced by the pipe extending down into the drain. These observations were made in the presence of Employees #1, #5, #26 who acknowledged the findings. Additionally Employee #26 stated "the pipe keeps falling down into the drain." Facility staff failed to ensure that the kitchen garbage disposal pipe maintained an air gap to prevent backup of containminates.	F 441		
F 492 SS=D	483.75(b) COMPLY WITH FEDERAL/STATE/LOCAL LAWS/PROF STD	F 492		

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F 492	Continued From page 29 The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. This REQUIREMENT is not met as evidenced by: A. Based on record review and staff interview for two (2) of six (6) newly hired employees, it was determined that facility staff failed to ensure that newly hired personnel were properly credentialed. Employees #30 and #31. The findings include: During a review of new hires in the past four (4) months the following was revealed: Employee #30 was hired as a Certified Nurse Assistant on April 3, 2013 the personnel file lacked evidence of a current certification, annual evaluation, and CPR [Cardiopulmonary Resuscitation] card. The employee worked for a period greater than one (1) year in absence of required credentialing. Employee #31 was hired as a Certified Nurse Assistant on August 30, 2012 the personnel file lacked evidence of a current certification, annual evaluation, and CPR card. The employee worked for nearly two (2) years in absence of required credentialing. A face-to-face interview was conducted with	F 492	**F 492** **How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.** The investigations for employees #30 and #31 were completed and recorded in their employee file. The employees were suspended until they were able to either provide documentation of their license, or terminated. The physicians will begin to record their hours at the community. **How you will 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 same deficient practice. All employee files are being audited to ensure compliance with annual evaluations, certification and CPR. The physicians will begin to record their hours at the community. **What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur.** All employee files are being audited to ensure compliance with annual evaluations, certifications and CPR. The results of the audits, and subsequent improvements, will be reported to the QA committee for a period of 3 months by the HR manager or designee, or until the community is in 100% compliance.	

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F 492	Continued From page 30 Employees #1 and #19 on June 6, 2014 who indicated the following: through review of the personnel files the facility revealed via memo that Employees #30, and #31 were " unable to be verified via the online Nursing Assistant Registry for the District of Columbia. The employees were immediately removed from the schedule and placed on Administrative Leave pending an investigation into the status/validity of [his/her] nursing assistant certifications. Facility staff failed to ensure that staff were properly credentialed. The records were reviewed on June 6, 2014. B. Based on record review and staff interview during a review of staffing [physician, physician assistant, or an advanced practice registered nurse], it was determined that facility staff failed to provide an accounting of the minimum of two-tenths (0.2) hours per week for each resident at the facility. The findings include: According the District of Columbia Municipal Regulations Chapter 32, Title 22B, Section 3211.4, "Beginning January 1, 2011, each facility shall have either a physician, physician assistant, or an advanced practice registered nurse, excluding hours per week attributed to medical director duties, available on-site for a minimum of two tenths (0.2) hours per week for each resident at the facility."	F 492	The physicians will begin to record their hours at the community. The hours will be submitted to QA monthly for a period of at least 3 months by the medical director or designee. **Indicate how you plan to monitor your performance to make sure that solutions are sustained. You must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction must be integrated into the quality assurance system.** All employee files are being audited to ensure compliance with annual evaluations, certifications and CPR. The results of the audits, and subsequent improvements, will be reported to the QA committee for a period of 3 months by the HR Director or designee, or until the community is in 100% compliance. The physicians will begin to record their hours at the community. The hours will be submitted to QA monthly for a period of at least 3 months. **Include dates when corrective action will be completed.** 9/8/14	

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F 492	Continued From page 31 A review of physician, physician assistant, and/or advanced practice registered nurse validation hours was conducted on June 6, 2014 1:30 PM. A face-to-face interview was conducted with Employee #1 on June 6, 2014 at approximately 1:30 PM, a query was made regarding the method that the facility utilizes to verify the minimum two tenths (0.2) hours per week of on-site availability of the medical team [physician, physician assistant and/or nurse practitioner]. Employee #1 stated " We do not have where the physicians sign in." At that time Employee #1 obtained an email [electronic mail] from the Medical Director which indicated an agreement that the " [Acute care facility ' s name] " medical team [doctors and providers] would provide on-site coverage during specified time allotments. In addition, 24/7 [twenty four hour/seven days per week] coverage is provided for telephone access. The information provided lacked evidence of an accounting of the minimum of two tenths (0.2) hours week for each resident at the facility. Facility staff failed to provide an accounting of the minimum of two-tenths (0.2) on-site hours per week for the physician, physician assistant, and/or advanced practice registered nurse.	F 492		
F 514 SS=E	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	F 514		

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F 514	Continued From page 32 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 four (4) of 22 sampled residents, it was determined that facility staff failed to maintain complete and accurate clinical records as evidenced by failure of Hospice team to document and/or acknowledge changes in residents ' status for three (3) residents; inconsistent advanced directives for one (1) resident and failure to consistently document the status of edema for one (1) resident as specified in the care plan. Residents #11, 16, 17 and 31 The findings include: A. There was no evidence that the facility had a process in place to reflect how the hospice staff acknowledged changes in residents ' status. Residents #11, 17 and 31 sustained changes in status and the clinical record lacked evidence of documentation or acknowledgment of the changes by the hospice staff. 1. The hospice staff failed to document and/or acknowledge changes in status sustained by Resident # 11. Additionally, the advanced	F 514	**F 514** **How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.** On 7/10 a meeting was held with the hospice organization to discuss this deficiency. Beginning 9/8/14 nurses will notify hospice of changes in condition as well as the family. **How you will 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 same deficient practice. All nurses will be in-serviced on notifying hospice staff every time they notify the family of an issue. All hospice charts will be audited to ensure compliance with this policy for a period of 3 months going forward by the DON or designee. **What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur.** All nurses will be in-serviced on notifying hospice staff every time they notify the family of an issue. Hospice resident charts will be audited once a month for 3 month by the DON or designee and results will be forwarded the QA committee to ensure compliance with this policy.	

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F 514	Continued From page 33 directives recorded by the primary care physician as compared to hospice services were inconsistent. A review of the clinical record revealed: A ' Resident Change Evaluation ' form dated May 27, 2014, noted, " Old Scab fell off during shower R [right] lower leg. MD [Medical Doctor] notified new order to clean wound with NSS [normal saline solution], pat dry apply Alleryn Q [every] 3 [three] days. RP [responsible party] called, no answer, message left on voice mail [Name of physician] notified at 6:45AM.[Name of family member] notified at 6:55 AM. " The ' Resident Change Evaluation ' form dated June 04, 2014 noted, " Skin tear on L [left] upper arm. MD notified new order received to clean L (left) upper arm skin tear with NSS (normal saline solution [unreadable] apply bacitracin [unreadable] cover it [unreadable] border gauze BID [twice a day] until healed ....voice message left to RP [responsible party] physician [physician ' s name] notified 9:20 PM family [family member ' s name] notified 10:00 PM. " A face-to-face interview was conducted with Employee #4 on June 6, 2014 at approximately 3:00 PM and stated that "There are regularly scheduled care conferences to address the hospice residents." There was no documented evidence relative to a method that the hospice staff utilized to acknowledge an awareness of changes in the status of Resident #11.	F 514	**Indicate how you plan to monitor your performance to make sure that solutions are sustained. You must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction must be integrated into the quality assurance system.** Hospice resident charts will be audited once a month for 3 month and results will be forwarded the QA committee to ensure compliance with this policy. **Include dates when corrective action will be completed.** 9/8/14	

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F 514	Continued From page 34 Employee #4 acknowledged the aforementioned findings on June 6, 2014 at approximately 3:15 PM. 1(a). A review of the clinical record for Resident #11 revealed a discrepancy in advanced directives orders between the primary care physician as compared to the hospice provider. Hospice " collaborative physician ' s orders " signed February 10, 2014 read: " Code Status: Full Code. " Physicians ' orders signed by the primary care physician on June 3, 2014 [originated November 3, 2011 read: " No CPR " [cardiopulmonary resuscitation]. The advanced directives between the two providers were inconsistent. The record was reviewed on June 6, 2014. 2. The hospice staff failed to document and/or acknowledge changes in status sustained by Resident # 17. A review of the clinical record revealed the following: The ' Resident Change Evaluation ' form dated January 9, 2014 noted, " New order received to decrease Lasix to 10mg po [by mouth] qd [every day] for edema L [left], Podiatry consult for over grown toe nails. Toe nails cut by [Physician Name] Resident P.O.A [Power of Attorney] voice mail message left 6PM ... [Name of physician] notified at 5PM. "	F 514		

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F 514	Continued From page 35 The ' Resident Change Evaluation ' form dated March 22, 2014 noted, " Left Upper arm skin discoloration ...MD aware 4:10 PM new order received to monitor left upper arm discoloration Q every shift ...notify MD of any changes ...Voice message left for resident responsible party at 4:30: PM. " The ' Resident Change Evaluation ' form dated March 28, 2014 noted, " Abrasion on Right Knee discolorations on left arm and left big toe " ... " MD [Medical Doctor] notified at 4:40 AM , ordered to clean site with NSS [Normal Saline Solution], apply skin prep daily leave open to air. 4:40 AM ...RP [Responsible Party] notified at 5:00 AM. " The ' Resident Change Evaluation ' form dated May 3, 2014 noted, " L [left] arm abrasion ... L [left] arm abrasion noted. MD aware at 6PM new order received to clean L (left) arm with NSS, [normal saline solution], pat dry, apply hydrogel then cover with Allevyn Q [every] 3 [three] days until healed ... family notified 5/3/14 at 3:30PM 6:30 PM. " A face-to-face interview was conducted with Employee #4 on June 6, 2014 at approximately 3:00 PM and stated that "There are regularly scheduled care conferences to address the hospice residents." There was no documented evidence relative to a method that the hospice staff utilized to acknowledge an awareness of changes in the status of Resident #17.	F 514		

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F 514	Continued From page 36 Employee #4 acknowledged the aforementioned findings on June 6, 2014 at approximately 3:15 PM. The clinical record was reviewed on June 6, 2014. 3. The hospice staff failed to document and/or acknowledge changes in status sustained by Resident # 31. A review of the clinical record revealed: The ' Interdisciplinary Progress Notes ' dated May 3, 2014 at 8:00 PM noted, " L [left] arm abrasion noted MD aware [unreadable] new order received to clean L [eft] arm abrasion with NSS [normal saline solution] pat dry [unreadable]apply hydrogel then cover with Allevyn Q 3 days until healed ....family notified. " The ' Interdisciplinary Progress Notes ' dated May 7, 2014 at 11:20 PM noted, " Vomited X 1 [one time] undigested food ...MD notified, no new order received. RP [responsible party notified)] ... R [right] foot swelling noted ...Resident felt pain when asked to straighten the R [right] leg... Tylenol 500 mg [milligrams] given with good effect. MD notified RP [responsible party] informed. " The ' Interdisciplinary Progress Notes ' dated June 5, 2014 At 8:00 PM noted, " L [Left] arm abrasion noted MD aware [unreadable] new order received to clean L [left] arm abrasion with NSS(normal saline solution) pat dry [unreadable]apply hydrogel then cover with Allevyn Q [every] 3 [three] days until healed ....family notified. " A face-to-face interview was conducted with	F 514		

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F 514	Continued From page 37 Employee #4 on June 6, 2014 at approximately 3:00 PM and stated that "There are regularly scheduled care conferences to address the hospice residents." There was no documented evidence relative to a method that the hospice staff utilized to acknowledge an awareness of changes in the status of Resident #31. Employee #4 acknowledged the aforementioned findings on June 6, 2014 at approximately 3:15 PM. The clinical record was reviewed on June 6, 2014. B. Facility staff failed to document the status of Resident #16 ' s peripheral edema as related to the care plan interventions for Congestive Heart Failure. According to Resident #16 ' s quarterly Minimum Data Set dated May 25, 2014 she/he was coded in Section I with Active Diagnoses which included Atrial Fibrillation, Coronary Artery Disease, Heart Failure, and Hypertension. Resident #16 ' s care plan for Congestive Heart Failure, initiated February 21, 2013 read as follows: " Approaches " included a directive to assess " ...for peripheral edema, changes in respiratory pattern ... " The nursing staff documented the following changes to Resident#16 ' s medications: March 27, 2014 " increase Lasix to 40 milligrams by mouth each day ... " ; April 3, 2014 " ...increase Metoxalone five (5) milligrams to one (1) tablet by mouth daily for Congestive Heart Failure for	F 514		

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F 514	Continued From page 38 three (3) days, then resume every Monday, Wednesday, and Friday ... " ; April 10, 2014 " ... increase Lasix to 40 milligrams by mouth twice daily ... " ; and June 3, 2014 " ...weekly weights x 4 (four times) secondary to weight loss. Continued on Lasix, 40 milligrams twice daily. " A review of Resident #16 ' s Physician ' s orders revealed that nursing staff transcribed a telephone order on April 10, 2014, " Increase Lasix, 40 milligrams by mouth twice daily for Congestive Heart Failure " ; A review of the Medication Administration Records [MAR] for April 10 - 30, 2014 and the months of May and June 2014 revealed that nursing staff administered Lasix 40mg twice daily as prescribed. According to the Interdisciplinary Progress Notes, on April 11, 2014 the nursing staff documented medication changes relative to Resident #16 ' s Congestive Heart Failure after visit to his/her Cardiologist. Resident #16 ' s record lacked documented evidence that nursing staff consistently assessed the resident ' s status [presence or absence] as it relates to peripheral edema as specified in the care plan.. A review of the Interdisciplinary Progress Notes for the period of April 9, 2014 through June 2, 2014 revealed that the notes lacked documented evidence that Resident #16 was consistently assessed regarding the status of edema. On June 3, 2014 at 10:30 AM the nursing staff documented " ...Resident remains on Lasix, 40 milligrams twice daily. Swelling to lower extremity diminished. [Illegible] follow-up intervention with physician. "	F 514		

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F 514	Continued From page 39 The medical staff progress notes were reviewed on June 5, 2014 at approximately 3:50 PM. The following are the physicians ' assessments of the lower extremities for edema: March 5, 2014 at 11:23 AM - the facility ' s physician noted within the section for History of Present Illness (HPI) " ...patient medications include Lasix twice daily for Hypertension and Congestive Heart Failure, no edema no rales noted ... " Within the section for Physical Examination, the physician noted " ...Lower Extremities no edema pulses present ... " March 27, 2014 - the Report of Consultation per the Nephrologist indicated " ...2+ pre-tibial edema ... Increase Furosemide [Lasix] from 20 to 40 milligrams a day ... " April 7, 2014 at 11:23 AM - the facility ' s physician noted within the section for History of Present Illness (HPI) " ...history of Congestive Heart Failure with recent exacerbation improved, edema much improved on TED stockings ... " Within the section for Physical Examination, the physician noted " Lower Extremity Edema +1 improving, pulses present ... " The Plan included " ...edema much improved ...recommend to resume Metolazone three (3) times a week to avoid dehydration; continue Lasix 40 milligrams daily ... " April10, 2014 at 12:40 PM - the Division of Cardiology Report under the section " HPI " [history of present illness], " ...has had worsening leg swelling for the past three (3) weeks and has more cough during the day ... "	F 514		

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F 514	Continued From page 40 The Physical examination section detailed, " ...Lower extremities had 2+ edema bilaterally ... " The treatment plan included " ...increased [his/her] Lasix to 40 milligrams twice daily ... " May 5, 2014 at 2:34 PM - the facility ' s physician documented within the History of Present Illness " ...no shortness of breath, edema improved ... " and in the Physical Examination section " ...Lower Extremities no edema pulses present ... " May 23, 2014 a Report of Consultation from the Cardiologist indicated " ...No heart failure symptoms ...no leg edema ... " There were no further entries from the medical staff. The medical staff failed to consistently document the assessment of Patient #16 ' s edema. A face to face interview was conducted with Employee #2 on June 3, 2014 at approximately 2:15 PM. Employee #2 stated that "Resident #16 had an adjustment to the diuretics prescribed for Congestive Heart Failure on or about May 23, 2014 after evaluation by his/her Cardiologist, and this was considered to have triggered significant weight loss in Resident #16." The record lacked documented evidence of adjustments to the diuretics on or about May 23, 2014. A face to face interview was conducted with Employee #15 on June 3, 2014 at 11:45 AM. When queried as to how the information regarding Resident #16 ' s edema status, the response was the physician had relayed the information. Employee #15 stated s/he does not	F 514		

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F 514	Continued From page 41 perform physical assessments of edema. She/he explained the Dietary staff relies on the report from the nursing and medical staffs. The facility staff failed to consistently document consistent and quantitative assessments of the status of Resident #16 ' s edema as specified in the comprehensive plan of care. The record was reviewed June 5, 2014.	F 514		