Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0014	A. BUILDING: _____ B. WING _____	06/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH & REHABILITATION CENTER AT	1330 MASSACHUSETTS AVENUE NW WASHINGTON, DC 20005

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L 051	3210.4 Nursing Facilities A charge nurse shall be responsible for the following: (a)Making daily resident visits to assess physical and emotional status and implementing any required nursing intervention; (b)Reviewing medication records for completeness, accuracy in the transcription of physician orders, and adherences to stop-order policies; (c)Reviewing residents' plans of care for appropriate goals and approaches, and revising them as needed; (d)Delegating responsibility to the nursing staff for direct resident nursing care of specific residents; (e)Supervising and evaluating each nursing employee on the unit; and (f)Keeping the Director of Nursing Services or his or her designee informed about the status of residents. This Statute is not met as evidenced by: Based on 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.	L 051	**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.** L051 Please see POC for F309	

Health Regulation & Licensing Administration
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 7/12/13

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L 051	Continued From page 1 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. 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.	L 051		

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L 051	Continued From page 2 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 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.	L 051		
L 052	3211.1 Nursing Facilities Sufficient nursing time shall be given to each resident to ensure that the resident receives the following: (a)Treatment, medications, diet and nutritional supplements and fluids as prescribed, and rehabilitative nursing care as needed; (b)Proper care to minimize pressure ulcers and contractures and to promote the healing of ulcers: (c)Assistants in daily personal grooming so that the resident is comfortable, clean, and neat as evidenced by freedom from body odor, cleaned and trimmed nails, and clean, neat and well-groomed hair;	L 052	L052 Please see POC for F312	

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L 052	Continued From page 3 (d) Protection from accident, injury, and infection; (e)Encouragement, assistance, and training in self-care and group activities; (f)Encouragement and assistance to: (1)Get out of the bed and dress or be dressed in his or her own clothing; and shoes or slippers, which shall be clean and in good repair; (2)Use the dining room if he or she is able; and (3)Particlpate in meaningful social and recreational activities; with eating; (g)Prompt, unhurried assistance if he or she requires or request help with eating; (h)Prescribed adaptive self-help devices to assist him or her in eating independently; (i)Assistance, if needed, with daily hygiene, including oral acre; and j)Prompt response to an activated call bell or call for help. This Statute is not met as evidenced by: 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:	L 052		

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L 052	Continued From page 4 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? 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	L 052		

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L 052	Continued From page 5 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 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.	L 052		
L 055	3211.4 Nursing Facilities Weekly time schedules shall be maintained and indicate the number and classifications of nursing personnel, including relief personnel who work on each unit for each tour of duty. This Statute is not met as evidenced by: 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,	L 055	L055 Please see POC for F 492	

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L 055	Continued From page 6 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." 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.	L 055		

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L 108	Continued From page 7	L 108		
L 108	3220.2 Nursing Facilities The temperature for cold foods shall not exceed forty-five degrees (45°F) Fahrenheit, and for hot foods shall be above one hundred and forty degrees (140°F) Fahrenheit at the point of delivery to the resident. This Statute 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 #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.	L 108	L108 Please see POC for F371	

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L 108	Continued From page 8 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 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	L 108		

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L 108	Continued From page 9 a temperature log that specifically identifies cooking temperatures, holding temperatures and serving temperatures. Facility staff failed to ensure foods were served at acceptable temperatures.	L 108		
L 128	3224.3 Nursing Facilities The supervising pharmacist shall do the following: (a)Review the drug regimen of each resident at least monthly and report any irregularities to the Medical Director, Administrator, and the Director of Nursing Services; (b)Submit a written report to the Administrator on the status of the pharmaceutical services and staff performances, at least quarterly; (c)Provide a minimum of two (2) in-service sessions per year to all nursing employees, including one (1) session that includes indications, contraindications and possible side effects of commonly used medications; (d)Establish a system of records of receipt and disposition of all controlled substances in sufficient detail to enable an accurate reconciliation; and (e)Determine that drug records are in order and that an account of all controlled substances is maintained and periodically reconciled. This Statute 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	L 128	L128 Please see POC for F431	

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L 128	Continued From page 10 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 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	L 128		

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L 128	Continued From page 11 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.	L 128		
L 212	3233.5 Nursing Facilities Each facility shall use its best efforts to resolve each grievance as soon as practicable, and shall report to the resident and the Resident's Representative on the status of the resolution of the grievance at least thirty (30) days. This Statute 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	L 212	L212 Please see POC for F166	

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L 212	Continued From page 12 failed to resolve a grievance related to missing clothing for Resident #13. The findings include: During a family interview conducted on June 3, 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	L 212		

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L 212	Continued From page 13 family member ' s concerns regarding the resident ' s missing items; and there was no evidence of a resolution to the resident's missing property. 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.	L 212		
L 306	3245.10 Nursing Facilities A call system that meets the following requirements shall be provided: (a)Be accessible to each resident, indicating signals from each bed location, toilet room, and	L 306		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH & REHABILITATION CENTER AT	1330 MASSACHUSETTS AVENUE NW WASHINGTON, DC 20005

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 306	Continued From page 14 bath or shower room and other rooms used by residents; (b)In new facilities or when major renovations are made to existing facilities, be of type in which the call bell can be terminated only in the resident's room; (c)Be of a quality which is, at the time of installation, consistent with current technology; and (d)Be in good working order at all times. This Statute is not met as evidenced by: Based on observations made 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]. These observations were made in the presence of Employees #1, #2, #6, and #7 who acknowledged the findings.	L 306	L306 Please see POC for F246	

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L 410	Continued From page 15	L 410		
L 410	3256.1 Nursing Facilities Each facility shall provide housekeeping and maintenance services necessary to maintain the exterior and the interior of the facility in a safe, sanitary, orderly, comfortable and attractive manner. This Statute is not met as evidenced by: Based on observations made 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 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.	L 410	L410 Please see POC for F241	