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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095022 | A. BUILDING ______ B. WING ______ | 11/23/2015 |

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| TRANSITIONS HEALTHCARE CAPITOL CITY | 2425 25TH STREET SE<br>WASHINGTON, DC 20020 |

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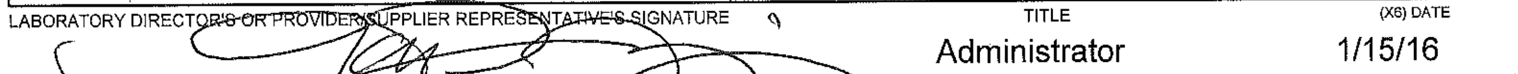
| F 000 | INITIAL COMMENTS<br><br>An unannounced Quality Comparative Survey was conducted at Transitions Healthcare - Captiol City from November 16, 2015 through November 23, 2015. Survey activities consisted of a review of 40 resident clinical records during Stage 1; review of 32 sampled residents during Stage 2; observations of staff practices; review of the facility's operating procedures; and interviews with residents, families, and facility staff. After analysis of the findings, it was determined that the facility is not in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities.<br><br>The following is a directory of abbreviations and/or acronyms that may be utilized in the report:<br><br>Abbreviations<br>AMS - Altered Mental Status<br>g-tube- Gastrostomy tube<br>EKG - 12 lead Electrocardiogram<br>NP - Nurse Practitioner<br>BID - Twice- a-day<br>EMS - emergency medical services (911)<br>HVAC - Heating ventilation/Air conditioning<br>Neuro - Neurological<br>B/P - Blood Pressure<br>CRF - Community Residential Facility<br>CNA- Certified Nurse Aide<br>DMH - Department of Mental Health<br>Peg tube - Percutaneous Endoscopic Gastrostomy | F 000 | Transitions Healthcare Capitol City is filing this Plan of Correction in accordance with State and Federal requirements. Submission of this Plan of Correction is not an admission of any of the deficiencies identified. This Plan of Correction is to serve as the facility's credible allegation of compliance with all the requirements of the Medicare/Medicaid programs. | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 1/15/16



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<br>NP - Nurse Practitioner<br>L - Liter<br>Dl - deciliter<br>CMS - Centers for Medicare and Medicaid Services<br>Lbs - pounds (unit of mass)<br>MAR - Medication Administration Record<br>MD- Medical Doctor<br>MDS - Minimum Data Set<br>Mg - milligrams (metric system unit of mass)<br>mL - milliliters (metric system measure of volume)<br>mg/dl - milligrams per deciliter<br>mm/Hg - millimeters of mercury<br>POS - physician ' s order sheet<br>Prn - As needed<br>Pt- Patient<br>TAR - Treatment Administration Record<br>PASRR - Preadmission screen and Resident Review<br>ARD - assessment reference date<br>IDT - Interdisciplinary team<br>ID - Intellectual disability<br>QIS - Quality Indicator Survey<br>D.C. - District of Columbia<br>D/C- Discontinue<br>Rp, R/P- Responsible Party<br>PO- By Mouth | F 000 | | |
| F 164 SS=D | 483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS<br><br>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.<br><br>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and | F 164 | 483.10(e), 483.75(l)(4) Personal Privacy/ Confidentiality of Records<br><br>1. The protection of resident's privacy while giving injectable medications was immediately reinforced upon discovery.<br>2. Medication Pass observations were conducted regarding privacy while giving injectable medications. Privacy was provided in every instance.<br>3. Licensed staff were inserviced regarding providing privacy while administering injectable medication. The Nursing Quality Improvement Team will audit for privacy during medication administration on a monthly basis. The results of these audits will be forwarded to the Director of Nursing for review and evaluation.<br>4. The Director of Nursing will present the findings of these audits along with any action plans for improvement to the Quality Improvement Committee which meets monthly and is chaired by the Administrator. | 11/18/15<br><br>11/25/15<br><br>11/30/15<br><br>2/3/16 |

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|---|---|---|---|---|
| F 164 | Continued From page 2 | F 164 | | |

meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.

Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.

The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.

The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.

This REQUIREMENT is not met as evidenced by:

Based on an observation and staff interview for one (1) of 32 Stage 2 sampled residents, it was determined that facility staff failed to respect one (1) resident ' s dignity by failure to keep the resident's body sufficiently covered while administering medication. Resident #103

The findings include:

Facility staff failed to respect Resident #103's dignity by failure to keep the resident's body sufficiently covered while administering medication.

On November 17, 2015 at approximately 11:35

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| F 164 | Continued From page 3<br>AM Employee #17 was observed from the hallway in room 329 with the door open removing Resident # 103 ' s shirt and administering an injection to his/her right arm. During the procedure the resident was visible to other residents, staff who were all present in the hallway at the time of the occurrence. A face-to-face interview was attempted with the employee immediately after the occurrence. He/she acknowledged the finding. | F 164 | | |
| F 241 SS=D | 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on an observation and staff interview for one (1) of 32 Stage 2 sampled residents, it was determined that facility staff failed to enhance one (1) resident's dignity during dining, as he/she sat idle while other residents dined. Resident #160.<br><br>The findings include:<br><br>Facility staff failed to enhance Resident #160's dignity during dining, as he/she sat idle, waiting to be served a meal while other residents dined.<br><br>On November 16, 2015 at approximately 12:38 PM, a dining observation was conducted on unit, 2 north. Four (4) of five (5) residents were | F 241 | 483.15(a) Dignity and Respect of Individuality<br><br>1. This resident does not routinely eat in this area for dining. Staff called for the tray to be delivered and subsequently was served.<br>2. A dining audit was conducted and all residents sitting at the same table were served together.<br>3. Licensed staff were inserviced regarding serving all the residents at the table at the same time to enhance dignity. The Nursing Quality Improvement Team will audit for Dignity during dining compliance on a monthly basis. The results of these audits will be forwarded to the Director of Nursing for review and evaluation.<br>4. The Director of Nursing will present the findings of these audits along with any action plans for improvement to the Quality Improvement Committee which meets monthly and is chaired by the Administrator. | 11/18/15<br><br>11/24/15<br><br>11/30/15<br><br>2/3/16 |

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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| F 241 | Continued From page 4<br>observed seated and eating their meals. Resident #160 [one (1) of the five (5) residents] was seated in his/her wheel chair at the table waiting for his/her meal to be served. Resident #160 called out, "Where is my tray. I don ' t think they are going to bring me nothing." Employee #22 who was present and feeding another resident stated, " Your food is on the way. They are going to bring you something. " At approximately 12:50 PM, Resident #160 ' s received his/her tray.<br><br>At the time of the observation, a face-to-face interview was conducted with Employee #7, who acknowledged the aforementioned findings.<br><br>Facility staff failed to enhance Resident #160's dignity during dining. | F 241 | 483.15 (e)(1) Reasonable Accommodation of Needs/Preferences<br><br>1. Upon discovery, the calls bells were placed within reach of the resident either by repositioning it on the bed or changing to a longer cord for the call bells in the bathrooms. | 11/18/15 |
| F 246 SS=E | 483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on observations made on November 17, 2015 at approximately 3:30 PM, it was determined that facility staff failed to accommodate the needs for two (2) of 32 Stage 2 sampled residents as evidenced by call bells | F 246 | 2. All call bells throughout the facility were inspected to ensure their proper position on the bed and their proper length in the bathrooms to ensure the accommodation of all residents' needs.<br>3. Nursing staff were inserviced regarding the accommodation of resident needs specific to call bell placement on the bed and the length of the call bell in the bathroom. The Nursing Quality Improvement Team will audit for the accommodation of needs specific to call bell placement and length on a monthly basis. The results of these audits will be forwarded to the Director of Nursing for review and evaluation.<br>4. The Director of Nursing will present the findings of these audits along with any action plans for improvement to the Quality Improvement Committee which meets monthly and is chaired by the Administrator. | 11/20/15<br><br>11/30/15<br><br>2/3/16 |

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|---|---|---|---|---|
| F 246 | Continued From page 5 | F 246 | | |

that were not within reach while the residents were in bed, as the call bells were observed on the floor and/or out of reach. Additionally, facility staff failed to ensure that pull cords to call bells located in resident bathrooms were fullly accessible in three (3) of 59 resident bathrooms. Residents' #10, #214, #242, #270, and #289.

The findings include:

1. Facility staff failed to ensure the Resident #10's call bell was accessible while he/she lied in bed.

The call bell in room #306 was observed on the floor, away from one resident who was in bed (B) and was not within his/her reach.

This observation was made during a one-to-one visit with the resident.

2.Facility staff failed to ensure the Resident #214 ' s call bell was accessible while he/she laid in bed.
On November 11, 2015 at 9:23 AM, Resident #214 was observed lying in bed. The resident stated, " I would like to use my call light. " Upon looking for the call the cord was observed extending from the wall and between the mattress and the bed frame, and out of the resident ' s reach.
This observation was made in the presence on Employee # 7, who acknowledged the finding.

3.Call bells located in the bathrooms of three (3) of 59 resident rooms that were observed were determined to have pull cords that were too short

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| F 246 | Continued From page 6 to be accessible by a resident while in the bathroom in the event of an emergency. The resdient rooms were assigned to Residents #242, Resient 289 and Resident 270. | F 246 | | |
| F 248 SS=D | 483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES<br><br>The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on observation, record review and staff interview for one (1) of 32 Stage 2 sampled residents, it was determined that facility staff failed to ensure that Resident #60, who was visually impaired received activities to accommodate his/her needs.<br><br>The findings include:<br><br>Resident #60 was observed lying in bed asleep at 11:00AM and again at 11:45AM on November 20, 2015. Employee # 21 was asked whether the resident would be awakened to eat lunch in the dining room. The employee responded that the resident got up for breakfast and went back to bed. He/she stated that the resident refused to get up earlier and stated that he/she was not ready to get up. He/she also added that the resident often refuses to get up and eats his/her meals in his/her room.<br><br>A review of the facility ' s Activities log revealed | F 248 | 483.15(f)(1) Activities Meet Interests/Needs Of Each Resident<br><br>1. An activities program designed to accommodate the needs of a visually impaired resident was put in place soon after discovery.<br>2. Activities programs for all other visually impaired residents were reviewed to ensure their needs were accommodated. No other program plans needed to be revised.<br>3. Activity staff were inserviced regarding the accommodation of needs for our visually impaired residents. The Activities Quality Improvement Team will audit for the accommodation of needs on a monthly basis. The results of these audits will be forwarded to the Director of Activities for review and evaluation.<br>4. The Director of Activities will present the findings of these audits along with any action plans for improvement to the Quality Improvement Committee which meets monthly and is chaired by the Administrator. | 11/23/15<br>12/15/15<br>11/30/15<br>2/3/16 |

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| F 248 | Continued From page 7<br>the following:<br><br>January 2015 - No documentation of activities.<br><br>February 2015 - There were three (3) of 28 occasions when the resident received activities.(moderate participation in pet therapy for February 18 and 25 and moderate participation in movies on February 27).<br><br>March 2015 -There was six (6) of 31 days of when the resident received activities. Moderate participation was documented for five (5) of the six (6) days [Movement/exercise, music therapy, group discussion and resident council] and the resident refused to participate in one (1) of six (6) days.<br><br>April 2015 - There was documentation that the resident participation in church service for one (1) day and refused to participate in activities for seven (7) days.<br><br>May2015 - There was one (1) of 31 days documented when the resident had moderate participation in church service.<br><br>June 2015 - There were three (3) of 30 days documented was listed under the area of Independent Hobby. The hobby was identified as " talking to self. "<br><br>August 2015 - There were four (4) of 31 documented days. On three (3) occasions the resident participated in moderate activities (the movies and a birthday party).<br><br>September 2015 - The resident is listed as having | F 248 | | |

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| F 248 | Continued From page 8<br>refused to participate in activities on nine (9) occasions and moderately participated in church service on one (1) occasion.<br><br>October 2015 - There was documented that the resident refused to participate on eight (8) occasions and participated in a birthday party on one (1) occasion.<br><br>November 2015 - one (1) the resident participated in a moderate activity, participation in Bible reading on three (3) occasions and refused to participate in any activities on three (3) occasions.<br><br>A face-to-face interview was conducted with Employee # 21 on November 20, 2015 at approximately 1:00PM. He/she was asked about the activities planned for the resident. Employee #21 responded that the resident preferred to remain in his/her room but that one-to-one sessions for Bible reading and listening to music were planned. However, a review of the activities log failed to reveal any evidence that the sessions occurred. The employee acknowledged the finding.<br><br>Facility staff failed to provide an ongoing program of activities designed to meet, the interests, the physical, and psychosocial well-being of Resident # 60 who was legally blind. | F 248 | | |
| F 253 SS=E | 483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES<br><br>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. | F 253 | 483.15(h)(2) Housekeeping & Maintenance Services<br><br>1. Air vents, privacy curtains, marred walls, and damaged geri-chair arm rests cited were addressed and corrected upon discovery.<br>2. All air vents, privacy curtains, resident room walls and geri-chair arm rests were evaluated to ensure a sanitary, orderly and comfortable interior.<br>3. Housekeeping and Maintenance staffs were inserviced on proper cleaning and repair techniques. The Facility Services Quality Improvement Team will audit for air vents, privacy curtains, marred walls and geri-chair arm rests on a monthly basis. The results of these audits will be forwarded to the Director of Facility Services for review and evaluation.<br>4. The Director of Facility Services will present the findings of these audits along with any action plans for improvement to the Quality Improvement Committee which meets monthly and is chaired by the Administrator. | 11/19/15<br>11/30/15<br>11/30/15<br>2/3/16 |

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| F 253 | Continued From page 9<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on observations made from November 16, 2015 thru November 20, 2015, 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: dusty air vents in three (3) of 59 residents bathrooms, privacy curtains were inadequately secured in two (2) of 59 residents' rooms, two (2) of 59 resident rooms had marred walls, and one (1) geriatric chair was observed with torn and tattered armrests in one (1) of 59 resident's rooms.<br><br>The findings include:<br><br>1. Air vents in three (3) of 59 resident bathrooms observed were soiled with dust on the inside and outside, bathrooms #317, # 310 and #145.<br><br>2. Privacy curtains were hanging loose and unhooked in two (2) of 59 residents rooms #317 and #323.<br><br>3. The walls in resident rooms #217 and #306 were marred in several areas.<br><br>Observations one (1) through three (3) were made in the presence of Employee #12 who acknowledged the findings.<br><br>On November 17, 2015 at approximately 3:30 PM an observation of a geriatric chair stored in | F 253 | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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| F 253 | Continued From page 10<br>room #306 and used by Resident #10 had armrests torn and tattered. Employee #10 acknowledged the finding. | F 253 | | |
| F 272 SS=D | 483.20(b)(1) COMPREHENSIVE ASSESSMENTS<br><br>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.<br><br>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following:<br>Identification and demographic information;<br>Customary routine;<br>Cognitive patterns;<br>Communication;<br>Vision;<br>Mood and behavior patterns;<br>Psychosocial well-being;<br>Physical functioning and structural problems;<br>Continence;<br>Disease diagnosis and health conditions;<br>Dental and nutritional status;<br>Skin conditions;<br>Activity pursuit;<br>Medications;<br>Special treatments and procedures;<br>Discharge potential;<br>Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and<br>Documentation of participation in assessment. | F 272 | 483.20(b)(1) Comprehensive Assessments<br><br>A. 1 & 2<br>1. Coding for the broken denture for Resident # 53 and the Hospice status for Resident # 147 was corrected soon after discovery.<br>2. Coding for any residents with damaged dentures and the one other resident receiving hospice services were reviewed to ensure correctness. No changes needed to be made to the MDS.<br>3. The MDS staff was inserviced regarding the proper coding for a broken dentures and hospice status. The Nursing Quality Improvement Team will audit for the proper coding of the MDS for broken dentures and hospice status on a monthly basis. The results of these audits will be forwarded to the Director of Nursing for review and evaluation.<br>4. The Director of Nursing will present the findings of these audits along with any action plans for improvement to the Quality Improvement Committee which meets monthly and is chaired by the Administrator. | 11/30/15<br><br>11/30/15<br><br>11/30/15<br><br>2/3/16 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095022 | A. BUILDING ______ B. WING ______ | 11/23/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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|---|---|---|---|---|
| F 272 | Continued From page 11 | F 272 | | |

This REQUIREMENT is not met as evidenced by:

A. Based on record review and staff interview for two (2) of 32 Stage 2 sampled residents, it was determined that facility staff failed to accurately code the quarterly Minimum Data Set (MDS) under Section O (Special Treatments, Procedures and Programs) for one (1) resident receiving hospice services and failed to accurately code the annual and quarterly MDS under Section L, Oral/Dental Status for one (1) resident who had a broken partial denture. Residents' #53 and #147.

The findings include:

Facility staff failed to accurately code the Annual Minimum Data Set [MDS] dated September 24, 2015 and the quarterly MDS dated October 20, 2015 under Section L, Oral/Dental Status for Resident #53.

A review of the clinical record for Resident #53 revealed the following Dental consultation notes:

The "Report of Consultation" from the Dentist dated June 13, 2015 revealed, "Tx (treatment): ...#4, #5, #6, #11 crown [illegible] provisional coverage placed. Recommendations: follow up visit [to] continue dental treatment."

Dental note dated August 4, 2015, " Patient having treatment in Silver Spring for crown and

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095022 | A. BUILDING ____ B. WING ____ | 11/23/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **TRANSITIONS HEALTHCARE CAPITOL CITY** | **2425 25TH STREET SE WASHINGTON, DC 20020** |

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|---|---|---|---|---|
| F 272 | Continued From page 12<br>bridge to stabilize bite and reduce dislodgement of teeth. Provisional bridge is broken patient is now refusing to continue tx (treatment) attempt made ... "<br><br>Section L, Oral/Dental Status of the annual and quarterly MDS assessments dated September 24, 2015 and October 20, 2015 respectively, lacked evidence of coding related to the resident ' s broken bridge as documented in the dentist ' s August 4, 2015 note. Section L [L0200] of the aforementioned MDS assessments were coded as " Z " none of the above.<br><br>A face-to-face interview was conducted with Employee #24 on November 20, 2015 at approximately 12:15 PM. He/she was asked how he/she performs dental assessments for Section L of the MDS. He/she stated I assessed the resident's mouth. He/she further stated that there were no concerns with the resident's mouth at the time of his/her assessment and he/she knew nothing about the concern with the resident's bridge.<br><br>There was no evidence that facility staff referenced that resident's clinical record to reconcile and or validate that the resident had no dental/oral health concerns. The record was reviewed on November 20, 2015.<br><br>2. A review of Resident #147 ' s History and Physical dated October 24, 2015 revealed that | F 272 | | |

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095022 | A. BUILDING ____ B. WING ____ | 11/23/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **TRANSITIONS HEALTHCARE CAPITOL CITY** | **2425 25TH STREET SE WASHINGTON, DC 20020** |

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| F 272 | Continued From page 13<br>he/she was admitted to hospice services on June 3, 2015 with diagnoses of dementia, and hypertension.<br><br>A physician's order dated June 3, 2015 read as follows: "Admit to Hospice Services R/T (related to) Dementia and Hypertension."<br><br>A review of the resident's quarterly MDS with an Assessment Reference Date of October 27, 2015 revealed that under Section " O" (Special Treatments, Procedures and Programs), the resident was not coded for receiving Hospice care.<br><br>A face-to-face interview was conducted with Employee #2 at approximately 11:00 AM on November 20, 2015. After reviewing the MDS, the employee acknowledged that the MDS was not coded to reflect that the resident was receiving hospice care. The record was reviewed on November 5, 2015.<br><br>B. Based on record review and staff interview for two (2) of 28 sampled residents, it was determined that facility staff failed to accurately code the Minimum Data Set (MDS) to identify the location and date of the Care Area Assessment (CAA) information on the annual Minimum Data Sets (MDS) under Section V0200A. Residents' #10 and 147.<br><br>The findings include:<br><br>According to Chapter 4 of the MDS 3.0 Users ' Manual, " for each triggered care area, use the " Location and Date of CAA Documentation " column on the CAA summary (Section V of the MDS 3.0) to note where the CAA information and | F 272 | 483.20(b)(1) Comprehensive Assessments (continued)<br><br>B. 1&2<br><br>1. The documentation for the location and dating of CAAs for Resident #10 and Resident # 147 was provided in the correction of the MDS soon after discovery.<br>2. A review of all CAAs was done to ensure that their location and date was provided. No further changes to the MDS were required.<br>3. The MDS staff was inserviced regarding the proper coding for the location and dates of the CAAs. The Nursing Quality Improvement Team will audit for the proper coding of the MDS CAA location and dates on a monthly basis. The results of these audits will be forwarded to the Director of Nursing for review and evaluation.<br>4. The Director of Nursing will present the findings of these audits along with any action plans for improvement to the Quality Improvement Committee which meets monthly and is chaired by the Administrator | 11/30/15<br><br>11/30/15<br><br>11/30/15<br><br>2/3/16 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| TRANSITIONS HEALTHCARE CAPITOL CITY | 2425 25TH STREET SE WASHINGTON, DC 20020 |

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|---|---|---|---|---|
| F 272 | Continued From page 14 | F 272 | | |

decision making documentation can be found in the resident ' s record ...written documentation of the CAA findings and decision making process may appear anywhere in the resident ' s record; for example in the progress notes, flow sheets etc ... "

1. Facility staff failed to identify the location and date of Care Area Assessment [CAA] information under Section V [V0200A], " Care Area Assessment Summary " of the Annual Minimum Data Set [MDS] for Resident #10.

A review of Resident #10 ' s annual MDS with an Assessment Reference Date (ARD) of November 26, 2014 revealed the following care areas were coded (e.g. triggered) as areas of concern: Cognitive Loss/Dementia, Visual Function, Urinary Incontinence/Catheter, Activities, Nutritional Status, Dental Care and Pressure Ulcers.

The record revealed that the location and date of CAA information for the identified care areas were recorded as " CAA WS (worksheet) dated 12/2/2014. "

There was no evidence that facility staff documented the date and location as to where in the clinical record the information related to the triggered care areas could be found.

A face-to-face interview was conducted with Employee #2 on November 23, 2015 at 4:00 PM. He/she acknowledged the findings. The record was reviewed November 23, 2015.

2. Facility staff failed to identify the location and date of Care Area Assessment (CAA) information

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095022 | A. BUILDING ______ B. WING ______ | 11/23/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| F 272 | Continued From page 15<br>under Section V [V0200A], " Care Area Assessment Summary " of the a Annual Minimum Data Set [MDS] for Resident #147.<br><br>A review of Resident #147's annual MDS with an Assessment Reference Date (ARD) of February 3, 2015 revealed the following care areas were coded (e.g. triggered) as areas of concern: Delirium, Cognitive Loss/Dementia, Visual Function, Communication, Urinary Incontinence/Catheter, Psychosocial Well Being , Mood State ,Activities, Falls, Nutrition, Dental Care and Pressure Ulcers.<br><br>The record revealed that the location and date of CAA information for the identified care areas were recorded as " care areas were recorded as " CAA WS (worksheet) dated 2/6/2015. "<br><br>There was no evidence that facility staff documented the date and location as to where in the clinical record the information related to the triggered care areas could be found.<br><br>A face-to-face interview was conducted with Employee #2 on November 23, 2015 at 4:00 PM. He/she acknowledged the findings. The record was reviewed November 23, 2015. | F 272 | | |
| F 276 SS=D | 483.20(c) QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS<br><br>A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months.<br><br>This REQUIREMENT is not met as evidenced | F 276 | 483.20(c) Quarterly Assessment at Least Every 3 Months<br><br>1. The quarterly MDS for Resident #318 soon after discovery.<br>2. A review of medical records/MDS showed all assessments to be correct and within date.<br>3. The MDS staff was inserviced regarding the timing of quarterly assessments when the resident may have been hospitalized some time within that 90 day period. The Nursing Quality Improvement Team will audit for the timely documentation of the quarterly MDS on a monthly basis. The results of these audits will be forwarded to the Director of Nursing for review and evaluation.<br>4. The Director of Nursing will present the findings of these audits along with any action plans for improvement to the Quality Improvement Committee which meets monthly and is chaired by the Administrator | 11/30/15<br>11/30/15<br>11/30/15<br>2/3/16 |

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095022 | A. BUILDING ______ B. WING ______ | 11/23/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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|---|---|---|---|---|
| F 276 | Continued From page 16<br>by:<br>Based on record review and staff interview for one (1) of 32 Stage 2 sampled residents, it was determined that facility staff failed to conduct a quarterly MDS (Minimum Data Set) RAI (Resident Assessment Instrument) within the required timeframe for Resident #318.<br><br>The findings include:<br><br>According to the Long Term Care Resident Assessment Instrument [RAI] User ' s Manual Version 3.0, October 2013, Chapter 2.6 stipulates " A quarterly OBRA [Omnibus Budget Reconciliation Act] review assessment is completed within 92 days of the Assessment Reference Date [ARD] of the most recent clinical assessment. "<br><br>Resident #318 had an Annual Minimum Data Set [MDS] Assessment on July 14, 2015 with an ARD (Assessment Reference Date) of July 14, 2015. The resident was discharged (return anticipated) to the hospital on August 11, 2015 and returned on August 17, 2015. The resident had another discharge (return anticipated) to the hospital on October 1, 2015 and returned October 9, 2015.<br><br>According to the nurse ' s and physician ' s progress notes, Resident #318 did not sustain a significant change in status between July 2015 and November 20, 2015 [date of this record review]. A quarterly MDS assessment was due on or about October 16, 2015.<br><br>At the time of this record review on November 6, 2015, there was no evidence that a quarterly MDS assessment was completed. The most recent OBRA assessment was July 14, 2015. | F 276 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095022 | A. BUILDING ____ B. WING ____ | 11/23/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TRANSITIONS HEALTHCARE CAPITOL CITY | 2425 25TH STREET SE WASHINGTON, DC 20020 |

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| F 276 | Continued From page 17<br><br>A face-to-face interview was conducted on November 20, 2015 at approximately 10:00 AM with Employee #14who acknowledged the findings.<br><br>There was no evidence in the clinical record that a quarterly MDS assessment was completed within the required timeframe for the resident. The record was reviewed on November 6, 2015. | F 276 | | |
| F 280 SS=D | 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP<br><br>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.<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on record review and staff interview for | F 280 | 483.20(d)(3), 483.10(k)(2) Right To Participate Planning Care-Revise CP<br><br>1 & 2<br>1. The Care Plans for Resident #64 and Resident #103 to reflect the management of functional status changes were revised soon after discovery.<br>2. A review of all Care Plan was done to ensure that each reflected the management of functional status changes. No other Care Plan required revision.<br>3. The Licensed Nursing staff was inserviced regarding the updating of Care Plans to reflect the management of functional status changes.. The Nursing Quality Improvement Team will audit for the Updating of Care Plans to reflect the Management of functional status changes on a monthly basis. The results of these audits will be forwarded to the Director of Nursing for review and evaluation.<br>4. The Director of Nursing will present the findings of these audits along with any action plans for improvement to the Quality Improvement Committee which meets monthly and is chaired by the Administrator. | 11/18/15<br>11/30/15<br>11/30/15<br>2/3/16 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095022 | A. BUILDING ______ B. WING ______ | 11/23/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TRANSITIONS HEALTHCARE CAPITOL CITY | 2425 25TH STREET SE WASHINGTON, DC 20020 |

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|---|---|---|---|---|
| F 280 | Continued From page 18 | F 280 | | |

two (2) of 30 Stage 2 sampled residents, it was determined that facility staff failed to review and revise care plans to manage functional status changes sustained by two (2) residents as coded on their respective Minimum Data Set [MDS] assessments. Resident's #64 and #103.

The findings include:

1. Facility staff failed to review and revise Resident #64 ' s Activities of Daily Living [ADL] care plan to accommodate declines in functional status.

A review of the July 2015, quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of July 7, 2015 as compared to the October 2015 quarterly MDS with an ARD date of October 7, 2015 revealed that Resident #64 ' s functional status declined in the areas of locomotion on and off the unit, and eating as follows:

The July 7, 2015 quarterly MDS assessment was coded as " 1/2 " supervision of one (1) person physical assist required for locomotion while on the unit [G0110E]. In comparison, the October 7, 2015 annual MDS assessment was coded as " 3/2 " extensive assistance of one (1) person required for locomotion while on the unit.

The July 7, 2015 quarterly MDS assessment was coded as " 1/2 " supervision of one (1) person physical assist required for locomotion while off the unit [G0110F]. In comparison, the October 7, 2015 annual MDS assessment was coded as " 3/2 " extensive assistance of one (1) person required for locomotion while off the unit.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095022 | A. BUILDING ______ B. WING ______ | 11/23/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TRANSITIONS HEALTHCARE CAPITOL CITY | 2425 25TH STREET SE WASHINGTON, DC 20020 |

| (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) COMPLETION DATE |
|---|---|---|---|---|
| F 280 | Continued From page 19 | F 280 | | |

The July 7, 2015 quarterly MDS assessment was coded as " 1/2 " supervision of one (1) person physical assist required for eating [G0110H]. In comparison, the October 7, 2015 annual MDS assessment was coded as " 2/2 " limited assistance of one (1) person required for eating.

A review of Resident #64 ' s care plan that was updated October 29, 2015 and lacked evidence of a revision related to the resident ' s decline in functional status, locomotion and eating. The current care plan read as follows: " Focus: Resident is dependent for ADL [activities of daily living] care; Goal: keep clean and odor free; Interventions: resident to receive shower per preference. "

A face-to-face interview was conducted with Employee #15 on November 20, 2015 at approximately 10:50 AM. A query was made regarding what type of ADL assistance does he/she provide to the resident. He/she stated the resident does not need much assistance from me, I set up [his/her] tray. I may open the utensils, He/she can feed [him/herself]. When transferring from the wheelchair to the commode [he/she] may need assistance to stand and pivot.

A face-to-face interview was conducted on November 20, 2015 at approximately 11:00 AM with Employee #8. After review of the care plan he/she acknowledged that the care plan lacked specific care approaches and interventions to address the decline with locomotion on and off the unit and eating. The record was reviewed on November 20, 2015.

2. Facility staff failed to review and revise

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095022 | A. BUILDING ______ B. WING ______ | 11/23/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **TRANSITIONS HEALTHCARE CAPITOL CITY** | **2425 25TH STREET SE WASHINGTON, DC 20020** |

| (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) COMPLETION DATE |
|---|---|---|---|---|
| F 280 | Continued From page 20 | F 280 | | |

Resident #103 ' s Activities of Daily Living [ADL] care plan to accommodate a decline and improvement in functional status.

A review of the quarterly MDS dated July 9, 2015 revealed: Under Section G, Functional Status, the resident required: Supervision with setup help only in locomotion " on " the unit and no setup or physical help from staff with locomotion " off " unit. The resident required extensive assistance and one person physical assist with bed mobility, transfers, dressing, eating, toilet use, and personal hygiene.

According to the quarterly MDS dated October 8, 2015 Under Section G , Functional Status, the resident required: Limited assistance in locomotion " on " the unit with one person physical assistance, and Supervision with one person physical assistance with locomotion " off " the unit. The resident required extensive assistance and one person physical assist with bed mobility, transfers, dressing, and personal hygiene. The resident required limited assistance with one person physical assistance in eating and toilet use.

In comparing the quarterly MDS form July 9, 2015 to October 8, 2015, the resident had a noted decline in locomotion " on " the unit. The resident previously required supervision and set up help only. The resident now requires limited assistance with one person physical assist in locomotion " on " the unit. The resident went from requiring supervision and no set up help, to supervision with one person physical assist in locomotion " off " the unit.

A review of the Care Plan, " Resident requires

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095022 | A. BUILDING ____ B. WING ____ | 11/23/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TRANSITIONS HEALTHCARE CAPITOL CITY | 2425 25TH STREET SE WASHINGTON, DC 20020 |

| (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) COMPLETION DATE |
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| F 280 | Continued From page 21<br>assistance for ADL (activities of daily living) Care, in ...grooming ... last revised on July 23, 2015, revealed, Interventions: " ...staff to assist resident with [his/her] ADL care every shift. "<br><br>There was no evidence that facility staff revised the ADL care plan with new goals and approaches to address the noted decline with locomotion " on " and " off " the unit.<br><br>A face-to-face interview was conducted with Employee #9 on November 23, 2015 at approximately 4:00 PM. They acknowledged the findings. The record was reviewed on November 23, 2015. | F 280 | | |
| F 281 SS=D | 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS<br><br>The services provided or arranged by the facility must meet professional standards of quality.<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on observation, record review and staff interview for one (1) of 32 Stage 2 sampled residents, it was determined that facility staff failed to consistently ensure that blood pressure measures obtained for Resident #53 was done so in accordanace with professional standards of quality.<br><br>The findings include:<br><br>Facility staff failed to obtain the resident ' s blood pressure on the upper arm in accordance with professional standards. | F 281 | 483.20(k)(3)(i) Services Provided Meet Professional Standards<br><br>1. A bariatric cuff was provided immediately Upon discovery and the resident's blood Pressure was taken immediately and found To be within normal limits.<br>2. All other residents who require a similarly sized blood pressure cuff were evaluated to ensure that this specialty cuff was readily available to the staff for on-going use. The facility maintains a stock of such cuffs in Central Supply.<br>3. The Licensed Nursing staff was inserviced regarding the proper BP cuff size, their proper use and their location<br>The Nursing Quality Improvement Team will audit for the presence of the proper BP cuffs and their location and use on the units on a monthly basis. The results of these audits will be forwarded to the Director of Nursing for review and evaluation.<br>4. The Director of Nursing will present the findings of these audits along with any action plans for improvement to the Quality Improvement Committee which meets monthly and is chaired by the Administrator | 11/18/15<br><br>11/18/15<br><br>11/30/15<br><br>2/3/16 |

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|---|---|---|---|---|
| F 281 | Continued From page 22 | F 281 | | |

F 281 Continued From page 22

According to The Lippincott Manual of Nursing Practice, Seventh Edition, " The positioning of the blood pressure cuff should be approximately 2.5 cm (1 inch) above the antecubital fossa [the elbow pit is the triangular area on the anterior view of the elbow of a human], " (p. 53).

A review of the order from [referring Medical Facility] dated October 30, 2015 revealed, " Order: Syphgnomanometer [a blood pressure cuff]; Large Adult Size 12 "

On November 19, 2015 at approximately 11:50 AM, an observation of the large adult size blood pressure cuffs were on hand and available for use by facility staff.

A face-to-face interview was conducted with Employee #18 [nurse assigned to the resident] on November 19, 2015 at approximately 12:33 PM. He/she stated, " I take the resident ' s blood pressure on [the residents ' ] forearm. "

A face-to-face interview was conducted with Resident #53 on November 19, 2015 at approximately 12:50 PM. When asked how the staff obtains his/her blood pressure readings. He/she stated, " Most of them [facility staff] take my blood pressure here, pointing to his/her left forearm. "

A face-to-face interview was conducted with Employee #20 on November 19, 2015 at approximately 4:09 PM. He/she stated, " We use Lippincott and we teach the staff to take the blood pressure on the upper arm. "

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 095022 | A. BUILDING ____ B. WING ____ | 11/23/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| TRANSITIONS HEALTHCARE CAPITOL CITY | 2425 25TH STREET SE WASHINGTON, DC 20020 |

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|---|---|---|---|---|
| F 281 | Continued From page 23<br>There was no evidence that facility staff measured the resident ' s blood pressure in the appropriate area of the arm in accordance with professional standards. | F 281 | | |
| F 282 SS=D | 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN<br><br>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on observation, record review, and staff interviews for one (1) of 32 Stage 2 sampled residents, it was determined that facility staff failed to ensure that one (1) resident having pressure ulcers received total pressure ulcer treatment by a qualified person in accordance with professional standards and physician orders. Resident #10.<br><br>The findings include:<br>A wound treatment observation was conducted on November 19, 2015 at 8:00 AM Following Resident 10 ' s consent to observe the procedure. Employees' # 4, 10, and 19 were present. Upon entering the room, Resident # 10 was observed lying in bed on his/her back. Employee #19 entered room closed door and donned a pair of plastic gloves without first washing his/her hands. Employee #19 then assisted in repositioning Resident #10 from his/her back onto the left side his/her left side. Once the resident was positioned on his/her side, open ulcers were | F 282 | 483.20(k)(3)(ii) Services by Qualified Persons/Per Care Plan<br><br>1. The dressing change protocols including proper infection control techniques, resident handling, etc. was afforded Resident #10 by a qualified person in accordance with professional standards and physician orders immediately upon discovery.<br>2. Wound rounds to observe dressing changes found that the facility's protocols and practices were afforded all other residents by a qualified person and in accordance with professional standards and physician orders.<br>3. The Nursing staff was inserviced regarding the facility's wound care protocol being performed by a qualified person in accordance with professional standards and physician orders. The Nursing Quality Improvement Team will audit for our wound rounds on a monthly basis to ensure on-going compliance in this area. The results of these audits will be forwarded to the Director of Nursing for review and evaluation.<br>4. The Director of Nursing will present the findings of these audits along with any action plans for improvement to the Quality Improvement Committee which meets monthly and is chaired by the Administrator | 11/18/15<br><br>11/30/15<br><br>11/30/15<br><br>2/3/16 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095022 | A. BUILDING ____ B. WING ____ | 11/23/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TRANSITIONS HEALTHCARE CAPITOL CITY | 2425 25TH STREET SE WASHINGTON, DC 20020 |

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|---|---|---|---|---|
| F 282 | Continued From page 24 | F 282 | | |

observed at multiple sites along the dorsal surface of his/her back, hips, buttocks, lower leg and heel/foot. The open ulcers were observed uncovered and in contact with bed linens when the resident was lying supine. At this time the Employee #19 with the same gloved hands, placed and positioned a clear trash bag in the trash receptacle located in the resident ' s room and with his/her feet, slid the trash receptacle near the nurse who would perform the dressing change. With the same gloved hands, Employee #19 returned to the resident and positioned his/her [gloved] hands along the residents ' shoulders/back as if to hold the resident in place for wound treatment. Upon doing so Employee #19 placed his/her hands directly over the resident's Stage 3 pressure ulcer of the right upper back.
At this time the State Agency Representative intervened with the dressing change as the aforementioned observations did not reflect infection control standards of practice.

The " Weekly Wound Report " dated November 13, 2015 revealed the following alterations in skin integrity:

Unstageable pressure ulcer of the Left dorsal foot measuring 3cm x 2cm x 0cm
Unstageable pressure ulcer of the Left hip measuring 1.5 cm x 1.5 cm x 0 cm
Stage III pressure ulcer of the Right upper back measuring 11cm x 6cmx 0.4cm
Stage III pressure ulcer of the Sacrum measuring 11cm x16cm x 1.5cm
Stage III pressure ulcer of the Right Ischium measuring 7cm x 3cm x0.9cm
Stage II pressure ulcer of the Left lateral heel measuring 2cm x 4cm x0cm

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095022 | A. BUILDING ____ B. WING ____ | 11/23/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TRANSITIONS HEALTHCARE CAPITOL CITY | 2425 25TH STREET SE WASHINGTON, DC 20020 |

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|---|---|---|---|---|
| F 282 | Continued From page 25<br>Stage III pressure ulcer of the Right hip measuring 8cm x 8cm x 0.5 cm<br>Stage II pressure ulcer of the Right lateral lower leg measuring 1cm x1cm x1 cm<br>Stage II pressure ulcer of the Left lower back measuring 6cm x7cm x0.5cm<br>Stage II pressure ulcer of the Right elbow measuring 3cm x3cm x 0cm<br><br>A review of the Physician ' s orders printed November 20, 2015 directed:<br>Cleanse with NSS (normal saline solution) pat dry apply hydrogel [wound dressing that provides moisture to a wound] cover with 4x4 gauze adhesive dressing daily every shift. This order was prescribed for the following pressure ulcers: right elbow, right hip, right ischium, right lateral lower leg, and right upper back.<br><br>A review of the clinical record revealed:<br>The quarterly Minimum Data Set (MDS) dated August 24, 2015 revealed the following:<br>Section M0300 (Current Number of unhealed pressure ulcers at each stage) the was coded as having a two (2) Stage 2, three (3) Stage 3, and five (5) Unstageable pressure ulcers indicating the resident had 10 pressure ulcers in total.<br>Under Section C (Cognitive Patterns) the resident had a BIMS (Brief Interview for Mental Status) score of 11 [a score of 8-12 reflects-moderate impairment] indicating that the resident ' s cognition is moderately impaired.<br>Under Section G (Functional Status) the resident required total dependence on staff with bed mobility, and was totally dependent on staff for dressing, toilet use and personal hygiene.<br>Under Section H Bladder and Bowel the resident | F 282 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095022 | A. BUILDING ______ B. WING ______ | 11/23/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TRANSITIONS HEALTHCARE CAPITOL CITY | 2425 25TH STREET SE<br>WASHINGTON, DC 20020 |

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|---|---|---|---|---|
| F 282 | Continued From page 26 | F 282 | | |

was coded as always incontinent

Interviews:
A face-to-face interview was conducted with Employees ' #10 (Unit Manager) on December 19, 2015 at approximately 11:30 AM. Employee #10 was asked why was Resident#10 was lying in a supine position with his pressure ulcers in direct contact with bed linens He/she stated, " The unlicensed staff removed them because they were soiled."
A face-to-face interview was conducted with Employee #19 (unlicensed staff) on December 19 2015 at approximately 11:45 AM when queried he/she stated, " I removed Resident#10 ' dressings and bunny boots because they were soiled and I knew they were going to do his/her wound care around 8:00 AM. The Licensed nurse knew I had removed the dressing and that the wounds were not covered. "

A face-to-face interview was conducted with Employees ' #20 on December 19 2015 at 3:00 PM when queried regarding the unlicensed staff members training and role during wound care he/she stated " unlicensed staff are trained to observe resident ' s skin for changes and to report them to the licensed nurse immediately, and at no time are unlicensed staff required or allowed to remove or replace dressings on wounds. "
After review of the aforementioned all employees acknowledged the findings.

There was no evidence that facility staff followed accepted standards of practice for infection control when managing wounds for Resident #10, as the resident ' s pressure ulcers were exposed because the dressings were removed and the

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095022 | A. BUILDING ______ B. WING ______ | 11/23/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TRANSITIONS HEALTHCARE CAPITOL CITY | 2425 25TH STREET SE WASHINGTON, DC 20020 |

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|---|---|---|---|---|
| F 282 | Continued From page 27<br>open areas were observed directly in contact with bed linens. Additionally, staff failed to practice proper hand hygiene, as Employee #19 failed to sanitize his/her hands prior to donning gloves and applied his/her hand directly over the resident ' s exposed stage 3 pressure ulcer during positioning. The clinical record was reviewed on November 19, 2015.<br><br>There was no evidence that facility staff failed to ensure that Resident #10 having pressure ulcers received total pressure ulcer treatment by a qualified person in accordance with professional standards. The clinical record was reviewed on November 23, 2015 | F 282 | | |
| F 309 SS=D | 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on record review and staff interview for two (2) of 32 Stage 2 sampled resident's, it was determined that facility staff failed to failed to provide the necessary care and services to ensure residents attain or maintain the highest practicable physical, mental, and/or psychosocial well-being as evidenced by facility staff ' s failure to administer insulin for one (1) resident as | F 309 | 483.25 Provide Care/Services For Highest Well Being<br><br>1.<br>1. Resident #53 has been receiving insulin as prescribed by the attending physician immediately after discovery. There have been no negative outcomes noted.<br>2. Physician orders for all residents with Insulin orders were double checked to ensure the physician orders were being implemented as prescribed. There were no other issues.<br>3. The License Nursing staff was inserviced regarding timely and appropriate administration of insulin per physician orders. The Nursing Quality Improvement Team will audit for the proper insulin administration on a monthly basis. The results of these audits will be forwarded to the Director of Nursing for review and evaluation.<br>4. The Director of Nursing will present the findings of these audits along with any action plans for improvement to the Quality Improvement Committee which meets monthly and is chaired by the Administrator | 11/18/15<br><br>11/30/15<br><br>12/31/15<br><br>2/3/16 |

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095022 | A. BUILDING ______ B. WING ______ | 11/23/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TRANSITIONS HEALTHCARE CAPITOL CITY | 2425 25TH STREET SE WASHINGTON, DC 20020 |

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|---|---|---|---|---|
| F 309 | Continued From page 28<br>directed by the medical team and assess one (1) resident ' s heart rate in accordance with physician ' s orders prior to the administration of an antihypertensive/antianginal medication. Residents' #53 and #54.<br><br>The findings include:<br><br>1. Facility staff failed to administer Novolog insulin to Resident #53 in accordance with physician ' s orders.<br><br>A review of the clinical record for Resident #53 revealed physician ' s orders dated October 24, 2015 that directed Lantus insulin [long acting insulin - duration of action 18-26 hours] 10 units at 6AM for diabetes mellitus.<br><br>An interim telephone order obtained from the nurse practitioner on November 20, 2015 at 7:57 AM read: " Novolog [a rapid acting insulin used to lower elevated blood glucose levels] insulin administer subcutaneously via sliding scale, 4 times daily. Novolog (150-200=2 Units); (201-254=3 units); Novolog (255-300=6 units); Novolog (301-350=8 units); Novolog (351-400=10 units). Call MD for blood sugar greater than 400 or less than 60. "<br><br>The medication administration record [MAR] revealed that Lantus insulin 10 units was administered to Resident #53 at 6:00 AM on November 20, 2015. | F 309 | 483.25 Provide Care/Services For Highest Well Being (continued)<br><br>2.<br>1. The heart rate of Resident #54 was assessed and appropriately documented soon after discovery.<br>2. All residents receiving anti-hypertensive/ antianginal medication with orders to assess their heart rates prior to administration and document the results were reviewed to ensure all documentation was present. No other adjustments needed to be made.<br>3. The License Nursing staff was inserviced regarding the need to precisely follow Physicians order to include heart rate parameters along with blood pressure parameters with the administration of antihypertensive/antianginal medications. The Nursing Quality Improvement Team will audit for the presence of documentation for the recording of the heart rate and blood pressure for such medications on a monthly basis. The results of these audits will be forwarded to the Director of Nursing for review and evaluation.<br>4. The Director of Nursing will present the findings of these audits along with any action plans for improvement to the Quality Improvement Committee which meets monthly and is chaired by the Administrator | 11/18/15<br><br>11/30/15<br><br>12/31/15<br><br>2/3/16 |

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 095022 | (X2) MULTIPLE CONSTRUCTION A. BUILDING ___ B. WING ___ | (X3) DATE SURVEY COMPLETED 11/23/2015 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TRANSITIONS HEALTHCARE CAPITOL CITY | 2425 25TH STREET SE WASHINGTON, DC 20020 |

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|---|---|---|---|---|
| F 309 | Continued From page 29<br>A review of the nursing notes revealed the following:<br><br>November 20, 2015 at 06:58 (6:58 AM) revealed, " Fingerstick [glucose] 340 mg/dl [normal glucose range 80 - 130 mg/dl as per American Diabetes Association] 10 units insulin given " .<br><br>November 20, 2015 at 07:57 (7:57 AM) revealed, " New order received from NP (nurse practitioner) [Name]: Novolog sliding scale, 4 times daily. Novolog (150-200=2 Units); (201-254=3 units); Novolog (255-300=6 units); Novolog (301-350=8 units); Novolog (351-400=10 units). Call MD [medical doctor] for blood sugar greater than 400 or less than 60. "<br><br>A telephone interview was conducted with Employee #13 on November 20, 2015 at 10:55 AM. He/she stated, " ... I called and notified the NP (nurse practitioner) that [Resident #53 ' s] glucose was elevated. I received a new order for sliding scale. The Fingerstick was 340 mg/dl. I gave 10 units of Lantus. I didn ' t give the Novolog per the sliding scale. "<br><br>Through record review and interviews it was determined that the nurse failed to administer Novolog insulin coverage in accordance with the physician's order. There was no evidence that the resident sustained any untoward effect. The record was reviewed on November 20, 2015.<br><br>2. Facility staff failed to consistently assess the Resident #54 ' s heart rate prior to the administration of an antihypertensive/antianginal medication [Metoprolol] for Resident #54. | F 309 | | |

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095022 | A. BUILDING ______ B. WING ______ | 11/23/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TRANSITIONS HEALTHCARE CAPITOL CITY | 2425 25TH STREET SE WASHINGTON, DC 20020 |

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|---|---|---|---|---|
| F 309 | Continued From page 30<br><br>A medication observation was conducted on November 16, 2015 at approximately 10:38 AM with Employee #16, the following occurred: Employee #16 prepared the resident ' s medication which included Metoprolol ER 25mg po [by mouth]. Prior to administering the medication Employee #16 assessed the blood pressure, however Employee #16 failed to assess and monitor the resident ' s Heart Rate.<br><br>A review of the physician's orders directed, Metoprolol ER [Extended Release] tab 25mg Give 0.5 tablet orally one [1] time a day related to unspecified essential hypertension. Hold for systolic blood pressure less than 120 or diastolic blood pressure less than 70 pr HR less than 60 original order date June 14, 2014.<br><br>A review of the medication administration records for July, August, September, October and November 2015 lacked evidenced of any monitoring of the resident's heart rate prior to administering Metroprolol ER.<br><br>A face-to-face interview was conducted with Employee #7 on November 18, 2015 at approximately 12:30 PM. After review of the above, he/she acknowledged the findings. | F 309 | 483.25(c) Treatment/Svcs to Prevent/Heal Pressure Sores<br><br>1. The dressing change protocols including proper infection control techniques, resident handling, hand washing, following the physician's orders. was afforded Resident #10 to ensure the resident received necessary treatment services to promote healing and prevent infection immediately upon discovery. | 11/16/15 |
| | | | 2. Wound rounds were done to observe Dressing changes to ensure the facility's dressing change and infection control protocols and practices were afforded all other residents and to ensure the receipt of necessary treatment services. | 11/30/15 |
| | | | 3. The Nursing staff was inserviced regarding the facility's wound care protocol, infection control techniques, hand washing and following physician orders being afforded to ensure the receipt of necessary treatment services to promote healing and prevent infection..<br>The Nursing Quality Improvement Team will audit for the wound rounds on a monthly basis to ensure on-going compliance in this area. | 11/30/15 |
| F 314 SS=D | 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES<br><br>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having | F 314 | The results of these audits will be forwarded to the Director of Nursing for review and evaluation.<br>4. The Director of Nursing will present the findings of these audits along with any action plans for improvement to the Quality Improvement Committee which meets monthly and is chaired by the Administrator | 2/3/16 |

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095022 | A. BUILDING ______ B. WING ______ | 11/23/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| TRANSITIONS HEALTHCARE CAPITOL CITY | 2425 25TH STREET SE WASHINGTON, DC 20020 |

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|---|---|---|---|---|
| F 314 | Continued From page 31 | F 314 | | |

pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

This REQUIREMENT is not met as evidenced by:

Based on observation, record review, and staff interviews for one (1) of 32 Stage 2 sampled residents, it was determined that facility staff failed to ensure that one (1) resident having pressure ulcers received necessary treatment and services in accordance with physician orders to promote healing, prevent infection from developing as evidenced by: the resident was observed lying in bed without dressing covering his/her pressure ulcers. Resident #10.

The findings include:

A wound treatment observation was conducted on November 19, 2015 at 8:00 AM Following Resident 10 ' s consent to observe the procedure. Employees' # 4, 10, and 19 were present. Upon entering the room, Resident # 10 was observed lying in bed on his/her back. Employee #19 entered room closed door and donned a pair of plastic gloves without first washing his/her hands. Employee #19 then assisted in repositioning Resident #10 from his/her back onto the left side his/her left side. Once the resident was positioned on his/her side, open ulcers were observed at multiple sites along the dorsal surface of his/her back, hips, buttocks, lower leg and heel/foot. The open ulcers were observed uncovered and in contact with bed linens when the resident was lying supine. At this time the Employee #19 with the same gloved hands, placed and positioned a clear trash bag in the

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095022 | A. BUILDING ______ B. WING ______ | 11/23/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| TRANSITIONS HEALTHCARE CAPITOL CITY | 2425 25TH STREET SE WASHINGTON, DC 20020 |

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|---|---|---|---|---|
| F 314 | Continued From page 32 | F 314 | | |

trash receptacle located in the resident ' s room and with his/her feet, slid the trash receptacle near the nurse who would perform the dressing change. With the same gloved hands, Employee #19 returned to the resident and positioned his/her [gloved] hands along the residents ' shoulders/back as if to hold the resident in place for wound treatment. Upon doing so Employee #19 placed his/her hands directly over the resident's Stage 3 pressure ulcer of the right upper back.

At this time the State Agency Representative intervened with the dressing change as the aforementioned observations did not reflect infection control standards of practice.

The " Weekly Wound Report " dated November 13, 2015 revealed the following alterations in skin integrity:

Unstageable pressure ulcer of the Left dorsal foot measuring 3cm x 2cm x 0cm
Unstageable pressure ulcer of the Left hip measuring 1.5 cm x 1.5 cm x 0 cm
Stage III pressure ulcer of the Right upper back measuring 11cm x 6cmx 0.4cm
Stage III pressure ulcer of the Sacrum measuring 11cm x16cm x 1.5cm
Stage III pressure ulcer of the Right Ischium measuring 7cm x 3cm x0.9cm
Stage II pressure ulcer of the Left lateral heel measuring 2cm x 4cm x0cm
Stage III pressure ulcer of the Right hip measuring 8cm x 8cm x 0.5 cm
Stage II pressure ulcer of the Right lateral lower leg measuring 1cm x1cm x1 cm
Stage II pressure ulcer of the Left lower back measuring 6cm x7cm x0.5cm

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095022 | A. BUILDING ______ B. WING ______ | 11/23/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **TRANSITIONS HEALTHCARE CAPITOL CITY** | **2425 25TH STREET SE WASHINGTON, DC 20020** |

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|---|---|---|---|---|
| F 314 | Continued From page 33<br>Stage II pressure ulcer of the Right elbow measuring 3cm x3cm x 0cm<br><br>Orders:<br>A review of the Physician ' s orders printed November 20, 2015 directed:<br>Cleanse with NSS (normal saline solution) pat dry apply hydrogel [wound dressing that provides moisture to a wound] cover with 4x4 gauze adhesive dressing daily every shift. This order was prescribed for the following pressure ulcers: right elbow, right hip, right ischium, right lateral lower leg, and right upper back.<br><br>A reveiw of the Minimum Data Set revealed:<br>The quarterly Minimum Data Set (MDS) dated August 24, 2015 revealed the following:<br>Section M0300 (Current Number of unhealed pressure ulcers at each stage) the was coded as having a two (2) Stage 2, three (3) Stage 3, and five (5) Unstageable pressure ulcers indicating the resident had 10 pressure ulcers in total.<br>Under Section C (Cognitive Patterns) the resident had a BIMS (Brief Interview for Mental Status) score of 11 [a score of 8-12 reflects-moderate impairment] indicating that the resident ' s cognition is moderately impaired.<br>Under Section G (Functional Status) the resident required total dependence on staff with bed mobility, and was totally dependent on staff for dressing, toilet use and personal hygiene.<br>Under Section H Bladder and Bowel the resident was coded as always incontinent<br><br>Interviews:<br>A face-to-face interview was conducted with Employee #10 (Unit Manager) on December 19, 2015 at approximately 11:30 AM. Employee #10 | F 314 | | |

| (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) COMPLETION DATE |
|---|---|---|---|---|
| F 314 | Continued From page 34 | F 314 | | |

was asked why was Resident #10 was lying in a supine position with his pressure ulcers in direct contact with bed linens He/she stated, " The unlicensed staff removed them because they were soiled."
A face-to-face interview was conducted with Employee #19 (unlicensed staff) on December 19 2015 at approximately 11:45 AM when queried he/she stated, " I removed Resident#10 ' dressings and bunny boots because they were soiled and I knew they were going to do his/her wound care around 8:00 AM. The Licensed nurse knew I had removed the dressing and that the wounds were not covered. "
A face-to-face interview was conducted with Employee #20 on December 19 2015 at 3:00 PM when queried regarding the unlicensed staff members training and role during wound care he/ she stated " unlicensed staff are trained to observe resident ' s skin for changes and to report them to the licensed nurse immediately, and at no time are unlicensed staff required or allowed to remove or replace dressings on wounds. "

After review of the aforementioned all employees acknowledged the findings.

There was no evidence that facility staff followed accepted standards of practice for infection control when managing wounds for Resident #10, as the resident ' s pressure ulcers were exposed because the dressings were removed and the open areas were observed directly in contact with bed linens. Facility staff failed to practice proper hand hygiene, as Employee #19 failed to sanitize his/her hands prior to donning gloves and applied his/her hand directly over the resident ' s exposed stage 3 pressure ulcer during positioning. In

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095022 | A. BUILDING ______ B. WING ______ | 11/23/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TRANSITIONS HEALTHCARE CAPITOL CITY | 2425 25TH STREET SE WASHINGTON, DC 20020 |

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|---|---|---|---|---|
| F 314 | Continued From page 35<br>addition, facilty staff failed to follow the physician's order to apply 4x4 gauze adhesive dressing daily every shift to the resident's pressure ulcers.<br>The clinical record was reviewed on November 19, 2015. | F 314 | 483.50(i) Food Procure, Store/Prepare/Serve-Sanitary<br><br>1. Grease Fryers<br>1. The fryer cited at the time of the survey was cleaned immediately upon discovery.<br>2. Both fryers were inspected for cleanliness and both were clean. | 11/16/15<br><br>11/16/15 |
| F 371 SS=E | 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY<br><br>The facility must -<br>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and<br>(2) Store, prepare, distribute and serve food under sanitary conditions<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on observations made on November 16, 2015 at approximately 9:30 AM, and on November 19, 2015 at approximately 9:45 AM, it was determined that the facility failed to prepare and serve foods under sanitary conditions as evidenced by one (1) of two (2) soiled grease fryers, a staff member ' s failure to test the three-compartment sink sanitizing solution as recommended by the manufacturer, a three-compartment sink sanitizing solution that twice tested at less than the recommended 150 parts per million (PPM), a staff member ' s failure to sanitize the thermometer in between food temperature verifications and 18 of 36 Glucerna therapeutic nutrition eight-ounce cans that were expired. | F 371 | 3. Cook/Supervisors were inserviced on the proper cleanliness of the grease fryers. The Dietary Quality Improvement Team will inspect the grease fryers monthly to ensure their cleanliness. The team will report their findings to the Director of Dietary.<br>4. The Dietary Director will evaluate the Results of these inspections and report Them and any plans for improvement to the Quality Improvement Committee which meets Monthly and is chaired by the Administrator.<br><br>2.&3. Sink Sanitizing Solution<br>1. The 3 compartment sink was drained and refilled with sanitizing solution to ensure the proper procedure was used to test the sanitizing solution per Manufacturer's specifications and to ensure the proper PPM solution strength.<br>2. This is the only 3 compartment sink Used for pot washing at this facility.<br>3. Pot Washers/Supervisors were inserviced on the proper measurement and strength of the sanitizing solution.<br>The Dietary Quality Improvement Team will inspect the sanitation process monthly to ensure compliance.. The team will report their findings to the Director of Dietary.<br>4. The Dietary Director will evaluate the Results of these inspections and report Them and any plans for improvement to the Quality Improvement Committee which meets Monthly and is chaired by the Administrator. | 12/30/15<br><br>2/3/16<br><br>11/16/15<br><br>11/16/15<br><br>12/30/15<br><br>2/3/16 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095022 | A. BUILDING ______ B. WING ______ | 11/23/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TRANSITIONS HEALTHCARE CAPITOL CITY | 2425 25TH STREET SE WASHINGTON, DC 20020 |

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|---|---|---|---|---|
| F 371 | Continued From page 36 | F 371 | 483.50(i) Food Procure, Store/Prepare/Serve-Sanitary (continued)<br>4. Food Thermometer | |
| | The findings include: | | 1. The employee involved was immediately Instructed on the proper method of Thermometer handling and sanitizing. | 11/18/15 |
| | 1. One (1) of two (2) grease fryers was soiled with leftover fried food particles. | | 2. All dining room servers and cooks were observed during the temperature taking process to ensure proper methods being used for handling and sanitizing. No other issues were noted. | 11/18/15 |
| | 2. Staff on two (2) occasions failed to test the three-compartment sink sanitizing solution as recommended by the manufacturer.<br><br>Staff, on the first occasion, left the test strip in the sanitizing solution for about 15 seconds, five (5) seconds more that the recommended ten seconds exposure time. | | 3.Supervisors and dining room servers were inserviced on the proper technique of handling and sanitizing thermometers. The Supervisors will inspect the temperature taking process routinely along with the Dietary Quality Improvement Team. Both will report their findings to the Director of Dietary. | 12/30/15 |
| | On the second occasion, staff counted to ten in about six (6) seconds before removing the test strip from the sanitizing solution. | | 4. The Dietary Director will evaluate the results of these inspections and report Them and any plans for improvement to the Quality Improvement Committee which meets Monthly and is chaired by the Administrator. | 2/3/16 |
| | 3. The three-compartment sink sanitizing solution twice tested at less than the manufacturer's recommended minimum of 150 parts per million (PPM) on November 16, 2015 at approximately 9:30 AM. | | 5. Outdated Glucerna<br>1. All expired cans of Glucerna were removed immediately upon discovery. | 11/18/15 |
| | | | 2. All cans of Glucerna in the unit's supply areas were inspected and revealed no further issues. | 11/18/15 |
| | A new pot sink dispenser for the three-compartment sink was installed on November 16, 2015 at approximately 3:30 PM and afterwards, the sanitizing solution tested at 200 PPM. | | 3. Licensed staff were inserviced regarding checking for expiration dates on tube feeding formula. The Nursing Quality Improvement Team will audit for compliance on a monthly basis and forward their audit results to the Director of Nursing. | 11/30/15 |
| | 4. Staff failed to wash, rinse, sanitize and air dry the thermometer used to measure food temperatures on the third floor dining room on November 16, 2015 at | | 4. The Director of Nursing will present the findings of these audits along with any action plans for improvement to the Quality Improvement Committee which meets monthly and is chaired by the Administrator | 2/3/16 |

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095022 | A. BUILDING ______<br>B. WING ______ | 11/23/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TRANSITIONS HEALTHCARE CAPITOL CITY | 2425 25TH STREET SE<br>WASHINGTON, DC 20020 |

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|---|---|---|---|---|
| F 371 | Continued From page 37<br>approximately 12:30 PM.<br><br>5. 18 of 36 Glucerna eight-ounce vanilla flavored therapeutic nutrition located in the Storage room on 2 North were expired as follows:<br><br>Six (6) were expired as of August 1, 2015<br>One (1) was expired as of October 1, 2015<br>11 were expired as of November 1, 2015.<br><br>Observations one (1) thru five (5) were made in the presence of Employee #11 and the last observation was made in the presence of Employee #12. They both acknowledged the findings. | F 371 | | |
| F 431 SS=D | 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS<br><br>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.<br><br>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.<br><br>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature | F 431 | 483.60(b),(e) Drug Records, Label/Store Drugs & Biologicals<br><br>1. Improperly stored ointments and the Insulin pen which was found out of date were Immediately removed upon discovery.<br>2. All treatment carts and medication refrigerators were inspected to ensure the proper storage of ointments and no insulin pen was out of date. No further issues were found.<br>3. Licensed staff was inserviced regarding checking for expiration dates on insulin pens and that ointments were properly stored. The Nursing Quality Improvement Team will audit for compliance on a monthly basis and forward their audit results to the Director of Nursing.<br>4. The Director of Nursing will present the findings of these audits along with any action plans for improvement to the Quality Improvement Committee which meets monthly and is chaired by the Administrator | 11/18/15<br><br>11/18/15<br><br>12/31/15<br><br>2/3/16 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095022 | A. BUILDING ______ B. WING ______ | 11/23/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TRANSITIONS HEALTHCARE CAPITOL CITY | 2425 25TH STREET SE WASHINGTON, DC 20020 |

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|---|---|---|---|---|
| F 431 | Continued From page 38<br>controls, and permit only authorized personnel to have access to the keys.<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on observation and staff interview during a medication storage in (1) of 1 one (1) treatment cart observation on November 16, 2015, it was determined that facility staff failed to ensure that four (4) tubes of ointments and creams were properly stored and one (1) of one (1) insulin injection pen was stored beyond the recommended time frame.<br><br>The findings include:<br><br>" Victoza pen Manufacture Recommended Storage: Prior to first use, Victoza® should be stored in a refrigerator between 36°F to 46°F (2°C to 8°C) (Table 14). Do not store in the freezer or directly adjacent to the refrigerator cooling element. Do not freeze<br>Victoza® and do not use Victoza® if it has been frozen.<br>After initial use of the Victoza® pen, the pen can be stored for 30 days at controlled room | F 431 | | |

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|---|---|---|---|
| | 095022 | A. BUILDING ______ B. WING ______ | 11/23/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TRANSITIONS HEALTHCARE CAPITOL CITY | 2425 25TH STREET SE WASHINGTON, DC 20020 |

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|---|---|---|---|---|
| F 431 | Continued From page 39 | F 431 | | |

temperature
(59°F to 86°F; 15°C to 30°C) or in a refrigerator (36°F to 46°F; 2°C to 8°C). Keep the pen cap on when not in use. "

During an inspection of the 1 South treatment cart on November 16, 2015 at approximately 9:00 AM, multiple tubes of ointments and creams were noted without caps replaced after use. The caps were not located in the designated drawers.

Treatment Cart Inspection:
Four (4) tubes of ointment without caps stored in treatment cart [no cap]
Two (2) tubes of Santyl Ointment [no cap]
One (1) tube of Fluocinonide cream 0.0 05% ----60 grams [no cap]
One (1) tube of Triple Antibiotic ointment [no cap]
Triamcinolone Acetonide Ointment 0.025% [no name on label]
There was no evidence that the medications ointments and creams were adequately stored to preserve their integrity.

Medication Refrigerator Inspection:
Victoza pen opened and dated as opened August 17, 2015 no expiration date present.
There was no evidence that facility staff ensured that one (1) of one (1) that the Victoza pen, stored for use was properly labeled with the date that the vial pen usage expired.

The observation was made in the presence of Employee #6. He/she stated that the manufacturer expiration date was what the staff was using not the 30 day rule as used for other injectable medications. Upon further discussion Employee #6 acknowledged the Victoza pen was expired after 30 days.

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095022 | A. BUILDING ______<br>B. WING ______ | 11/23/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TRANSITIONS HEALTHCARE CAPITOL CITY | 2425 25TH STREET SE<br>WASHINGTON, DC 20020 |

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|---|---|---|---|---|
| F 441 SS=D | 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS<br><br>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.<br><br>(a) Infection Control Program<br>The facility must establish an Infection Control Program under which it -<br>(1) Investigates, controls, and prevents infections in the facility;<br>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and<br>(3) Maintains a record of incidents and corrective actions related to infections.<br><br>(b) Preventing Spread of Infection<br>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.<br>(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.<br>(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.<br><br>(c) Linens<br>Personnel must handle, store, process and transport linens so as to prevent the spread of infection. | F 441 | 483.65 Infection Control, Prevent Spread, Linens<br>1.<br>1. The dressing change protocols including proper infection control techniques, resident handling, hand washing, following the physician's orders. was afforded Resident #10 to ensure the resident received necessary treatment services to promote healing and prevent infection immediately upon discovery.<br>2. Wound rounds were done to observe dressing changes to ensure the facility's dressing change and infection control protocols and practices were afforded all other residents and to ensure the receipt of necessary treatment services.<br>3. The Nursing staff was inserviced regarding the facility's wound care protocol, infection control techniques, hand washing and following physician orders being afforded to ensure the receipt of necessary treatment services to promote healing and prevent infection..<br>The Nursing Quality Improvement Team will audit for the wound rounds on a monthly basis to ensure on-going compliance in this area.<br>The results of these audits will be forwarded to the Director of Nursing for review and evaluation.<br>4. The Director of Nursing will present the findings of these audits along with any action plans for improvement to the Quality Improvement Committee which meets monthly and is chaired by the Administrator | 11/18/15<br><br>11/30/15<br><br>11/30/15<br><br>2/3/16 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095022 | A. BUILDING ______ B. WING ______ | 11/23/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TRANSITIONS HEALTHCARE CAPITOL CITY | 2425 25th St., SE WASHINGTON, DC 20020 |

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|---|---|---|---|---|
| F 441 | Continued From page 41<br>This REQUIREMENT is not met as evidenced by:<br><br>Based on observation, record review, and staff interviews for three (3) of 32 Stage 2 sampled residents, it was determined that facility staff failed to follow accepted standards of infection control practices as to prevent cross contamination and reduce the transmission of infection and disease as evidenced by: failure to ensure that one (1) resident's pressure ulcers were consistently covered with dressings in accordance with physician's orders; failure to maintain appropriate hand hygiene and infection control practices during a tracheal suctioning treatment for one (1) resident; and failure to maintain proper hand hygiene practices during the administration of medication for one (1) resident. Residents' #10, #53, and, #147.<br><br>The findings include:<br><br>According to the Centers for Disease Control and Prevention [CDC] Guidelines for Hand Hygiene in Health-Care Settings; Hand-hygiene technique includes:<br>" How should you wash your hands? Wet your hands with clean, running (warm or cold), turn off the tap, and apply soap, lather your hands by rubbing them together with the soap. Be sure to lather the back of your hands, between your fingers, and under your nails, scrub your hands for at least 20 seconds. Need a timer? Hum the " Happy Birthday " song from beginning to end twice; rinse your hands well under clean running water, dry your hands using a clean towel or air dry them. <http://www.cdc.gov/handwashing/when-how-hand washing.html>. | F 441 | 483.65 Infection Control, Prevent Spread, Linens (continued) | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095022 | A. BUILDING ______ B. WING ______ | 11/23/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **TRANSITIONS HEALTHCARE CAPITOL CITY** | **2425 25TH STREET SE WASHINGTON, DC 20020** |

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|---|---|---|---|---|
| F 441 | Continued From page 42 | F 441 | 483.65 Infection Control, Prevent Spread, Linens (continued) | |

1.Facility staff failed to follow accepted standards of infection control practices as evidenced by the observation of Resident #10 lying in bed without dressing covering multiple pressure ulcers observed along the resident ' s back, hips, buttock, lower leg and heel/foot. Additionally, facility staff failed to practice proper hand hygiene and placed a gloved hand directly over and exposed Stage 3 pressure ulcer while positioning Resident #10 in preparation for a wound treatment.

A wound treatment observation was conducted on November 19, 2015 at 8:00 AM Following Resident 10 ' s consent to observe the procedure. Employees' # 4, 10, and 19 were present. Upon entering the room, Resident # 10 was observed lying in bed on his/her back. Employee #19 entered room closed door and donned a pair of plastic gloves without first washing his/her hands. Employee #19 then assisted in repositioning Resident #10 from his/her back onto the left side his/her left side. Once the resident was positioned on his/her side, open ulcers were observed at multiple sites along the dorsal surface of his/her back, hips, buttocks, lower leg and heel/foot. The open ulcers were observed uncovered and in contact with bed linens when the resident was lying supine. At this time the Employee #19 with the same gloved hands, placed and positioned a clear trash bag in the trash receptacle located in the resident ' s room and with his/her feet, slid the trash receptacle near the nurse who would perform the dressing change. With the same gloved hands, Employee #19 returned to the resident and positioned his/her [gloved] hands along the residents ' shoulders/back as if to hold the resident in place

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|---|---|---|---|---|
| F 441 | Continued From page 43<br>for wound treatment. Upon doing so Employee #19 placed his/her hands directly over the resident's Stage 3 pressure ulcer of the right upper back. At this time the State Agency Representative intervened with the dressing change as the aforementioned observations did not reflect infection control standards of practice.<br><br>The " Weekly Wound Report " dated November 13, 2015 revealed the following alterations in skin integrity:<br><br>Unstageable pressure ulcer of the Left dorsal foot measuring 3cm x 2cm x 0cm<br>Unstageable pressure ulcer of the Left hip measuring 1.5 cm x 1.5 cm x 0 cm<br>Stage III pressure ulcer of the Right upper back measuring 11cm x 6cmx 0.4cm<br>Stage III pressure ulcer of the Sacrum measuring 11cm x16cm x 1.5cm<br>Stage III pressure ulcer of the Right Ischium measuring 7cm x 3cm x0.9cm<br>Stage II pressure ulcer of the Left lateral heel measuring 2cm x 4cm x0cm<br>Stage III pressure ulcer of the Right hip measuring 8cm x 8cm x 0.5 cm<br>Stage II pressure ulcer of the Right lateral lower leg measuring 1cm x1cm x1 cm<br>Stage II pressure ulcer of the Left lower back measuring 6cm x7cm x0.5cm<br>Stage II pressure ulcer of the Right elbow measuring 3cm x3cm x 0cm<br><br>A review of the clinical record revealed:<br>The quarterly Minimum Data Set (MDS) dated August 24, 2015 revealed the following:<br>Section M0300 (Current Number of unhealed | F 441 | 483.65 Infection Control, Prevent Spread, Linens (continued) | |

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 095022 | A. BUILDING ____ B. WING ____ | 11/23/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| F 441 | Continued From page 44<br>pressure ulcers at each stage) the was coded as having a two (2) Stage 2, three (3) Stage 3, and five (5) Unstageable pressure ulcers indicating the resident had 10 pressure ulcers in total.<br>Under Section C (Cognitive Patterns) the resident had a BIMS (Brief Interview for Mental Status) score of 11 [a score of 8-12 reflects-moderate impairment] indicating that the resident ' s cognition is moderately impaired.<br>Under Section G (Functional Status) the resident required total dependence on staff with bed mobility, and was totally dependent on staff for dressing, toilet use and personal hygiene.<br>Under Section H Bladder and Bowel the resident was coded as always incontinent<br><br>Interviews:<br>A face-to-face interview was conducted with Employees ' #10 (Unit Manager) on December 19, 2015 at approximately 11:30 AM. Employee #10 was asked why was Resident#10 was lying in a supine position with his pressure ulcers in direct contact with bed linens He/she stated, " The unlicensed staff removed them because they were soiled."<br>A face-to-face interview was conducted with Employee #19 (unlicensed staff) on December 19 2015 at approximately 11:45 AM when queried he/she stated, " I removed Resident#10 ' dressings and bunny boots because they were soiled and I knew they were going to do his/her wound care around 8:00 AM. The Licensed nurse knew I had removed the dressing and that the wounds were not covered. "<br>A face-to-face interview was conducted with Employees ' #20 on December 19 2015 at 3:00 PM when queried regarding the unlicensed staff members training and role during wound care he/ she stated " unlicensed staff are trained to | F 441 | 483.65 Infection Control, Prevent Spread, Linens (continued) | |

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| F 441 | Continued From page 45<br>observe resident ' s skin for changes and to report them to the licensed nurse immediately, and at no time are unlicensed staff required or allowed to remove or replace dressings on wounds. "<br>After review of the aforementioned all employees acknowledged the findings.<br><br>There was no evidence that facility staff followed accepted standards of practice for infection control when managing wounds for Resident #10, as the resident ' s pressure ulcers were exposed because the dressings were removed and the open areas were observed directly in contact with bed linens. Additionally, staff failed to practice proper hand hygiene, as Employee #19 failed to sanitize his/her hands prior to donning gloves and applied his/her hand directly over the resident ' s exposed stage 3 pressure ulcer during positioning.<br>The clinical record was reviewed on November 19, 2015.<br><br>2. Facility staff failed to follow accepted standards of infection control practices related to hand hygiene to prevent potential cross contamination and spread of infection while conducting tracheal suctioning for Resident #53.<br><br>Facility Policy:<br>" Respiratory Care/Nursing Suctioning A Tracheostomy Tube " policy last updated 10/09/09 stipulated, " Procedure- Equipment Needed: 1. Normal saline or sterile H20 ...2. Suction kit (catheter, N/S [normal saline], 2 sterile gloves), sterile field...5. Portable suction device with container and connecting tubing... "<br>" General Information, Procedure Steps and | F 441 | 483.65 Infection Control, Prevent Spread, Linens (continued)<br><br>2.<br>1. Hand hygiene was immediately reviewed with these employees after the observation<br>2. Observations were done with staff while performing tracheal suctioning on other residents. Corrections were made on the spot and one-on-one education was done whenever necessary.<br>3. The Nursing staff was inserviced regarding the facility's handwashing protocol and infection control techniques during tracheal suctioning.<br>The Nursing Quality Improvement Team will audit and observe tracheal suctioning on a monthly basis to ensure on-going compliance in this area.<br>The results of these audits and observations will be forwarded to the Director of Nursing for review and evaluation.<br>4. The Director of Nursing will present the findings of these audits along with any action plans for improvement to the Quality Improvement Committee which meets monthly and is chaired by the Administrator | 11/18/15<br>11/19/15<br>12/30/15<br>2/3/16 |

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|---|---|---|---|---|
| F 441 | Continued From page 46<br>Rationale ...3. Prepare needed equipment: a. open suction kit. Maintain sterile technique ...8. Place the sterile glove on the hand that will advance the catheter down the tracheostomy tube. Maintain sterile technique ...19. Discard disposable equipment ... "<br><br>On November 19, 2015 at 11:00 AM an observation was conducted of Employee #18 performing tracheal suctioning on Resident #53. Employee #18 first washed his/her hands for approximately 15 seconds. He/she turned off the faucet with bare hands and then dried his/her hands with a paper towel and applied gloves...Employee #18 opened three (3) bottles of sterile saline, turned on the suction machine, manipulated the suction tubing and water bottle connection. With the same gloved hands, Employee #18 then opened and placed a sterile package of gloves on the resident ' s bed. With gloved hands he/she picked up one of the sterile gloves. At this time, Employee #6 (the Unit Manager) who was present stated words to the employee that the writer was unable to hear. Employee #18 then returned the sterile glove to the package and removed the gloves from his/her hands. Employee #18 went to the bathroom located in the resident ' s room to wash his/her hands, leaving the sterile gloves exposed. Employee # 18 wash his/her hands for approximately five (5) seconds and turned the faucet off with his/her bare hand, and dried his/her hands with a paper towel. Employee #18 returned to the resident ' s bed and applied the previously exposed gloves...After suctioning the resident, Employee #18 washed his/her hands in the bathroom located in the resident ' s room hands for approximately 20 seconds. He/she returned to the resident ' s room, disposed of | F 441 | 483.65 Infection Control, Prevent Spread, Linens (continued) | |

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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|---|---|---|---|---|
| F 441 | Continued From page 47<br>supplies used during suctioning. Without gloved hands, Employee #18 removed the suction canister and tubing from the suction machine, took the items to the resident ' s bathroom, and set them on the ledge to the mirror. The employee then proceeded to empty the contents of the canister with the tubing still attached into the commode. Employee #18 then returned the used suction canister with tubing to the suction machine and set it up for reuse.<br><br>Facility staff failed to use accepted standards of infection control practice for hand washing and use of sterile gloves during a tracheal suctioning procedure.<br><br>A face-to-face interview was conducted with Employees #6 and #18 immediately following the observation. The both acknowledged to the findings.<br><br>3.Facility staff failed to maintain proper hand hygiene practices during the administration of medication for Resident #147.<br><br>A medication observation was conducted on November 16, 2015 at approximately 10:38 AM with Employee #16, and Employee #7 the following occurred: Employee #16, after preparing the residents medication entered the residents room, wet hands with running water, applied soap washed the front and back of his/her hands, between his/her fingers, and under his/her nails. However, Employee #16, scrubbed his/her hands for and sanitized hands less than 20 seconds. Employee #7 entered the room to assist Employee #16, rinsed hands, applied soap and washed hands for less than 20 seconds. | F 441 | 483.65 Infection Control, Prevent Spread, Linens (continued)<br><br>3.<br>1. Upon discovery, staff was immediately instructed to wash hands for 20 seconds. One-on-one education was done.<br>2. Observations were done with other staff members and their hand washing techniques with no issues found.<br>3. The Nursing staff was inserviced regarding the facility's handwashing protocol. The Nursing Quality Improvement Team will audit and observe handwashing on a monthly basis to ensure on-going compliance in this area.<br>The results of these audits and observations will be forwarded to the Director of Nursing for review and evaluation.<br>4. The Director of Nursing will present the findings of these audits along with any action plans for improvement to the Quality Improvement Committee which meets monthly and is chaired by the Administrator | 11/18/15<br>11/18/15<br>12/31/15<br>2/3/16 |

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

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|---|---|---|---|---|
| F 441 | Continued From page 48<br>A face-to-face interview was conducted on November 18, 2015 at approximately 12:30 PM and 2:00 PM with Employees #16 and #7. After review of the above both Employees acknowledged the findings. The observation was made on November 16, 2015. | F 441 | | |
| F 463 SS=E | 483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH<br><br>The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities.<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on observations made on November 16, 2015 at approximately 10:45 AM, it was determined that the facility failed to ensure that call bells in resident's room function as intended as evidenced by non-functioning call bells in four (4) of 59 residents ' rooms surveyed.<br><br>The findings include:<br><br>Call bells in resident rooms #202, #231, #306 and #317 failed to initiate an alarm when tested.<br><br>These observations were made in the presence of Employee #12 who acknowledged the findings. | F 463 | 483.70(f) Resident Call System-Rooms/ Toilet/Bath<br><br>1. Call bells cited at the time of the survey Were immediately repaired upon discovery.<br>2. All call bells were tested to ensure proper working order.<br>3. Maintenance Staff was inserviced on the proper techniques of call bell maintenance and repairs. The Maintenance Supervisor and Maintenance Quality Improvement Team will monitor the proper functioning of the call bell system on at least a monthly basis. The results of this monitoring will be forwarded to the Director of Facility Services.<br>4. The Director of facility Services will present the findings of these monitoring audits along with any action plans for improvement to the Quality Improvement Committee which meets monthly and is chaired by the Administrator. | 11/19/15<br>11/19/15<br>12/31/15<br>2/3/16 |
| F 465 SS=D | 483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON<br><br>The facility must provide a safe, functional, | F 465 | 483.70(h) Safe/Functional/Sanitary/ Comfortable Environ<br><br>1. The kitchen floor was washed, cleaned and stains removed wherever possible at the time of the survey.<br>2. The Director of Facility Services has met with Feature Flooring and a different type of chemical is being recommended to remove the surface dirt and stains from the kitchen floor. | 11/16/15<br>2/3/16 |

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

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|---|---|---|---|---|
| F 465 | Continued From page 49<br>sanitary, and comfortable environment for residents, staff and the public.<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on observations made on November 16, 2015 at approximately 9:30 AM, and on November 19, 2015 at approximately 9:45 AM, it was determined that the facility failed to ensure that the kitchen environment was sanitary as evidenced by a kitchen floor that was stained, discolored and marred.<br><br>The findings include:<br><br>During an observation of the kitchen on November 16, 2015 at 9:30 AM, in the presence of Employee #11 the kitchen floor was observed to be stained, discolored and marred throughout. | F 465 | 483.70(h) Safe/Functional/Sanitary/ Comfortable Environ (continued)<br>3. The Supervisors will be Inserviced on the new chemical and upgraded techniques for the proper care of the kitchen floor.<br>The Dietary Quality Improvement Team will monitor the floor for cleanliness on a monthly basis.<br>They will forward the results of their Monitoring efforts to the Director of Dietary.<br>4. The Director of Dietary will present the findings of these reports along with any action plans for improvement to the Quality Improvement Committee which meets monthly and is chaired by the Administrator | 2/3/16<br><br>2/3/16 |
| F 469<br>SS=D | 483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM<br><br>The facility must maintain an effective pest control program so that the facility is free of pests and rodents.<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on observations made on November 16 through November 19, 2015, it was determined that the facility failed to maintain the environment free of pest and insects as evidenced by a crawling pest observed in one (1) resident ' s | F 469 | 483.70(h)(4) Maintains Effective Pest Control Program<br><br>1. The facility's pest control company was called and the areas were exterminated. The areas are free of pests.<br>2. All areas of the facility have been exterminated and continued to be exterminated on a rotating and continuous schedule. No pests have been seen.<br>3. The pest control company is in the Facility 3-4 times per month, thorough Inspects and exterminates each area of The facility and reports their findings to the Directors of Facility Services and Dietary.<br>4. The Directors of Facility Services and Dietary will present the findings of these reports along with any action plans for improvement to the Quality Improvement Committee which meets monthly and is chaired by the Administrator. | 11/30/15<br><br>11/30/15<br><br>12/31/15<br><br>2/3/16 |

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| F 469 | Continued From page 50<br>room and flying pest seen on the 3 South nursing unit in on e (1) of six (6) nursing units observed during the survey period.<br><br>The findings include:<br><br>1. A crawling pest was observed on the wall adjacent to the closet in resident room #128 on November 17, 2015 at approximately 1:12 PM.<br><br>2. Flying pests were observed on the 3 South nursing unit on multiple occasions throughout the survey period (November 16 through November 19, 2015). | F 469 | | |
| F 514 SS=D | 483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE<br><br>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on staff interviews and record review for two (2) of 32 Stage 2 sampled residents, it was | F 514 | 483.75(l)(1) Res Records – Complete/ Accurate/Accessible<br><br>1.<br>1.The physician's assessment of the Resident's blood pressure has been added to the medical record.<br>2. Review of the medical records of other Residents consultation reports found all were acknowledged by the physician.<br>3. The physician was given a one-on-one Inservice by the Administrator on the need to acknowledge the results from any consultation. Implementation of the recommendations is totally up to the attending physician. The physician acknowledged his understanding.<br>The Nursing Quality Improvement Team will audit physician's acknowledgement of consultations on a monthly basis to ensure on-going compliance in this area. The results of these audits and observations will be forwarded to the Director of Nursing for review and evaluation.<br>4. The Director of Nursing will present the findings of these audits along with any action plans for improvement to the Quality Improvement Committee which meets monthly and is chaired by the Administrator | 11/27/15<br>11/27/15<br>12/31/15<br>2/3/16 |

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

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| F 514 | Continued From page 51<br>determined that facility staff failed to maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized as evidenced by: the physician failed to document an assessment of one (1) resident's blood pressure and failed to transcribe the order for the resident's trach size into the electronic medical record system; and failure to accurately code the electronic medication administration record for one (1) resident who had an elevated blood glucose level. Residents' # 53 and #366.<br><br>The findings include:<br><br>1. The physician failed to document an assessment of Resident #53 ' s blood pressure in the active clinical record.<br><br>A review of the report of consultation dated October 30, 2015 revealed, " ...Order: Discontinue Diovan and Metoprolol.<br><br>Diagnosis: Diarrhea side effects of hypertension medications. "<br><br>A face-to-face interview was conducted with the attending physician for Resident #53 on November 23, 2015 at approximately 4:30 PM. He/she stated I address the issue with the resident ' s blood pressure. I assessed (him/her). I did not agree with the consultation to take the | F 514 | 483.75(l)(1) Res Records – Complete/ Accurate/Accessible (continued)<br><br>2.<br>1. The Nursing Staff immediately transcribed the correct trach size in the resident's electronic medical record.<br>2. A review of the medical records for all residents with trachs revealed the correct trach size was noted.<br>3. The Nursing staff was inserviced regarding proper documentation of trach size. The Nursing Quality Improvement Team will audit the medical records for evidence of the proper trach size on a monthly basis to ensure on-going compliance in this area.<br>The results of these audits and observations will be forwarded to the Director of Nursing for review and evaluation.<br>4. The Director of Nursing will present the findings of these audits along with any action plans for improvement to the Quality Improvement Committee which meets monthly and is chaired by the Administrator | 11/18/15<br>11/30/15<br>12/31/15<br>2/3/16 |

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

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|---|---|---|---|---|
| F 514 | Continued From page 52 resident off [his/her] the blood pressure medication. I did not document the assessment in the clinical record. " | F 514 | 483.75(l)(1) Res Records – Complete/ Accurate/Accessible (continued) | |
| | There was no documented evidence of the physician ' s assessment of the resident's blood pressure in the active clinical record. The record was reviewed on November 23, 2015. | | | |
| | 2. Facility staff failed to transcribe the order for the resident's trach size into the electronic medical record system for Resident #53. | | 3. | |
| | The May 2015 Physician ' s Order Sheet signed and dated by the physician on May 20, 2015 directed, " Trach tube size Shiley #6 " . | | 1. The proper code was entered into the electronic medical record soon after the | 11/18/15 |
| | A review of electronic medical record system was conducted on November 23, 2015. There was no evidence that the order for the tracheostomy tube size was transcribed into the electronic system. | | 2. Other medical records were audited for proper coding. No other issues were found. | 11/30/15 |
| | A face-to-face interview was conducted with Employee # 6 on November 20, 2015 at approximately 10:00 AM. He/she acknowledged the findings. The record was reviewed on November 20, 2015. | | 3. The Nursing staff was inserviced regarding proper coding on the electronic Medicine Administration Record. The Nursing Quality Improvement Team will audit for proper coding on a monthly basis to ensure on-going compliance in this area. The results of these audits and observations will be forwarded to the Director of Nursing for review and evaluation. | 12/31/15 |
| | 3.Facility staff failed to accurately code the electronic medication administration record for Resident # 366 who had elevated blood glucose. | | 4. The Director of Nursing will present the findings of these audits along with any action plans for improvement to the Quality Improvement Committee which meets monthly and is chaired by the Administrator discovery of the error. | 2/3/16 |
| | The November 2015 Medication Administration | | | |

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

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| (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) COMPLETION DATE |
|---|---|---|---|---|
| F 514 | Continued From page 53<br>Record revealed that on November 3 and 20, 2015 at 0600 " 8 " was coded in the allotted spaces for signature and codes. According to the MAR " Chart codes/Follow Up Codes " revealed that " 8=nauseated/vomiting " .<br><br>A review of the nursing notes revealed:<br>November 3, 2015 revealed, " Fingerstick 309 mg/dl " .<br>November 20, 2015 at 06:58 (6:58 AM) revealed, " Fingerstick 340 mg/dl 10 units insulin given " .<br>November 20, 2015 at 07:57 (7:57 AM) revealed, " New order received from NP (nurse practitioner) [Name]: Novolog sliding scale, 4 times daily. Novolog (150-200=2 Units); (201-254=3 units); Novolog (255-300=6 units); Novolog (301-350=8 units); Novolog (351-400=10 units). Call MD for blood sugar greater than 400 or less than 60. "<br><br>A telephone interview was conducted with Employee # 13 on November 20, 2015 at 10:55 AM. He/she stated, " The resident had no nausea or vomiting. Putting in the code is an error, it should have been a " 9 " (other/see nurse notes). I called and notified the NP (nurse practitioner). I received a new order for sliding scale. The Fingerstick was 340 mg/dl. I gave 10 units of Lantus. I didn ' t give the novolog per the sliding scale. "<br><br>A face-to-face interview was conducted with Resident #366 on November 20, 2015 at 10:58 AM. He/she stated, " No, I ' m alright. I feel good, I ' m not nauseated. I had no nausea or vomiting today. I have not felt that way in a long time. If I didn ' t feel good you would know about it. "<br><br>Through record review and interviews it was | F 514 | 483.75(l)(1) Res Records – Complete/ Accurate/Accessible (continued) | |

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095022 | A. BUILDING ______<br>B. WING ______ | 11/23/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **TRANSITIONS HEALTHCARE CAPITOL CITY** | **2425 25TH STREET SE<br>WASHINGTON, DC 20020** |

| (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) COMPLETION DATE |
|---|---|---|---|---|
| F 514 | Continued From page 54<br>determined that the nurse entered the incorrect code when recording information on the electronic medication administration record. The record was reviewed on November 20, 2015. | F 514 | | |