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Health Regulation & Licensing Administration (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: __ 12/09/2014 B. WING HFD02-0020 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2425 25TH STREET SE TRANSITIONS HEALTHCARE CAPITOL CITY WASHINGTON, DC 20020 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) L 000 Continued From page 1 L 000 3200.1 Nursing Faculties mm/Hg - millimeters of mercury POS physician 's order sheet 12/15/14 1. Resident #160 was readmitted to the As needed Prn facility and his care plan was updated to Patient Ptaddress his advanced dementia Treatment Administration Record TAR -He was evaluated by the facility's psychiatrist PASRR - Preadmission screen and Resident 1/16/15 who wrote that the "Pt does not meet the Review criteria for Pica. It appears that he has a assessment reference date ARD hyper oral fixation related to his dementia. interdisciplinary team IDT -Behavioral interventions implemented at Intellectual disability ID -N.H. have been effective." Quality Indicator Survey QIS -2. All residents with Advanced Dementia District of Columbia D.C. were screened to ensure accurate information D/Cdiscontinue 1/12/15 about the care and services needed by Rp. R/P- responsible party these residents is known to his/her PO-By Mouth caretakers. 3. A new Behavioral Health contract was initiated at the facility which will afford 1/5/15 L 001 L 001 3200.1 Nursing Facilities increased access to Psychiatry and Psychology services. An inservice was Each nursing facility shall comply with the Act, done with the clinical staff regarding the these rules and the requirements of 42 CFR Part referral of residents for evaluation by 483, Subpart B, Sections 483.1 to 483.75; Subpart Psychiatry to ensure the prompt imple-D, Sections 483.150 to 483.158; and Subpart E, mentation of Physician orders for these 1/12/15 section 483,200 to 483,206, all of which shall services and the clarification of terms such constitute licensing standards for nursing facilities in as "close monitoring" and "1:1." Additionally, the District of Columbia. the Inservice address the need for the This Statute is not met as evidenced by: accurate notification of caretakers of the care and needs for these specific residents. A. Based on observation, record review and staff Compliance auditing will be interview for one (1) of 53 sampled residents, it was conducted by the Quality Assurance Nurse determined that facility staff failed to implement on a routine basis to ensure proper appropriate treatment and services to correct the communication of the residents needs, assessed problem of Resident #160 placing care and services as well as the prompt nonnutritive item 's in his/her mouth. access of Behavioral Health evaluations. The results of those audits will be The findings include: forwarded to the Director of Nurses for his evaluation. According to the Psychiatric Times " Pica is the 4. The Director of Nurses will review the data pathological craving for and eating of a nonnutritive

item "

from these monitoring efforts done by the Quality Assurance Nurse and present his

analysis and any action plans for

improvement to the

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	adults with complica problem that must b individualized design but not harmful cons http://www.psychia	of pica in mentally handicapped ted histories presents a clinical e approached through and the presence of aversive sequences. " atrictimes.com/eating-disorders/uce-contributing-causes-and-trea		Quality Assurance/Performance Imp Committee which meets monthly ar chaired by the Administrator		1/12/15			
	September 22, 2014 diagnoses: End Sta Dependent, Dement	story and Physical completed on the resident had the following age Renal Disease- Dialysis tia and Hypertension. The tatus was assessed as							
	November 12, 2014 (Cognitive Skills for Resident was coded [never/rarely made of 0200 (Behavior), the physical behavioral others (e.g. hitting, I grabbing), Section resident was coded assistance in bed made in the properties of the properties	nimum Data Set completed . Under Section C1000 Daily Decision Making), the d as severely impaired decisions]. Under Section E e resident was coded as symptoms directed towards kicking, pushing, scratching, on G (Functional Status), the as requiring extensive hobility, and transfers; and ance in toileting, dressing, al hygiene. Section G 0400 on in Range of Motion), the as having no impairment to emities. Under Section K onal Status), the resident was a mechanical altered diet.							

Health Regulation & Licensing Administration (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: _ B. WING HFD02-0020 12/09/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **2425 25TH STREET SE** TRANSITIONS HEALTHCARE CAPITOL CITY WASHINGTON, DC 20020 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (EACH CORRECTIVE ACTION SHOULD BE PREFIX PRÉFIX OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) L 001 L 001 Continued From page 3 A review of the care plan entitled, "Problematic Manner in which resident acts characterized by inappropriate behavior " last updated September 9, 2014 revealed: "Goal- resident will eliminate intake of foreign objects [times] 90 days. To ensure resident safety [times] 90 days. Interventions: Place resident close to nursing station for safety and close monitoring. Remove harmful substances from room. Remove non-edible but frequently ingested objects from resident's room." A review of the "Resident Care Card" [no date] revealed that under the heading "Precautions," the line was left blank. However, under the heading ' Nutrition. " the resident was listed as a feeder, on aspiration precautions, required assisted to be fed meals. Under the heading "Ambulation/Mobility." the resident required a wheelchair with seatbelt, and 1:1 hourly rotation, monitoring for fall prevention. Under the heading "Safety, "the resident required a seatbelt when up [in] wheelchair. Under ' Physical Needs," the staff escorted the resident to dialysis on Monday, Wednesday and Friday. Under "Activities of Daily Living," the resident's was provided total care by staff. A review of the Physician's Order Sheet signed and dated October 24, 2014 directed, "Exelon [indicated for the treatment of Dementia] Patch 9.5 mg per 24 hours, apply one patch topically daily for Dementia: Paxil Jused to treat Major Depressive Disorder] 10 mg take one tablet by

Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: _ B. WING HFD02-0020 12/09/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **2425 25TH STREET SE** TRANSITIONS HEALTHCARE CAPITOL CITY WASHINGTON, DC 20020 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (EACH CORRECTIVE ACTION SHOULD BE PREFIX OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) L 001 L 001 Continued From page 4 mouth daily for Depression" The interim physician's order dated September 5, 2014 directed, "One-on-one hourly rotation monitoring for fall prevention q [every] shift." A review of the facility's "Behavior Monitoring Sheets" for September, October and November 2014 revealed that Resident #160 was monitored for Paranoia, Resistance to Care, and Scratching. However, during this time, the resident was coded as "zero," indicating that no behaviors were observed. A review of the "Consult for Therapy "dated October 9, 2014 revealed, "Please evaluate Resident [second to] pocketing foods. " A review of the "Speech Therapy Plan of Care" dated October 31, 2014 revealed that the reason for referral was for "reports of pocketing food." The start of care was October 31, 2014 and the resident was discharged from care on November 14, 2014. A review of the Doctor's Progress Notes from July 15, 2014 to November 21, 2014 lacked evidence that the attending physician addressed the resident ' s behavior of ingesting foreign substances in his/her mouth.

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	the last consult was There was no evide by a psychiatrist to resident's behavior The team note date PM revealed. "91	chiatric Consults revealed that so conducted October 24, 2013. Since that the resident was seen evaluate and address the of ingesting nonnutritive items and November 21, 2014 at 11:30 call at 3:35 PM. Arrived at 3:)			
	PM. Resident was [hospital name] [se AV (Arteriovenous) evaluation at the en	transported at 3:50 PM to econd] to declott of [right] upper graft site. Resident is still und nd of the shift "				
	Inter-Agency Refer indicated] and the Columbia Fire and forms lacked evide	Metropolitan Washington Area ral Transfer Form " [no date D.C. Fire & EMS[District of Emergency Medical System] ence that facility staff the receiving hospital and the the resident's behavior of tive items.				
	December 8 2014	views were conducted on I between 10:00 AM and 4:00 I ssigned to care for Resident #1	PM 60.			
	Facility staff stated	d the following:				
	tries to get out of t Resident#160 was	ited, "Resident #160 talks and the wheelchair. At one point is briefly on 1:1 monitoring. es in the restraint reduction rs a seatbelt in the wheelchair.				
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	He/she would che that he/she got. "	w on his/her shirt every chance				
	to be provided for The Resident was and eating everyt /she chewed on s He/she went on t	as asked what type of care need. Resident #160. He/she stated, is a 1:1. He/she was chewing up hing so he/she was put on 1:1; heocks and shirts in the drawer. The socks are that Resident #160 had to be in the hallway at the nurseing in his/her way that could be en.	ne			
	Employees #25 s being tracked [no Management Te	stated, "Resident #160 was no ot being followed by the Behavio am]	t			
	tracked but that	stated that he/she is not being all staff has been notified to star ement forms when behaviors are	t e			
	candidates for 1 1:1 monitoring is intense behavio	vas asked what type of residents :1 are monitoring. He/she stated s for fall risks and residents with rs that need to be monitored. rs include agitation, 1:1 monitori ent from acting out."	u,			
ı	1:1 monitoring.	as asked why Resident #160 wa He/she stated, " Resident #160 ng for safety and putting things in He/she is at the nursing	7 15			

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	station every day w his/her room are lo	vith supervision. The gloves in cated far from the bed. He/she isident #160 was sent out to have tted, and that he/she was fine			
	Resident #160. He on hourly monitoring times he/she is at also in the restraing asked if Resident with his/her hands cannot grab anyth Employee #23 stated was not alert gnaw on his/her to holds his/her drink used when feeding He/she eats all of	is asked about the care of e/she stated that the resident was ing for elopement. Some of those the nursing station and he/she is it reduction program. When #160 was able to grab anything Employee# 23 stated that he/shing and that he/she is a feeder. Ited that Resident #160 can 't tall and oriented x 3, he/she likes to owel while feeding. The staff of when taking a sip and a towel is g to protect his/her clothes. his meals in the dining room and the staff does not feed es. "	e		
	Resident #160. E was on 1:1 monit more than a mon station to prevent when in the whee around if the sea because there is	as asked about the care for Employee #22 stated that he/she oring for high risk of falling for th. He/she sits close to the nursi falls. He/she wears a seatbelt elchair and someone would be toelt was removed by the residen always a charge nurse at the He/she stated that Resident #160 onitored for anything else.	ng		

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			L		
	Employee #29 was	asked about the care for			
	Resident# 160, Emi	ployee# 29 stated that he/she	1 2		
	takes Resident #16	0 to the dining room and that			İ
	he/she is a feeder.	Whenever Resident# 160 is in			
	his/her room," I mal	ke sure that I check on the			
	resident every 5 mil	nutes. I place a plastic/paper bit			
	on [Resident #160]	when [he/she] is fed and			
	sometimes ne/sne	puts things in his/her mouth. around the bib to keep him/her			
	from putting other t	hings in his/her mouth."	may and " I have		
	i nom patting other t	milgo III illorito. III e e e e			
	<u> </u>				
	Employee #31 was	asked about the care of			
	Resident #160. Em	ployee #31 stated that he/she esident #160 when he/she is in			
	keeps an eye on Ke	esident #160 because he/she is			
	unable to feed him/	/herself. Sometimes when			
	Resident #160 is b	eing fed he/she tries to put thing	ıs		
	in his/her mouth, w	hen he/she does this the staff			
	can usually talk to	the resident and he/she will stop).		
	Sometimes he/she	likes to chew on his/her shirts.			
	On December 9 2	014 at approximately 10:30 AM	a		
	face-to-face intervi	ew was conducted with			
	Employees #1, 2, 8	8, and 25. They stated that 1:1			
	monitoring means	that a certified nurse aide is			
	assigned to the res	sident for a defined period of tim	e;		
	and acknowledged	i the findings.	ļ		
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	Continued From parthere was no evide implemented to addingesting nonnutritive communicated to the resident 's behavior non-food items. The facility staff implemented address the resident nonnutritive items. The "Resident Callacked problem ideinterventions for the mouthing/chewing. The resident was a underwent diagnost he/she had ingested gloves." A face to face inter 2014 at approximating and 2. The fine acknowledged. The record was resident was resident was resident was a underwent diagnost before the face interpretation of	ge 9 ence that 1:1 monitoring was dress the resident 's behavior of we items and that facility staff ne medical team regarding the er of mouthing/chewing on a care plan lacked evidence that ented specific interventions to not 's behavior of ingesting are Card " for Resident #160 non-food items. admitted to the hospital, stic studies that determined that ad non-food items identified as " eview was done on December9, tely 3:00 PM with Employee 's dings were reviewed and viewed on December 9, 2014. d review and staff interview for olded residents, it was determined ited to inform one (1) resident at	TAG	3200.1 Nursing Facilties (cont.) B. 1. This resident was discharged from facility without his/her complete addroxed being signed. 2. All new residents' admissions particle have been reviewed to ensure that admission paperwork was complete that each resident/Resposnible Parinformed of their rights, all rules an regulations governing resident con responsibilities; their rights and being Medicare and Medicaid services in (such as, equal access to waiving written assurance of residents eligic costs for services and changes in costs for services and changes in cost for services and understanding of the Admissions Staff to ensure the competecy and understanding of the all rules and regulations governing conduct and responsibilities; their benefits for Medicare and Medicai in writing (such as, equal access to rights, written assurance of reside eligibility, and costs for services a changes in cost for services). To engoing compliance, the Admissi Quality Improvement Team will complete a monthly audit of the adpaperwork for new residents and their findings to the Director of Adand Marketing.	om the mission 1 ackets all ed and rty was d duct and nefits for writing rights, ibility, and cost for sted with ir he ir rights and d services o waiving nts and ensure ons dmission report missions	1/21/14
	the time of admiss regulations govern responsibilities; the Medicare and Medicare a	ions of their rights, all rules and hing resident conduct and eir rights and benefits for dicaid services in writing (such as aiving rights, written assurance of c, costs for services and changes		4. The Director of Admissions and will present the finding of the Adm Quality Improvement Team along any action plans for improvement Quality Assurance/Performance I Ment Committee which meets mo Is chaired by the Administrator.	issions with to the mprove-	1/12/15

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ADACH DEDICIENCY MITST	r RE PRECEDED BY F	ENCIES ULL REGULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
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1		lant/rannancible				
evidenced by failure to have a resident/responsible party sign the applicable admission forms. Resident #102.						
The findings include	ə :					
Employee #53 on Dapproximately 10:0 admission process resident a day or two Someone from administration meet with the residute of the ensure all aspects.	December 8, 20° O AM. When que he/she stated, the to get accoministions and the feat and/or the rests of the admissions admissions.	14, at ueried about the 'I usually give the odated. b business office esponsible party				
Employee #14 on approximately 10:4 admission's procestated, "There is resident is here. The admissions. I was admissions. I was a review of the factincluded information resident/responsibilities and responsibilities and their rights and Medicaid services to waiving rights.	December 8, 20 45 AM. When quess for Resident is a process in plather in the financial part notified of this 'clity's admission to notify [the ple party] of their party] of their pas governing residual benefits for Maritten assurance written assurance weitten assurance in written a	14 at ueried about the #102; he/she ce when the is completed wit after the fact. " on 's packet rights and all esident conduct y in the facility; ledicare and as, equal access ce of residents	3			
	Continued From pare evidenced by failure party sign the applic #102. The findings include #102. The findings include #102. The findings include #102. A face -to-face inte Employee #53 on Dapproximately 10:0 admission process resident a day or to Someone from admission process resident a day or to Someone from admission process resident a day or to Someone from admission yeare discussed and A face-to-face inte Employee #14 on approximately 10:4 admission's process tated, "There is resident is here. To admissions. I was A review of the factincluded information resident/responsibilities and regulation and responsibilities and their rights and Medicaid services to waiving rights, eligibility, costs for the supposition of the faction of the factio	ROVIDER OR SUPPLIER IONS HEALTHCARE CAPITOL CITY SUMMARY STATEMENT OF DEFICIT (EACH DEFICIENCY MUST BE PRECEDED BY FOR LSC IDENTIFYING INFORMAT) Continued From page 10 evidenced by failure to have a resic party sign the applicable admission #102. The findings include: A face -to-face interview was condicted Employee #53 on December 8, 20 approximately 10:00 AM. When quadmission process he/she stated, resident a day or two to get accome Someone from admissions and the meet with the resident and/or the resident and/or the resident and signed." A face-to-face interview was condicted in the resident in the resident and signed." A face-to-face interview was condicted in the resident is here. The financial party admissions. I was notified of this included information to notify [the resident/responsible party] of their rules and regulations governing reand responsibilities during the stand their rights and benefits for M Medicaid services in writing, such to waiving rights, written assurance ligibility, costs for services and collisions.	ROVIDER OR SUPPLIER ROVIDER OR SUPPLIER RONS HEALTHCARE CAPITOL CITY SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 10 evidenced by failure to have a resident/responsible party sign the applicable admission forms. Resident #102. The findings include: A face -to-face interview was conducted with Employee #53 on December 8, 2014, at approximately 10:00 AM. When queried about the admission process he/she stated, "I usually give the resident a day or two to get accomodated. Someone from admissions and the business office meet with the resident and/or the responsible party to ensure all aspects of the admission processes are discussed and signed." A face-to-face interview was conducted with Employee #14 on December 8, 2014 at approximately 10:45 AM. When queried about the admission's process for Resident #102; he/she stated, "There is a process in place when the resident is here. The financial part is completed with admissions. I was notified of this " after the fact. " A review of the facility 's admission 's packet included information to notify [the resident/responsible party] of their rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility; and their rights and benefits for Medicare and Medicaid services in writing, such as, equal access to waiving rights, written assurance of residents eligibility, costs for services and changes in cost for	ROVIDER OR SUPPLIER ROVIDER OR SUPPLIER ROUNDER OR SUPPLIER ROUNDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 10 evidenced by failure to have a resident/responsible party sign the applicable admission forms. Resident #102. The findings include: A face to-face interview was conducted with Employee #53 on December 8, 2014, at approximately 10:00 AM. When queried about the admission process he/she stated, "I usually give the resident a day or two to get accomodated. Someone from admissions and the business office meet with the resident and/or the responsible party to ensure all aspects of the admission processes are discussed and signed." A face-to-face interview was conducted with Employee #14 on December 8, 2014 at approximately 10:45 AM. When queried about the admission's process for Resident #102; he/she stated, "There is a process in place when the resident is here. The financial part is completed with admissions. I was notified of this " after the fact." A review of the facility 's admission 's packet included information to notify [the resident/responsible party] of their rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility; and their rights and benefits for Medicare and Medicaid services in writting, such as, equal access to waiving rights, written assurance of residents eligibility, costs for services and changes in cost for	OF DEFICIENCIES F CORRECTION HFD02-0020 E. WING	OF DEFINICATION NUMBER: HFD02-0020 B WING SWINDS PROVIDERS PLAN OF CORRECTION EACH CORRECTION ACTION SHOULD BE PROVIDERS PROVIDERS PLAN OF CORRECTION SWINDS PROVIDERS PR

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L 001	Continued From page 11			L 001	3200.1 Nursing Facilties (cont.)		ļ
2 33 .	,					į	
						3	
	A review of the clin	ical record for Resi	ident #102			ļ	
	lacked evidence the	at all forms related	to the				
	admission 's proce	ess were signed, in	dicating that 🖐				
	the resident was in	tormed of his/her ii	ignis, and				Ē
	benefits for Medica	ire and Medicalu Si	ervices.				į.
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	A face-to-face inte	rview was conduct	ed with				ļ
i	Employee #13 on I	December 8, 2014	at				ŀ
	approximately 11:3	ROAM Employee	#13 was				ì
	queried regarding	why the admission e stated that all co	ntracts are to			ĺ	ì
	not signed. He/sn	esident or respons	ible party when				
	the resident is adn	nitted into the facili	ty.			ļ	1
	the leader to adv						
				Ì			
	There was no evic	lence that facility s	tatt ensured				ŀ
	that Resident #10	2 and/or resident '	s responsible				
	party was informe	d of his/her rights, ning resident condu	uct and				i
	regulations govern	nd rights and bene	fits for Medicare		c.		
	and Medicaid serv	vices.			1 Physician's files found to be la	icking	
					an annual screening for TB have	been	1/12/15
		المحالية مناجعة	and the findings		undated.	1	1/12/15
	Employees #13 a	nd #14 acknowledg	ged the midnigs ecord was	Ì	2. All Physicians file are complet	ce of a	11 12/10
	reviewed on Dece	2014. The clinical rember 8, 2014.	55514 1146		annual TB screenings with evider Chest x-ray or an annual PPD.	ioc oi a	ļ
	Leviewed ou pece	JIII.001 0, 20 1 11			13 The Medical Records Quality In	nprovement	
					Team will monitor Physician Cred	dentials for	
		.	0 t k d	i i	completeness on a monthly basis	s and report	1/12/15
	C. Based on reco	ord review and staff	r interview for	ļ	their findings to the Director of M	edical	1/12/10
	seven (7) of 17 s	ampled physician r	ecolus, it was	t	Records.	rds	
	determined that t	he facility staff faile e free of communic	cable diseases.	-	The Director of Medical Reco will present her findings and any	action	1/12/15
	Dhysicians' # 41	43, 44, 45, 47, 49,	and 50.		plans for improvement to the Qu	ality	
	Filyaidiana # Ti	· + 1 · · 1 · · - 1 · · · · · · · ·			Assurance/Performance Improve	ement	!
					Committee which meets monthly	/ and is	
				<u> </u>	chaired by the Administrator.		

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L 001	Continued From p	page 12	L 001		
L 001	Centers for Disea Guidelines for Promycobacterium To Setting, 2005. Man Reports (MMWR) "TB Screening For as Low Risk - all should receive by additional testing exposure to M. to care workers) with positive test resuradiograph results of the symptom screening Process Medium Risk - as should receive by HCWs should receive by HCWs should receive by the symptom screening process one chest radiograph results one chest radiograph results should receive as the facility staff [Purified Proteir Screening was 44, 45, 47, 49, 48, 47, 49, 48, 47, 49, 48, 47, 49, 48, 48, 48, 47, 49, 48, 48, 48, 48, 48, 48, 48, 48, 48, 48	ase Control and Prevention (CDC eventing the Transmission of "uberculosis (TB) in Health Care lorbidity and Mortality Weekly) 2005:54(RR17); 1-141 stipulate Procedures for Settings Classifier HCWs (health care workers) aseline screening upon hire us is not necessary unless an uberculosis occursHCWs (health care workers) at the abaseline positive or newly set to exclude TB disease "The edures for Settings Classified as II HCWs (health care workers) aseline screening upon hire are every the screening annually (i.e. the for all HCWs and testing for tuberculosis for HCWs with a every positiveshould recograph result to exclude TB disease in a connewly positiveshould recograph result to exclude TB disease in a symptom screen annually. "It failed to ensure an annual PPD of Derivative]/TB [Tuberculosis] performed for Physicians' #41, 43, 44, 45, 49, and 12 records lacked documented	es d alth s., eive se.		
	50 's personne evidence that the	ol records lacked documented the physicians was screened view of Physician #47's personned that the tuberculosis skin test	ļ		

Health Regulation & Licensing Administration (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED STATEMENT OF DEFICIENCIES **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING: _ 12/09/2014 B. WING HFD02-0020 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2425 25TH STREET SE TRANSITIONS HEALTHCARE CAPITOL CITY WASHINGTON, DC 20020 (X5) COMPLETE DATE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES EACH CORRECTIVE ACTION SHOULD BE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX CROSS-REFERENCED TO THE APPROPRIATE OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) TAG L 001 3200.1 Nursing Facilties Continued From page 13 L 001 was last completed on September 8, 2011. There was no evidence that the physician was screened annually. A face-to-face interview was conducted on December 8, 2014 at approximately 10:30 AM with Employee #20 who acknowledged the aforementioned findings. There was no evidence that the facility staff assured that physicians' #41, 43, 44, 45, 47, 49, and 50 were free of communicable diseases. The records were reviewed on December 8, 2014. 1. Resident #38 D. Based on observation and staff interviews for 1. The staff member involved was counsled one (1) of 53 sampled residents, it was determined and inserviced on proper Infection Control that the facility staff failed to demonstrate care 12/5/14 techniques while feeding a resident. consistent with current infection control practices to 2. Monitoring rounds are done in the dining prevent contamination and the spread of infection rooms and on the units to ensure that all as evidenced by the staff 's failure to use sanitary staff who are feeding residents use measures while feeding the resident; and to follow proper Infection Control techniques. 1/12/15 accepted standards of hand hygiene practices to 3. Nursing staff were inserviced on Infection help prevent the spread of infection. Resident #38. Control and Feeding to ensure their understanding in this area. Monitoring The findings include: rounds are being done on a weekly basis by memebers of the Nursing Quality 1. Facility staff failed to use sanitary measures while Improvement Team for on-going compliance. feeding Resident #38. The results of these monitoring efforts are forwarded to the Director of Nursing for his 1/12/15 The Annual Minimum Data Set (MDS) dated, review and analysis. August 25, 2014 revealed the admitting diagnoses 4. The Director of Nursing will present the included Cerebrovascular Accident, Hemiplegia or findings of this monitoring Hemiparesis, Hypertension, and Seizure disorder along with any action plans for improvement 1/12/15 for Resident #38. Under Section G- Functional to the QualityAssurance/Performance Status, it also revealed that the resident was totally Improvement Committee which meets dependent with Activities of Daily Living (ADL's). monthly and is chaired by the Administrator.

Health Regulation & Licensing Administration					(X3) DATE SUF	RVEY
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L 001	dining observation Resident #38 was a #39. Employee #39 stomach with both the resident withou put both hands in hwas chewing food, the resident, without On December 1, 2 face-to-face intervitemployee #39 regifindings. He/she are Facility staff failed with current infection contamination and clinical record was 2. Facility failed to hand hygiene praction infection. A tour of 3 South was noted that Rec. Diff [Clostridium that affects the dig 2014 at approximation was noted that Rec. Diff [Clostridium that affects the dig 2014 at approximation observed walking assigned room] wo other PPE (personand carrying clear minimize exposur	214 at approximately 12:55 PM, a was conducted on unit, 1 North. observed being fed by Employee awas observed rubbing his/her hands, then continuing to feed t sanitizing. Additionally, he/she his/her pocket, while the resident Then he/she resumed feeding		2. Resident #314 1. The staff member involved was and inserviced on proper Infection techniques/Hand Washing to previous contamination and the spreadinfection. 2. Monitoring rounds are done in a isolation situation to ensure the pruse of PPE and infection control to prevent cross contamination and spread of infection. 3. Nursing staff were inserviced or Control/Hand Washing to prevent Contamination and the Spread of Monitoring rounds are being done weekly basis by the Infection Confor on-going compliance. The results of these monitoring efforwarded to the Director of Nursi review and analysis. 4. The Director of Nursing will prefindings of this monitoring along with any action plans for im to the QualityAssurance/Perform	Control ent ad of . any oper echniques d the n Infection Cross Infection. on a trol Nurse forts are ng for his esent the provement	12/8/14 12/8/14 1/12/15

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L 001	Continued From page 15			L 001			
	mask]. Once in the clean linen in a cha his/her face, place located underneath the room without fir Employee #37 ackr of the observation. There was no evide acceptable standar help prevent potent spread of infection.	e room, Employee # ir, removed the ma d it in the trash rec- the hand washing est washing his/her howledged the find ence that facility sta rds of hand hygiene tial cross contamin	eptacle sink, and left hands. ing at the time aff followed e practices to				
L 027	L 027 3207.2 Nursing Facilities The Medical Director shall:		L 027	3207.2 Nursing Facilities 1. The Medical Director and the A Physician were counseled regardi D.C. regulations for re-admission	ng the	1/12/15	
	(a)Coordinate med	lical care in the fac	ility;		resident. 2. The admission and re-admission and re-admission.	on records	
	(b)Implement resid	dent care policies;			of the residentsfollowed by this At Physician were reviewed to ensur	·e [1/12/15
	(c)Develop written policies;	medical bylaws ar	nd medical		compliance. 3. The Clinical Managers and Qu Assurance Nurse will monitor new sions and re-admissions of reside	ality v admis-	11 (2115
	(d)Serve as liaison physicians to ensu implementation of	n with attending phure the prompt issu forder;	ysician ance and		facility to ensure that the resident seen by the Attending Physician v 72 hours. The results of their mo	is within nitoring	!
	premises to identi	e)Review incidents and accidents that occur on the remises to identify hazards to health and safety;			will be forwarded to the Director of Nurses for his review and analysi 4. The Director of Nursing will provide the provided the provide	is. esent the	1/12/15
	policies are follow				findings of this monitoring along action plans for improvement to QualityAssurance/Performance Improvement Committee which n	the	
	(g)Assist the Administrator in arranging twenty-four (24) hours of continuous physician services a day for medical emergencies and in developing				monthly and is chaired by the Ad	ministrator.	1/12/15

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED
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L 027	Continued From page	ge 16	L 027		
	procedures for eme	rgency medical care; and			
	/h)Ensure that atter	nding medical professionals who			
	treat residents in the	e			
	facility have current U.S. Drug Enforcen	District of Columbia licenses,			
	Agency and D.C. C	ontrolled Substance registration			
	on file in the facility	d annual certification of their			
	freedom from				
	communicable dise	eases.			
	This Statute is not	met as evidenced by:			
	Based on record re	view and staff interview for one			
	(1) of 53 sampled retailed the medical director	esidents, it was determined that r failed to ensure that the			
	physician performe	ed a physical assessment of the			
	resident within 72 h facility. Resident #	nours [his/her] readmission to the 92.	3		
	The findings include	e:			
	A review of the resi	ident 's clinical record revealed			Ì
	that the [he/she] wa	as readmitted to the facility on 4. Review of the physical	i		
	assessment section	n of the clinical record revealed			
	that the resident 's	last physical examination was	ļ 2		
	completed on July	14, 2014.			
	According to the D	istrict of Columbia Municipal			
	regulations for Nurs	sing Facilities 3207.2 subsection rector shall ensure that each	•		
	resident is seen by	a physician within 72 hours afte	er		
	admission.				
	According to a revi	iew of the physical assessments			
	on the clinical reco	ord the first documented he physician [after the			
	readmission] was i	in the form of an "Attending's			
	Note " dated Octo	ber 19, 2014.			

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IKANSII		AAVOL	INGTON, DC 20		DECTION	44.67
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	Employee #2 was c 9:30AM. The emplo The record was revi The medical directo physician performed	view was conducted with onducted at approximately byee acknowledged the findiniewed on December 7, 2014. In failed to ensure that the d a physical assessment of thours [his/her] readmission to	ne			
L 052	3211.1 Nursing Fac Sufficient nursing til resident to ensure t receives the following	me shall be given to each hat the resident	L 052	3211.1 Nursing Facilities		
	supplements and fluit rehabilitative nursing (b)Proper care to m	ninimize pressure ulcers and				
	(c)Assistants in dail resident is comforta evidenced by freed	promote the healing of ulcer by personal grooming so that able, clean, and neat as om from body odor, cleaned clean, neat and well-groomed	the and			
		accident, injury, and infection	1;			
	(e)Encouragement, self-care and group	, assistance, and training in activities;				
	(f)Encouragement					
	(1)Get out of the be	ed and dress or be dressed ir	۱			

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STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE S COMPLE	
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L 052	Continued From pag	ge 18	L 052	,	EEE SOOD OF THE PROPERTY OF TH	
	his or her own clothi which shall be clean	ng; and shoes or slippers, and in good repair;				
	(2)Use the dining ro	om if he or she is able; and				
	(3)Participate in mea activities; with eating	aningful social and recreational g;				
	(g)Prompt, unhurried requires or request h	d assistance if he or she nelp with eating;				
	(h)Prescribed adapt him or her in eating independently;	ive self-help devices to assist				
	(i)Assistance, if need including oral acre; a	ded, with daily hygiene, and				
	j)Prompt response to help.	o an activated call bell or call for				
	This Statute is not r	met as evidenced by:				
	interview for seven (was determined that sufficient nursing tim and services to attai practicable physical, well-being as evider physician's orders for needed) pain medical ensure that one (1) in position; implement impaction for one (1) appropriate treatment	ons, record review and staff (7) of 53 sampled residents, it it facility staff failed to ensure the was given to provide care in the residents' highest, mental, and psychosocial faced by failure to: clarify or the use of multiple PRN (as ations for one (1) resident; resident was fed in an upright measures to prevent fecal in resident; ensure that the protential for ingestion of the second or the second of				
	non-food items; obta accordance with phy	dent 's potential for ingestion of ain a psychiatric consultation in vsician's orders for one (1) with advanced dementia and for				

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L 052	Continued From page	ge 19	L 052	3211.1 Nursing Facilities (cont.)	
	fmedication used to	ght loss; and administer Procriotreat Anemia] in accordance rders. Residents' #42, 92, 15: 357.	ļ		
	The findings include	e:			
	time was given to c	ed to ensure sufficient nursing clarify physician's orders for the N (as needed) pain medication	e s	Resident #42 Resident #42 Resident has clarified the orders for the use of multiple PRN pain medications. The Physician order for all residents with multiple PRN pain medications have been	1/12/15
	March 4, 2014 reve	ident's history and physical da ealed the resident's admitting d: Diabetes Mellitus with eadache.	ted	reviewed to ensure that it is clear when each is to be used. 3. Inservice education was conducted for the Licensed Nurse Staff regarding the need to clarify Physician orders for the use of multiple PRN pain medications.	1/12/15
	A review of the Phy dated November 2	ysician's Order sheet signed a 8, 2014 revealed the following	nd :	The Nursing Quality Improvement Team will monitor this issue on a monthly basis to ensure compliance. The results of this monitoring will be forwarded to the	
	(2) tablets (650mg) needed for pain/ te 100.0 F [Fahrenhe facetyl-p-aminophe	ab 325 mg [milligram], take two) by mouth every 6 [six] hours emp [temperature] greater than it] (use caution with APAP enol, total daily dose greater th order date September 25, 201	as l nan	Director of Nurses for his review. 4. The Director of Nurses will review the da from these monitoring efforts done by the Nursing Quality Assurance Team and present his analysis and any action plans for improvement to the Quality Assurance/Performance Improvement Committee which meets monthly and is	or
	tablet by mouth ev	nalgesic] tab 4mg: take one (ery 4 hours as needed for pair d September 10, 2014;	1)	chaired by the Administrator.	

Health Re	egulation & Licensing	Administration				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3) DATI COM			
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/VA) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	\	(X5) COMPLETE
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					i i	
L 052	Continued From pag	ge 20	L 052	3211.1 Nursing Facilities (cont.)		
					İ	
)	Lidocaine patch 5%	[analgesic]: Apply one (1) patch			Į	
	daily, original order	date September 9, 2014."			ĺ	
	A face-to-face inten	view was conducted on			İ	
	December 9, 2014 \	with Employee #7 at				
	approximately 1:00	PM. After review of the above				
ļ	physician 's orders,	Employee #7 acknowledged				
	that the PRN pain in	nedications, noting that the ed evidence of parameters for				
	pain [mild, moderate	e, or severel.				
	pani (ma, maasiat	,				
ĺ	_	· · · · · · · · · · · · · · · · · · ·				
	Facility staff failed to	o ensure sufficient nursing time		2. Resident #92		
	was given to clarify	physician's orders for the use of nedications for one (1) resident.		1. A Bowel Protocol was implement	ted for	4140145
	Haitible Lizia batti i	modication of one (1) recision		Resident #92 due to the history of f	ecai	1/12/15
				impaction. 2. All resident who have a history of	of fecal	1/12/15
		ger to a control		impaction have been evaluated for		
	2. Facility staff faile	ed to ensure sufficient nursing		need for a bowel protocol.		
	time was given to it fecal impaction for l	nplement measures to prevent		3. Inservice education was conduct	ted for	
	recar impaction for i	NGSIGGIII #04.		the Licensed Nurse Staff regarding	the need	
	A review of the clini	ical record revealed that the		to implement the facility's bowel profor any resident with a history of bo	wel	
	resident was readm	nitted to the facility on September		impaction.	,,,,,,,	1/12/15
	27, 2014. A hospita	al discharge summary dated		The Nursing Quality Improvement	Team	
	September 24, 201	4 revealed; "GI [Gastro	-	will monitor this issue on a monthly	,	
	Intestinal performe	d a colonoscopy today, which other than some stool		basis to ensure compliance. The r	esults of	
	impaction."			this monitoring will be forwarded to Director of Nurses for his review.	ıne	
	,			4. The Director of Nurses will revie	w the data	
	Another colonosco	py report dated 9/25/2014		from these monitoring efforts done	by the	
	[September 25, 20]	14] revealed the following, "Hard		Nursing Quality Assurance Team	and	
	impacted clay stool	found in the rectum. Underlying the ruled out in rectum.		present his analysis and any action	n plans for	
	Petechiae mucosa			improvement to the	nrovement	ĺ
	. 5.557///35 ///45554			Quality Assurance/Performance Im Committee which meets monthly a	nd is	1/12/15
				chaired by the Administrator.		

Health Regulation & Licensing Administration (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING: ___ B. WING 12/09/2014 HFD02-0020 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2425 25TH STREET SE TRANSITIONS HEALTHCARE CAPITOL CITY WASHINGTON, DC 20020 (X5) COMPLETE DATE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX CROSS-REFERENCED TO THE APPROPRIATE OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) L 052 Continued From page 21 3211.1 Nursing Facilities (cont.) ascending colon. Two biopsies taken. Recommendations: Resume regular diet as tolerated. Begin taking soap water enema and manual disimpaction. Follow-up on the results of the biopsy specimens." Further review of the Team Notes on the clinical record lacked documented evidence of measures to address the resident 's fecal impaction. A face-to-face interview was conducted with Employee #2 at approximately 9:30AM on December 9, 2014. He/she acknowledged the aforementioned findings. The record was reviewed on December 7, 2014. 3. Resident #157 Facility staff failed to ensure sufficient nursing time 1. The staff member was inserviced imwas given to implement measures to prevent fecal mediately upon discovery of the proper impaction. positioning of a resident while feeding. 12/1/14 2. All dining rooms are monitored to promote care in a manner that maintains or enhances 3. Facility staff failed to give sufficent nursing time to the residents' dignity and respect by 12/1/14 ensuring their proper position while being ensure that Resident #157 was fed in an upright fed. position. 3. Inservices have been done to emphasize the need to properly position our residents The Quarterly Minimum Data Set (MDS) dated while they are being fed their meals. 1/9/15 September 24, 2014 revealed the admitting Compliance auditing will be conducted by diagnoses under Section I (Active Diagnoses) the Quality Assurance Nurse on a routine included Cerebrovascular Accident, Hemiplegia or basis. The results of those audits will be Hemiparesis, and Parkinson's disease for Resident forwarded to the Director of Nurses for his #157, Under Section G- Functional Status, it also evaluation. revealed that the resident was totally dependent The Director of Nurses will review the data with Activities of Daily Living (ADL's). from these monitoring efforts done by the Quality Assurance Nurse and present his On December 1, 2014 at approximately 12:50 PM, a analysis and any action plans for dining observation was conducted on unit, 1 North. improvement to the Resident #157 was observed sitting in a reclining Quality Assurance/Performance Improvement position in a geriatric chair, near a dining 1/12/15 Committee which meets monthly and is chaired by the Administrator.

Health Regulation & Licensing Administration (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: __ 12/09/2014 B. WING HFD02-0020 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2425 25TH STREET SE TRANSITIONS HEALTHCARE CAPITOL CITY WASHINGTON, DC 20020 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG DEFICIENCY) TAG 3211.1 Nursing Facilities (cont.) L 052 Continued From page 22 L 052 4. Resident #160 1. Resident #160 was readmitted to the table. Employee #32 was observed feeding 12/15/14 facility and his care plan was updated to Resident #157, while in a reclining position. address his advanced dementia He was evaluated by the facility's psychiatrist On December 1, 2014 at approximately 1:05 PM, a who wrote that the "Pt does not meet the 1/16/15 face-to-face interview was conducted with criteria for Pica. It appears that he has a Employee #32 regarding the resident's position, hyper oral fixation related to his dementia. while eating. He/she said, "I should get some help Behavioral interventions implemented at to sit him/her up." He/she requested the assistance N.H. has been effective." All residents with of a nearby employee who assisted him/her to Advanced Dementia were screened to ensure reposition the resident in an upright position. accurate information about the care and services needed by hese residents is known to Facility staff failed to give sufficient nursing time to his/her caretakers. ensure that Resident #157 was fed in an upright 3. A new Behavioral Health contract position. The clinical record was reviewed on 1/5/15 was initiated at the facility which will afford increased access to Psychiatry and December 1, 2014. Psychology services. An inservice was 4. Facility staff failed to ensure sufficient nursing done with the clinical staff regarding the time was given to ensure that appropriate treatment referral of residents for evaluation by and services were provided to correct and/or Psychiatry to ensure the prompt implemanage Resident#160 's potential for ingestion of 1/12/15 mentation of Physician orders for these services and the clarification of terms such non-food items. According to the History and Physical completed on as "close monitoring" and "1:1." Additionally, September 22, 2014 Resident #160 's diagnoses the Inservice address the need for the included: End Stage Renal Disease- Dialysis accurate notification of caretakers of the Dependent, Dementia and Hypertension. Under the care and needs for these specific residents. section labeled "mental status," the physician Compliance auditing will be conducted by the Quality Assurance Nurse recorded "confused." on a routine basis to ensure proper communication of the residents needs, According to the Minimum Data Set completed care and services as well as the prompt November 12, 2014. Under Section C1000 access of Behavioral Health evaluations. (Cognitive Skills for Daily Decision Making), the The results of those audits will be Resident was coded as severely impaired forwarded to the Director of Nurses for his [never/rarely made decisions]. Under Section E evaluation. 0200 (Behavior), the resident was coded as 4. The Director of Nurses will review the data physical behavioral symptoms directed towards from these monitoring efforts done by the others (e.g. hitting, kicking, pushing, scratching, Quality Assurance Nurse and present his grabbing ...), Section G (Functional Status), the analysis and any action plans for resident was coded as requiring extensive improvement to the assistance in bed mobility, and transfers, and Quality Assurance/Performance Improvement 1/12/15 Committee which meets monthly and is chaired by the Administrator

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IKANSH					DROVIDER'S PLA	N OF CORRECTION	(X5) COMPLETE
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	required total assisteating, and personal (Functional Limitational Lim	al hygiene. Section in Range of M as having no imperites. Under Sonal Status), the matter #160 's care part #160 's care part #160 's care part assessed the by inappropriate are intake of foreing ensure resident safety and close ubstances from resident part of the safety and close ubstances from resident in the safety and close ubstances from resident in the safety and close ubstances from resident in the safety and close ubstances from resident in the safety and close ubstances from resident in the safety and close in the safet	on G 0400 otion), the pairment to ection K resident was ered diet. Idan revealed the following /hich resident behavior " last ed: "Goal- gn objects t safety [times] lent close to monitoring. oom. Remove				
	A review of the "I revealed that under line was left blank Nutrition," the reseaspiration precaut meals. Under the the resident required 1:1 hourly rotation. Under the heading a seatbelt when use a seatbelt when use a seatbelt when use a seatbelt when use a seatbelt when use a seatbelt when use a seatbelt when use a seatbelt when use a seatbelt when use a seatbelt when use a seatbelt when use a seatbelt when use a seatbelt when use a seatbelt when use a seatbelt when use a seatbelt when used in a seatbelt when used in the seatbelt when used in the seatbelt was a seatbelt when used in the seatbelt when used in the seatbelt was a seatbelt when used in the seatbelt was a seatbelt when used in the seatbelt was a seatbelt when used in the seatbelt was a seatbelt when used in the seatbelt was a seatbelt when used in the seatbelt was a seatbelt when used in the seatbelt was a seatbelt when used in the seatbelt was a seatbelt when used in the seatbelt was a seatbelt when used in the seatbelt was a seatbelt when used in the seatbelt was a seatbelt when used in the seatbelt was a seatbelt when used in the seatbelt was a seatbelt when used in the seatbelt was a seatbelt when used in the seatbelt was a seatbelt when used in the seatbelt was a seatbelt was a seatbelt when used in the seatbelt was a seat	er the heading "P . However, under sident was listed a tions, required asi- heading "Ambul red a wheelchair of the g "Safety," the re p [in] wheelchair. the staff escorted ay, Wednesday ar / Living," the resi- e by staff. hysician's Order S . 2014 directed,	recautions," the recautions," the heading " as a feeder, on sisted to be fed ation/Mobility," with seatbelt, and all prevention. esident required Under " I the resident to and Friday. Undedent's was Sheet signed and "Exelon"	d 			

FORM APPROVED Health Regulation & Licensing Administration (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ B. WING HFD02-0020 12/09/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **2425 25TH STREET SE** TRANSITIONS HEALTHCARE CAPITOL CITY WASHINGTON, DC 20020 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) L 052 Continued From page 24 L 052 9.5 mg per 24 hours, apply one patch topically daily for Dementia; Paxil [used to treat Major Depressive Disorder 10 mg take one tablet by mouth daily for Depression" The interim physician's order dated September 5, 2014 directed, "One-on-one hourly rotation monitoring for fall prevention q [every] shift." A review of the facility's "Behavior Monitoring Sheets "for September, October and November 2014 revealed that Resident #160 was monitored for Paranoia, Resistance to Care, and Scratching. However, during this time period, the resident was coded as "zero," indicating that no behaviors were observed. There was no evidence that staff identified as targeted behavior and/or consistently monitored the assessed behavior of [potential] " intake of foreign objects " [per care plan]. A review of the "Consult for Therapy" dated October 9, 2014 revealed, "Please evaluate Resident [secondary to] pocketing foods." A review of the "Speech Therapy Plan of Care" dated October 31, 2014 revealed that the reason for referral was for "reports of pocketing food." The start of care was October 31, 2014 and the resident was discharged from care on November 14, 2014. A review of the Doctor's Progress Notes from July 15, 2014 to November 21, 2014 lacked evidence that the attending physician addressed the resident ' s behavior of mouthing and/or chewing non-food items. There was no evidence that the physician and/or medical team was informed regarding the assessed behaviors.

Health Regulation & Licensing Administration

Health Re	egulation & Licensing	Administration			(X3) DATE SURVEY
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		COMPLETED
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L 052	Continued From pa	ge 25	L 052		
	Psychiatric Consult October 24, 2013. psychiatrist was aw #160 for behavior o items. A nurse 's note dat PM revealed, "911	ing specialists ' notes revealed a was most recently conducted There was no evidence that the vare and/or evaluated Resident of mouthing/chewing non-food ted November 21, 2014 at 11:30 call at 3:35 PM. Arrived at 3:45			
	PM. Resident was [hospital name] [se AV (Arteriovenous) evaluation at the er	transported at 3:50 PM to cond] to declott of [right] upper graft site. Resident is still under nd of the shift "			
	communicate to a real (hospital) entitled 'Inter-Agency Refered indicated] and the Columbia Fire and lacked evidence the receiving hospitals.	ms utilized by the facility to receiving provider/facility "Metropolitan Washington Area ral Transfer Form " [no date D.C. Fire & EMS[District of Emergency Medical System] at facility staff communicated to ital and the transport agency, the rof [potential for] ingesting			
	December 8, 2014	riews were conducted on between 10:00 AM and 4:00 PM ssigned to care for Resident #160			
	Facility staff stated	the following:			
	tries to get out of t Resident#160 was He/she participate	ted, "Resident #160 talks and he wheelchair. At one point is briefly on 1:1 monitoring. It is in the restraint reduction is a seatbelt in the wheelchair. It won his/her shirt every chance			
					i

Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ B. WING HFD02-0020 12/09/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2425 25TH STREET SE TRANSITIONS HEALTHCARE CAPITOL CITY WASHINGTON, DC 20020 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) L 052 Continued From page 26 L 052 Employee #28 was asked what type of care needed to be provided for Resident #160. He/she stated, ' The Resident was a 1:1. He/she was chewing up and eating everything so he/she was put on 1:1; he /she chewed on socks and shirts in the drawer. He/she went on to state that Resident #160 had scheduled times to be in the hallway at the nurses ' station with nothing in his/her way that could be grabbed and eaten. Employees #25 stated, "Resident #160 was not being tracked [not being followed by the Behavior Management Team] Employee #26 stated that [Resident #160] is not being tracked but that all staff has been notified to start behavior management forms when behaviors are observed. " Employee #26 was asked what type of residents are candidates for 1:1 are monitoring. He/she stated, ' 1:1 monitoring is for fall risks and residents with intense behaviors that need to be monitored. Intense behaviors include agitation, 1:1 monitoring keeps the resident from acting out. " Employee# 8 was asked why Resident #160 was on 1:1 monitoring. He/she stated, " [Resident #160] is on 1:1 monitoring for safety and putting things in his/her mouth. He/she is at the nursing station every day with supervision. The gloves in his/her room are located far from the bed. He/she also stated that [Resident #160] was sent out to have his/her graft de-clotted, and that he/she was fine when sent out. " Employee # 23 was asked about the care of Resident #160. He/she stated that the resident

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PRINTED: 01/02/2015 FORM APPROVED Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A, BUILDING: B. WING HFD02-0020 12/09/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2425 25TH STREET SE TRANSITIONS HEALTHCARE CAPITOL CITY WASHINGTON, DC 20020 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PRFFIX OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) L 052 Continued From page 27 L 052 was on hourly monitoring for elopement. Some of those times he/she is at the nursing station and he/she is also in the restraint reduction program. When asked if Resident#160 was able to grab anything with his/her hands Employee# 23 stated that he/she cannot grab anything and that he/she is a feeder. Employee #23 stated that Resident #160 can 't talk and was not alert and oriented x 3. he/she likes to gnaw on his/her towel while feeding. The staff holds his/her drink when taking a sip and a towel is used when feeding to protect his/her clothes. He/she eats all of his meals in the dining room except breakfast, and the staff does not feed him/her with gloves. " Employee #22 was asked about the care for Resident #160. Employee #22 stated that he/she was on 1:1 monitoring for high risk of falling for more than a month. He/she sits close to the nursing station to prevent falls. He/she wears a seatbelt when in the wheelchair and someone would be around if the seatbelt was removed by the resident because there is always a charge nurse at the nursing station. He/she stated that Resident #160 was not being monitored for anything else. Employee #29 was asked about the care for Resident# 160. Employee# 29 stated that he/she takes [Resident #160] to the dining room and that he/she is a feeder. Whenever [Resident# 160] is in his/her room." I make sure that I check on the resident every 5 minutes. I place a plastic/paper bib on [Resident #160] when [he/she] is fed and sometimes he/she puts things in his/her mouth. They place a towel around the bib to keep him/her

from putting other things in his/her mouth."

Employee #31 was asked about the care of

Health Re	egulation & Licensing	Administration			(X3) DATE SURVEY
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L 052	Continued From pa	ge 28	L 052		:
	keeps an eye on Re the room. I feed Re unable to feed him/ Resident #160 is be in his/her mouth, who can usually talk to t	ployee #31 stated that he/she esident #160 when he/she is in esident #160 because he/she is herself. Sometimes when eing fed he/she tries to put thingthen he/she does this the staff he resident and he/she will stop likes to chew on his/her shirts.			
	face-to-face intervio	014 at approximately 10:30 AM a ew was conducted with 3, and 25. They stated that 1:1 that a certified nurse aide is sident for a defined period of time the findings.			
	management of Re [potential] " intake plan]. According to interviews, there we knowledge of and/resident's behavior objects." There we intake of foreign of and/or monitored a no evidence that for medical team regamouthing/chewing. The "Resident Collected problem identical team identical team identical team regamouthing/chewing."	ence how staff implemented the esident #160 's behavior of of foreign objects " [per care the aforementioned staff vere inconsistencies in the or interventions related to the or of [potential] " intake of foreignas no evidence that [potential] bjects " was identified, tracked as a targeted behavior. There was cility staff communicated to the arding the resident 's behavior of on non-food items. Care Card " for Resident #160 entification, goals and specific the management of gron-food items.	in "		

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L 052	Continued From pag	ge 29	L 052			
	November 21, 2014 transported to an acclotted graft site. A review of hospital was admitted to the An Endoscopy [diagexamine the upper con December 2, 201 admission]. A specin procedure and label removal. "A review a tan black disrupted 14.5x7x2 cm [centin progress note dated read: "EGD [Endhardened plastic objurned out to have the Facility staff failed to treatment and service Resident #160's as ingestion of non-foothat the medical tear resident's assesse lacked evidence that ingestion of foreign to the receiving hospitalization. A face-to-face intervacetal face intervacetal and approximate and service during an Endoscop post hospitalization.	records revealed Resident #160 hospital on November 22, 2014. nostic procedure to visually digestive system] was performed 4 [10 days post hospital men was obtained during the ed "stomach, foreign body of the pathology report read: "d plastic foreign body measuring becers]. A Gastroenterology December 3, 2014 8:32 AM oscopy] 12/2/14 revealed fects in the stomach which he appearance of gloves "do implement appropriate besessed problem of potential ditems. There was no evidence m was informed about the depital. The resident was ign object(s) in the stomach was ign object(s) in the stomach was ign object(s) in the stomach was informed about the depital. The resident was ign object(s) in the stomach was ign object(s) in the stomach was informed on December 9, aly 3:00 PM with Employees #1 gs were reviewed and				
	acknowledged. The record was revi	ewed on December 9, 2014.				ı
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FORM APPROVED Health Regulation & Licensing Administration (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION DENTIFICATION NUMBER: A. BUILDING: _ B. WING 12/09/2014 HFD02-0020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2425 25TH STREET SE TRANSITIONS HEALTHCARE CAPITOL CITY WASHINGTON, DC 20020 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) L 052 L 052 Continued From page 30 3211.1 Nursing Facilities (cont.) 5. Facility staff failed to ensure sufficient nursing 5. Resident #170 time was givent to obtain a Psychiatric consult in 1/12/15 The resident was seen by the Consultant accordance with the physician's order for one (1) Psychiatrist per Physician orders. resident diagnosed with weight loss. Resident #170. 2. All medical records were audited to 1/12/15 ensure all Physician orders to obtain a A review of the Nutrition Quarterly notes dated Psychiatric consultation was followed. August 29, 2014 - 12 PM revealed, "...Resident A new Behavioral Health contract being seen by SLP [speech language pathology] for was initiated at the facility which will afford 1/5/15 tx [treatment] for oropharyngeal dysphasia per St increased access to Psychiatry and [speech therapist] order 8/20/14. Per SLP Psychology services. An inservice was comments and discussion with writer, resident was done with the clinical staff regarding the refusing Puree solids and diet was changed to referral of residents for evaluation by mechanical soft on 8/28/14. SLP reported to this Psychiatry to ensure the prompt implewriter that resident has exhibited episodes of mentation of Physician orders for these speaking about various things which seem " 1/12/15 services. Compliance auditing will be paranoia" in nature. Resident with dx [diagnosis] of conducted by the Quality Assurance Nurse dementia and may benefit from psych consult to on a routine basis to ensure the prompt evaluate resident especially in light of recent weight access of Behavioral Health evolutions. loss. Recommend (1) psych [psychiatric] consult -The results of those audits will be evaluate resident R/T [related to] h/o [history of] forwarded to the Director of Nurses for his dementia, recent sig. [significant] wt [weight] evaluation. decrease and lab refusals. " 4. The Director of Nurses will review the data from these monitoring efforts done by the Physician's Interim Orders dated August 29, 2014 at Quality Assurance Nurse and present his 4:40 PM directed, "Psych consult - evaluate analysis and any action plans for Resident R/T [related to] H/O [history of] dementia, improvement to the recent significant weight loss." Quality Assurance/Performance Improvement Committee which meets monthly and is 1/12/15 A review of the clinical record lacked evidence that chaired by the Administrator facility staff followed through on physician's orders to obtain the order for the psychiatric consult. A face-to-face interview was conducted with Employee #6 on December 9, 2014 at approximately 1:45 PM. He/she stated that the psychiatric consult was obtained as directed by the physician. However, after reviewing the clinical

record, he/she acknowledged that there

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L 052	Continued From page	ge 31	L 052	3211.1 Nursing Facilities (cont.)	ļ	
	was no evidence of record was reviewe	a psychiatric consult. The d on December 9, 2014.				
	was given to obtain	o ensure sufficient nursing time a Psychiatric consult in e physician's order for one (1) with weight loss.				
	6. Facility staff faile was given to admin physician's orders	ed ensure sufficient nursing time hister Procrit in accordance to		6. Resident #183 1. Procrit order was obtained from the Attending Physician and administered immediately. Subsequent orders or the state of the stat	d (1	12/1/14 1/12/15
	with an original ord directed " Procrit II inject 1 ML [millilite [subcutaneous] eve	vember 2014 Physician's Order, ler date of August 5, 2014, NJ (injection) 40,000 units/M er] (40,000 units) SUB Q ery month on the 8th to keep HB een 10 and 11 gm/d		Procrit have been administered per the Attending Physician's orders. 2. the medical records for Residents of Procrit order were evaluated to ensur medication was administered according the Attending Physician's orders. 3. Inservice training was provided to following Staff regarding the need to following the Attending Physician orders.	with a re the ing to the	1/9/15
	10:00 AM, reveale was blank; which is administered.	AR for November 8, 2014, timed d the allotted signature space ndicated the Procrit was not		an effort to provided necessary care/vices to our residents. Clinical Mana along with the Nursing Quality Improvement of the administration procrit on a frequent basis and submaresults of their audit to the Director of for his analysis.	egers Evement of nit the of Nurses	1/9/15
	Employee #7 on D approximately 11:: record, he/she ack findings. The reco 2014. There was no evic administered Proc	erview was conducted with December 1, 2014 at 30 AM. After reviewing the clinic knowledged the aforementioned ord was reviewed on December dence that facility staff crit to Resident #183 in orders.		4. The Director of Nurses will review from these monitoring efforts done be Quality Assurance Nurse and prese analysis and any action plans for improvement to the Quality Assurance/Performance Improcement to the Committee which meets monthly and chaired by the Administrator.	oy the ent his rovement	1/12/15
	There was no evid	dence that facility staff		Quality Assurance/Performance Impr Committee which meets monthly and	rovement d is	

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	was given to adminiphysician's orders. 7. Facility staff faile consultation in according for one (1) resident dementia. Resident A review of the cliniorder dated Septent consult for inappropublic). A face to face interconducted on Decentian Decentian Physician's He/she responded facility once a week residents who requadmitted that the physician's order for the physician's order	to ensure sufficient nursing time ister Procrit in accordance to d to obtain a Psychiatric ordance with physician's orders diagnosed with advanced #357. Ical record revealed a physician's order 17, 2014 for a psychiatrist oriate behavior (urinating in erview with Employee #3 was ember 8, 2014, at approximately was queried regarding the order for a psychiatrist was at the k and had been busy with that the psychiatrist was at the k and had been busy with sired immediate attention. He/she sychiatric consult for Resident scheduled.		7. Resident #357 1. The resident was seen by the Consultar Psychiatrist per Physician orders. 2. All medical records were audited to ensure all Physician orders to obtain a Psychiatric consultation were followed 3. A new Behavioral Health contract was initiated at the facility which will afford increased access to Psychiatry and Psychology services. An inservice was done with the clinical staff regarding the referral of residents for evaluation by Psychiatry to ensure the prompt implementation of Physician orders for these services. Compliance auditing will be conducted by the Quality Assurance Nurse on a routine basis to ensure the prompt access of Behavioral Health evolutions. The results of those audits will be forwarded to the Director of Nurses for his evaluation. 4. The Director of Nurses will review the diffrom these monitoring efforts done by the Quality Assurance Nurse and present his analysis and any action plans for improvement to the Quality Assurance/Performance Improvem Committee which meets monthly and is chaired by the Administrator.	1/15/15 1/12/15 1/5/15 1/12/15 ata
L 099	3219.1 Nursing Fa	cilities	L 099		
	Food and drink sha from spoilage, safe	all be clean, wholesome, free e for human consumption, and			

Health Regulation & Licensing Administration (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: _ 12/09/2014 HFD02-0020 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2425 25TH STREET SE TRANSITIONS HEALTHCARE CAPITOL CITY WASHINGTON, DC 20020 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 3219.1 Nursing Facilities L 099 Continued From page 33 L 099 1. & 2 Cutting Boards and Sheet Pans served in accordance with the requirements set 1. Cutting Boards and Sheet Pans found 12/1/14 forth in Title 23, Subtitle B, D. C. Municipal soiled at the time of the survey were Regulations (DCMR), Chapter 24 through 40. cleaned immediately upon discovery. This Statute is not met as evidenced by: 2. All Cutting Boards and Sheet Pans Based on observations made in the main kitchen on were inspected to insure all were free of stains and carbon build-up. Those which December 1, 2014 at approximately 10:00 AM and 12/3/14 could not be cleaned or destained were on December 3, 2014 at approximately 2:00 PM, it was determined that the facility failed to store, discarded. 3. Inservices were given to the Dietary Staff prepare, distribute and serve food under sanitary regarding the proper cleaning and conditions as evidenced by four (4) of seven (7) maintenance of Cutting Boards and Sheet soiled cutting boards, one (1) of three (3) soiled Pans. The Dietary Supervisors and the sheet pan, one (1) of five (5) dented cans of applesauce and one (1) of 14 dented cans of red Dietary Quality Improvement Team will peppers in dry food storage, one (1) of six (6) torn the cleanliness of the cutting boards and sheet pans on a monthly basis and 1/9/15 splash curtain from the dishwashing machine, report their findings to the Director of uncovered pans (19) of turkey burgers in the walk-in refrigerator, one (1) of one (1) torn air curtain in the Nutritional Services. walk-in refrigerator and in the walk-in freezer and a 4. The Director of Nutritional Services will present the findings of this monitoring soiled and discolored kitchen floor. along with any action plans for improvement 1/12/15 to the QualityAssurance/Performance The findings include: Improvement Committee which meets monthly and is chaired by the Administrator. 1. Four (4) of seven (7) cutting boards were soiled. 3. Dented Cans 1. All dented cans found in the dry storage 12/1/14 room were removed immediately upon 2. One (1) of three (3) sheet pans was soiled. discovery. 2. All cans were reviewed to ensure any 3. One (1) of five (5) large cans of applesauce 12/1/14 cans with dents were stored appropriately. stored in the dry storage room was dented and one 3. Inservices were given to the Dietary Staff (1) of 14 large cans of red peppers stored in the dry regarding the proper storage of dented cans. food storage room was also dented. The Dietary Supervisors and the Dietary 1/9/15 Quality Improvement Team will 4. One (1) of six (6) splash curtains from the monitor the storage of dented cans dishwashing machine was torn. on a monthly basis and report their findings to the Director of Nutritional Services. 5. 19 pans of uncooked turkey burgers were stored 4. The Director of Nutritional Services in the walk-in refrigerator uncovered. will present the findings of this monitoring along with any action plans for improvement 1/12/15 to the QualityAssurance/Performance Improvement Committee which meets

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L 099	Continued From pa	1) air curtain from the walk-in	L 099	3219.1 Nursing Facilities (cont.) monthly and is chaired by the Administra 4. & 6.Splash Curtain and Air Curtain	
	refrigerator was torr curtain from the wal	n and one (1) of one (1) air k-in freezer was also torn.		 The torn air curtain and splash curtain have been replaced. All air curtains and splash curtains we 	1/12/15
	7. The kitchen floor with discoloration.	r was soiled in numerous areas		inspected to insure there were no further 3. Inservices were given to the Dietary S	12/5/14
	These observations Employee #19 who	s were made in the presence of acknowledged the findings.		regarding the inspection and care of the splash curtain in the dishwasher and the curtain in the refrigerator. The Dietary Supervisors and the Dietary	
L 141	3226.1 Nursing Fac	cilities	L 141	Quality Improvement Team will monitor these specialty curtains	1/9/15
	all medication shall	d under a self-administer order, be prepared and administered physician or by a licensed nurse, met as evidenced by:		on a monthly basis and report their findir to the Director of Nutritional Services. 4. The Director of Nutritional Services will present the findings of this monitorin along with any action plans for improven	}
	interviews for one (was determined that to assess one (1) r	ion, record review and staff (1) of 53 sampled residents, it at the interdisciplinary team failed esident's ability to self administer afe manner. Resident #116.		to the QualityAssurance/Performance Improvement Committee which meets monthly and is chaired by the Administra 5. Turkey Burgers 1. Turkey burgers were immediately covered to the control of the contro	
	The findings includ			upon discovery. 2. All other food in the refrigerator was inspected to ensure their proper storage 3. Inservices were given to the Dietary regarding the proper storage of prepped	12/1/14 Staff
	December 1, 2014 Resident #116 was Flovent inhaler (In	on observation conducted on at approximately 10:00 AM, s observed administering his/her shaled Corticosteroid) and		food. The Dietary Supervisors and the Dietary Quality Improvement Team will monitor the storage of prepped foods on a monthly basis and report their find	1/9/15
	shooked his/her co positioned the inha administered one seconds, and adm	eroid) nasal spray. The resident ontainer of Flovent inhaler; aler in his/her mouth and (1) puff; waited for three (3) linistered a second (2) puff, inister one (1) spray of Flonase in	ן ו	to the Director of Nutritional Services. 4. The Director of Nutritional Services will present the findings of this monitorinal along with any action plans for improve to the QualityAssurance/Performance Improvement Committee which meets monthly and is chaired by the Administration.	ng ment 1/12/15

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L 141	Continued From page 35 According to Drugs.com; " If more than 1 (one) inhalation is to be used, wait a few minutes and repeat. After inhaling, rinse your mouth with water and spit it out."		1. 141 3219.1 Nursing Facilities (cont.) 7. Kitchen Floor 1. The areas of the kitchen floor found discolored were attended to upon discolored were attended to ensure no further areas of discolored.			12/1/14
	Facility staff failed to follow the manufacturer's specifications for administration of Flovent accurately. Review of the facility's policy titled " Self Administration of Non-Narcotic Medication " dated 03/08, Policy #1404450A-00 revealed; (1) Residents are assessed for self-administration of medications upon request and physician order, (4) The interdisciplinary team will determine the final decision on whether or not the resident is competent in self-administration of any or all medication; (6) The MAR (Medication Administration Record) must reflect what medication that the resident is self-administering." The "Physician's Order" form signed November 29, 2014 directed: "Flovent HFA (Hydrofluoroalkane) Inhaler 110 mcg (micrograms) inhale [two] (2) puffs twice daily for allergy relief; Flonase Nasal Spray- Administer 1 [one] spray to each nostril twice daily for allergic rhinitis."			3226.1 Nursing Facilities 1. Resident #116 was re-educated and observed administering the medication and was deemed capable of self-administration of his/her medication. 2. There are no other residents who are self-administering their medication. 3. Inservice education was provided to the IDT members on the facility's policy and practice of Self Administration of Drugs by our residents. Clinical Managers or their designees will routinely monitor their residents who have been deemed capable of the self administration of their medicate and report their findings to the Director of Nurses. 4. The Director of Nurses will review the offrom these monitoring efforts done by the Clinical Managers and present his analyst and any action plans for improvement to Quality Assurance/Performance Improvement Committee which meets monthly and is chaired by the Administrator.	dication	1/9/15
					o are d to the / and rugs by r their capable dedication ctor of w the data by the	1/9/15
					ent to the provement	1/12/15
	Medication Adminis that the resident wa	ember and December 2014 tration Records lacked evidence s self-administering [his/her] forementioned medications were at 10:00 AM.	ļ			

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L 141	Continued From page	ge 36		L 141					
	There was no evide Interdisciplinary Cal was safe for Reside medications. Additi there were no instru#116 when he/she December 1, 2014 A face-to-face inter Resident #116 on Dapproximately 11:3 aforementioned obtainhaler and Flonase Further stated, the how to use the inhale office and no one hime. However; son the inhaler go to him	re Team (IDT) detent #116 to self ad fonally, it was observations provided to self administered if at approximately 1 view was conducted to AM regarding the servation. He/she self-administering e spray since it was doctor demonstrated are and nasal spray sinstructed [himmetimes [he/she] "	ermined that it minister erved that o Resident medications on 1:00 AM. ed with at e stated that the Flovent is first ordered. Ited to him/her ay in his/her /her] since that						
	A face-to-face inter December 3, 2014 Employees #5 and #116] self administ and Flovent inhale medications."	at approximately #55. Both stated ters his/her Flonas	12:00 PM with , "[Resident se nasal spray						
	The interdisciplina #116's ability to se safe manner. The was reviewed on D	If administer medi observation and o	cations in a						

Health Regulation & Licensing Administration (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A, BUILDING: _ 12/09/2014 B. WING HFD02-0020 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2425 25TH STREET SE TRANSITIONS HEALTHCARE CAPITOL CITY WASHINGTON, DC 20020 (X5) COMPLETE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) L 141 Continued From page 37 2014. 3227.3 Nursing Facilities L 152 L 152 3227.3 Nursing Facilities 12/1/14 1. Temperatures were adjusted upon discovery. Proper storage temperature shall be maintained for 2. All medication refrigerators were ineach medication according to the manufacturer's spected to ensure their proper temperature. 12/1/14 direction. 3. Inservice was given to the licensed nursing staff regarding the appropriate This Statute is not met as evidenced by: temps of med refrigerators. The Clinical Based on an observation and staff interview of one Managers and the Nursing Quality (1) of two (2) medication storage refrigerators, it 1/12/15 Improvement Team will monitor the was determined that facility staff failed to store temperature of medication refrigerators medications in accordance with the manufacturer's on a monthly basis and report specifications. Unit 3 South. their findings to the Director of Nursing. 4. The Director of Nursing will present the The findings include: findings of this monitoring 1/12/15 along with any action plans for improvement to the QualityAssurance/Performance According to the monograph for drugs manufacturer Improvement Committee which meets specifications, the following medications were monthly and is chaired by the Administrator. identified for requiring storage of refrigerated unopened vials of medications between 36-46 degrees Fahrenheit. http://www.drugs.com/monograph> Facility staff failed to ensure that medications were stored at the appropriate temperature in accordance with the manufacturer's specifications. During the medication storage observation, the following medications were observed stored in the refrigerator located on 3 South. The internal temperature was observed between 48 - 50 degrees Fahrenheit. The observation was made in the presence of Employee #7 on December 1,

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Health Regulation & Licensing Administration (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: B. WING HFD02-0020 12/09/2014 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2425 25TH STREET SE TRANSITIONS HEALTHCARE CAPITOL CITY WASHINGTON, DC 20020 (X5) COMPLETE DATE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) L 152 Continued From page 38 2014 at approximately11:00 AM. Five (5) of five (5) unopened vials of Lantus 100 units/ml (Long Acting insulin) One (1) of two (2) unopened vials of Levemir Two (2) of two (2) unopened vials of Latanoprost ophthalmic solution One (1) of one (1) unopened vial of Timolol ophthalmic solution One (1) of four (4) unopened vials of Novolog injection 110 units/ml Two (2) of two (2) unopened vials of Pneumovax injection One (1) of one (1) unopened vial of Systane Ultra ophthalmic solution One (1) of one (1) unopened vial of Procrit A face-to-face interview was conducted on December 1, 2014 with Employees #7 at approximately 11:30 AM regarding the aforementioned findings. After review of the above, he/she acknowledged the findings. Facility staff failed to store medications in accordance with the manufacturer's specifications. 3227.4 Nursing Facilities L 153 L 153 3227.4 Nursing Facilities 1. The medication was returned to the pharmacy upon discovery of the absence of 12/1/14 Medication that is dispensed by a pharmacy within an expiration date on the label. the facility for use within the facility shall be labeled 2. All other medications were reviewed to to identify the generic chemical or brand name, ensure that each label had an expiration strength, lot number and expiration date. date. There were no other occurrences. 12/1/14 This Statute is not met as evidenced by: Based on observation, record review and staff

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L 153 Continued From page 39 interview for one (1) of two (2) medication storage refrigerators, it was determined that facility staff failed to ensure that medications, when received from pharmacy, had an expiration date on the medication package/label. South at approximately 10:00 AM. The medication package for Resident #11, contained Lorazepam (sedative) 10 tabs [tablets] Img [milligram] tablets. There was no evidence of an expiration date on the medication package/label. Employee #7 reviewed the back and front of the package/label. A face-to-face interview was conducted on December 1, 2014 with Employees #7 approximately 11:30 AM regarding the aforementioned findings. After review of the above, he/she acknowledged the findings. Facility staff failed to ensure that medications, when received from pharmacy, had an expiration date on the aforementioned findings. After review of the above, he/she acknowledged the findings. Facility staff failed to ensure that medications, when received from pharmacy, had an expiration date printed on the package/label. Facility staff failed to ensure that medications, when received from pharmacy, had an expiration date printed on the aforementioned findings. After review of the above, he/she acknowledged the findings. Facility staff failed to ensure that medications, when received from pharmacy, had an expiration date printed on the package/label. Facility staff failed to ensure that medications, when received from pharmacy, had an expiration date printed on the package and failed to locate the expiration date on the aforementioned findings. Facility staff failed to ensure that medications, when received from pharmacy, had an expiration date printed on the package and failed to locate the expiration date on the aforementioned findings. Facility staff failed to ensure that medications, when received from pharmacy and pharmacy and pharmacy and pharmacy and pharmacy and pharmacy and pharmacy and pharmacy and pharmacy and pharmacy and pharmacy and pharmacy and pharmacy and	TRANSIT	IONS HEALTHCARE C	ADITOL CITY					
interview for one (1) of two (2) medication storage refrigerators, it was determined that facility staff failed to ensure that medications, when received from pharmacy, had an expiration date on the medication storage observation conducted with Employee #57 on Unit 3 South at approximately 10:00 AM. The medication package for Resident #111, contained Lorazepam (sedative) 10 tabs [tablets] 1mg [milligram] tablets. There was no evidence of an expiration date on the medication package/label. Employee #7 reviewed the back and front of the package afailed to locate the expiration date of the medication. Facility staff failed to ensure that medications, when received from pharmacy, had an expiration date on December 1, 2014 with Employees #7 at approximately 11:30 AM regarding the aforementioned findings. After review of the above, he/she acknowledged the findings. Facility staff failed to ensure that medications, when received from pharmacy had an expiration date on the aforementioned findings. After review of the above, he/she acknowledged the findings.	PREFIX	(EACH DEFICIENCY MUST	BE PRECEDED BY FULL REGULATORY	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	COMPLETE	
received from pharmacy, had an expiration date printed on the package/label.	TAG	Continued From paginterview for one (1) refrigerators, it was failed to ensure that from pharmacy, had the package/label. The findings include During a medication with Employee #57 approximately 10:00 for Resident #111, one tabs [tablets] 1mm. There was no evide medication package the back and front one locate the expiration. Facility staff failed to receive from pharmal printed on the package on the package on the package of the packa	ge 39 of two (2) medication storage determined that facility staff medications, when received an expiration date printed on 3 South Unit. storage observation conducted on Unit 3 South at 0 AM. The medication package contained Lorazepam (sedative) g [milligram] tablets. Ince of an expiration date on the chabel. Employee #7 reviewed of the package and failed to a date of the medication. In ensure that medications, when macy, had an expiration date age/label. In eview was conducted on with Employees #7 at 0 AM regarding the dings. After review of the above, ed the findings. In ensure that medications, when macy, had an expiration date	L 153	3227.4 Nursing Facilities (cont.) 3. Inservice was given to the Licen Nursing Staff to ensure the return of medications without labels with expediates on them. Monitoring will be a monthly basis by the Clinical Marrand Quality Assurance Nurses. The results of their monitoring will be forwarded to the Director of Nurses review and analysis. 4. The Director of Nurses will present findings of this monitoring along with any action plans for import to the QualityAssurance/Performant Improvement Committee which me	sed f iration done on lagers e for his ent the rovement ce ets	1/12/15	

Health Regulation & Licensing Administration (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED DENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: 12/09/2014 B. WING HFD02-0020 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2425 25TH STREET SE TRANSITIONS HEALTHCARE CAPITOL CITY WASHINGTON, DC 20020 (X5) COMPLETE DATE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX CROSS-REFERENCED TO THE APPROPRIATE OR LSC IDENTIFYING INFORMATION) TAG TAG L 161 Continued From page 40 L 161 3227.12 Nursing Facilities L 161 L 161 3227,12 Nursing Facilities 1. Medication with an expiration date of 11/30/14 was destroyed upon discovery. 12/1/14 Each expired medication shall be removed from 2. All medications were reviewed to ensure any medication due to expire on 11/30/14 usage. This Statute is not met as evidenced by: 12/1/14 was destroyed. Based on an observation of one (1) of two (2) 3. Inservice was given to the licensed medication storage refrigerators, it was determined nursing staff regarding the timely destruction that facility staff failed to label and store medications of expired medication. The Clinical Managers in accordance with accepted professional principles and the Nursing Quality Improvement Team as evidenced by: medications stored beyond the will monitor the destruction of expired medication on a monthly basis and report 1/12/15 expiration date. Unit 3 South. their findings to the Director of Nursing. 4. The Director of Nursing will present the The findings include: findings of this monitoring along with any action plans for improvement 1/12/15 to the QualityAssurance/Performance Facility staff failed to ensure that medications Improvement Committee which meets were not stored beyond the expiration date. monthly and is chaired by the Administrator. One (1) of one (1) vial of (Procrit/ Epoetin 20,000 units 1ml [milliliter] daily) expiration date printed on vial 11/14 [November 2014]. The observation was made on December 1, 2014 at approximately 10:00 AM. in the presence of Employee #8 who acknowledged the findings.

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L 161	Continued From pag	ge 41	L 161				
	Based Facility staff failed to not stored beyond the one (1) of one (1) virunits 1ml [milliliter] of	o ensure that medications were ne expiration date: al of (Procrit/ Epoetin 20,000 daily) expiration date printed on er 2014]. The observation was		3229.4 Nursing Facilities 1. This resident was discharged from facility without his/her complete admissions packet being signed. 2. All new residents' admissions packet been reviewed to ensure that admission paperwork was complete that each resident/Responsible Partinformed of their rights, all rules and regulations governing resident conditions governing resident conditions and Medicaid services in violations, equal access to waiving right, written assurance of residents eligible costs for services and changes in conservices). 3. Inservice education was completed 12/16/14 the Admissions Staff to ensure their competency and understanding of the requirements for notification of their all rules and regulations governing reconduct and responsibilities; their right, written assurance of residents to rights, written assurance of residents.	ckets all d and y was l uct and efits for writing ghts, bility, and bet for led with he rights, resident ghts and services waiving ts	11/21/14	
L 182	3229.4 Nursing Fac	ilities	L 182	eligibility, and costs for services and changes in cost for services). To en	sure		
	and discharge, the the social services following: (a) Direct service, in interventions, casever residents, families a necessary by the social services.	cluding therapeutic work and group work services to and other persons considered ocial worker;		on-going compliance, the Admission Quality Improvement Team will complete a monthly audit of the administration paperwork for new residents and restheir findings to the Director of Admiand Marketing. 4. The Director of Admissions and A will present the finding of the Admis Quality Improvement Team along wany action plans for improvement to Quality Assurance/Performance Improvement Impro	nission port port pissions Marketing pisions with pothe prove-	12/29/14 1/12/15	
	(b)Advocacy on bel	hair of residents;	3)	Ment Committee which meets mont Is chaired by the Administrator.	thly and		

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L 182	Continued From pa	ge 42	L 182		
	(c)Discharge planni	ng;			ļ
	(d)Community liaiso	on and services;			
	(e)Consultation with Interdisciplinary Care Team;	n other members of the facility's			
	(f)Safeguarding the records; and	confidentiality of social service			
	facility on subjects resident's rights, per confidentiality.	e training to other staff of the including, but not limited to, sychosocial aspects of aging and met as evidenced by:			
	review for one (1) determined that far medically related serious resident maintaine psychosocial well implement dischart the resident's individeparted the facili response to a call resident would be	nd staff interviews, and record of 53 sampled residents, it was cility staff failed to provide social services to ensure one (1) d physical, mental and being as evidenced by failing to ge planning services and assess vidual needs in that the resident by against medical advice in received from facility staff that the responsible for incurring costs sher continued stay at the facility	е		
:	The findings include	de:			
	October 13, 2014 post inpatient adn Retention, and Ur	is admitted to the facility on for sub acute rehabilitation statu hission for " Fatigue, Urinary inary Tract Infection."	s		
	Interim physician'	s orders revealed the following:			

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L 182	Continued From pag	је 43		L 182			
	"October 14, 2014-Therapy Clarification (five) 5 [times a] were Care)- Therapeutic Neuro (neurological Repair, Activities of Application [as need October 14, 2014-12 Clarification]- Physic evaluation and treat strengthening, trans balance activities." An " Initial Social Secon October 14, 2014 responsible. A oriented [times] 3 (titerm memory appearage Resident is here to services Resident A " Transitions Hear revealed; " Novemb PM); Type-Call; Staspoke to the [genda application. [He/shequalify for Medicaid have to leave from could not pay." Ensocial worker or any responsible party were responsible party wer	12:30 PM- [Occupating]: (1) Evaluate patie ek [for] 12 weeks; PC Exercises, Therapeu) rehabilitation and No Daily Living and Moded] and Cognition To 2:45 PM- [Physical Total Therapy to see patient for gait training efer, transfer and start evice Assessment "evealed; "Discharge for the terror to the conditional Comments: three), and [his/her] for the patient is here on a short existence of the patient completing end and the patient completing end and the patient completing end and the patient completing end and the patient completing end and the patient completing end and the patient completing end and the patient completing end and the patient completing end and the patient completing end end the patient completing end end end end end end end end end end	ent, (2) Treat DC (Plan of tic Activity, leural dality raining. Therapy atient for 3, and a Medicaid would not /she] would the/she] ked if the bying the				
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L 182	Continued From pag	ge 44	L 182					
	Against Medical Adv (Responsible Party) discharge resident h documented) agains 21, 2014 around 12: were not notified of if fashion so we are ta Worker) tried to pers [resident's relative] t facility can order me they insisted on taki November 21, 2014 November 21, 2014 Note- Resident's RF read the form used if medical advice and involved when disch medical advice." A "Leaving Facility A dated November 21 (explanation of circu leaving facility)- Fan lapse in a timely fas resident home. " A face-to-face interv Employee #54 on D approximately 9:53 aforementioned con something regarding insurance lapsing. I [resident's responsible out. I did not know resident/responsible	I and family decided to nome (resident's address at medical advice on November 10 PM. RP and family said they insurance lapse in a timely aking him home. SW (Social suade RP and resident's to give us a day at least so the edications for the resident, but ing the resident home on 1. I 10 PM- Focus: Discharge P and his [resident's relative] to discharge a resident against know that there are risks harging their loved one against was not notified of insurance shion and decided to take I was conducted with the encember 8, 2014 at AM regarding the notern. He/she stated; "It was go the business office and the latried to get them to stay, but the ble party] was rushing [him/her] anything about the party planning to take [him/her] attil the day it occurred." When						

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L 182	Continued From pag	ge 45	L 182				
	living status, including mobility? He/she state resident 's needs witherapists and occur discharge. I make re-	nducted with e party related to his/her prior ng assistive devices for ated, "No, I coordinate the vith the doctors, physical pational therapist before eferrals to obtain PCA (Patient ad any medical equipment if					
	[resident's family me approximately 12 N (resident/ responsib what was covered of stated; "No admiss a private nurse to he	ew was conducted with the ember] on December 8, 2014 at oon. He/she stated they ole party) were not informed of or the cost of anything. Further ion packet was signed. We hired elp when [he/she] came home. vice a week. We are paying for ets."					
	on December 9, 20 When queried about plans; he/she state	conducted with Employee #17 14 at approximately 12:50 PM. It Resident #102's discharge d that the discharge plan would the resident to Occupational and ervices at home.					
	services and asses needs prior to resid	to implement discharge planning is Resident #102's individual lent's departure from the facility vice. The clinical record was nber 9, 2014.					
			1				

FORM APPROVED Health Regulation & Licensing Administration (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A BUILDING: B. WING 12/09/2014 HFD02-0020 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **2425 25TH STREET SE** TRANSITIONS HEALTHCARE CAPITOL CITY WASHINGTON, DC 20020 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES ΙD (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) L 214 Continued From page 46 L 214 3234.1 Nursing Facilities 1. The two surge protectors noted on the floor L 214 L 214 3234.1 Nursing Facilities 12/5/14 at the time of the survey were immediately secured upon discovery. Each facility shall be designed, constructed, 2. A review of the facility found no other located, equipped, and maintained to provide a 12/5/14 surge protectors on the floor. functional, healthful, safe, comfortable, and 3. Maintenance Staff was inserviced on the supportive environment for each resident, employee proper way to install a surge protector. 12/12/14 and the visiting public. The Maintenance Quality Improvement This Statute is not met as evidenced by: Team will inspect the facility for the proper Based on observations made on December 5, 2014 1/9/15 mounting of surge protectors on a at approximately 12:30 PM, it was determined that monthly basis. The results of their the facility staff failed to maintain resident inspections will be forwarded to the Director environment free of accident hazards as evidenced of Facilities for his review and analysis. by loose surge protectors observed on the floor of 4. The Director of Facilities will present the 1/12/15 two (2) of 68 resident's rooms. findings of this auditing along with any action plans for improvement to the Quality Assurance/Performance Improvement The findings include: Committee which meets monthly and is 1. Surge protectors were observed in use, on the chaired by the Administrator. floor of resident's rooms #253 and # 258, two of 68 resident's rooms surveyed. These observations were made in the presence of 3245.1 Nursing Facilities Employee #19 who confirmed the findings. 12/5/14 1. The call bell in room 103B was repaired immediately upon discovery. 2. All call bells on that unit were tested 12/5/14 L 297 L 297 3245.1 Nursing Facilities to ensure proper working order. 3. Maintenance staff was inserviced on the A nursing station space shall be provided on each

Health Regulation & Licensing Administration STATE FORM

alarm when tested.

The findings include:

unit for the supervision and care of each resident.

Based on observations made on December 1, 2014

2014 at approximately 12:30 PM, it was determined

that the facility failed to maintain resident call bells

in good working condition as evidenced by a call

bell in one (1) of 63 resident's rooms that did not

at approximately 10:00 AM and on December 5,

This Statute is not met as evidenced by:

1/12/15

proper techniques for call bell maintenance

and repair. The Maintenance Supervisors

Team will monitor the proper functioning of

They will report their findings to the Director

and Maintenance Quality Improvement

the call bell system on a monthly basis.

will present his findings and any action

Committee which meets monthly and is

plans for improvement to the Quality Assurance/Performance Improvement

of Facilities for his analysis.

4. The Director of Facilities

chaired by the Administrator.

Health Regulation & Licensing Administration (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A, BUILDING: B. WING 12/09/2014 HFD02-0020 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2425 25TH STREET SE TRANSITIONS HEALTHCARE CAPITOL CITY WASHINGTON, DC 20020 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX PRÉFIX OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) L 297 L 297 Continued From page 47 3256.1 Nursing Facilities 1. Exhaust Vents 1. The call bell in resident room #103 (B) did not 1. The three exhaust fans found soiled with function as intended, one (1) of 68 resident's rooms dust particles at the time of survey were 12/9/14 surveyed. cleaned upon discovery. 2. Exhaust fans throughout the facility were These observations were initially made in the evaluated to ensure all were without dust 12/9/14 presence of Employee #3 on December 1, 2014 at particles. approximately 10:00 AM and confirmed by 3. Housekeeping staff were inserviced on the Employee #19 on December 5, 2014 at proper cleaning of exhaust vents. The approximately 12:30 PM. **Environmental Services Quality Improvement** 1/10/15 Team will monitor the cleanliness of the exhaust vents on a routine basis and L 410 L 410 3256.1 Nursing Facilities forward the results of their auditing to the Director of Facilities for his analysis. Each facility shall provide housekeeping and 4. The Director of Facilities will present the maintenance services necessary to maintain the findings of this auditing along with any action exterior and the interior of the facility in a safe, plans for improvement to the Quality sanitary, orderly, comfortable and attractive Assurance/Performance Improvement manner. Committee which meets monthly and is This Statute is not met as evidenced by: chaired by the Administrator. Based on observations made on December 1, 2014 2. Fire Sprinklers at approximately 10:00 AM and on December 5, 1. The four fire sprinklers found soiled with 2014 at approximately 12:30 PM, it was determined 12/9/14 dust particles at the time of survey were that the facility failed to provide housekeeping and cleaned upon discovery. maintenance services necessary to maintain a 2. Fire sprinklers throughout the facility were sanitary, orderly, and comfortable interior as evaluated to ensure all were without dust 12/9/14 evidenced by soiled exhaust vents in three (3) of 68 particles. residents' rooms, soiled fire sprinklers in four (4) of 3. Housekeeping staff were inserviced on the 68 resident's rooms and short call bell cords in four proper cleaning of fire sprinklers. The (4) of 68 residents' rooms. **Environmental Services Quality Improvement** 1/10/15 Team will monitor the cleanliness of the The findings include: fire sprinklers on a routine basis and forward the results of their auditing to the 1. Exhaust vents were soiled with dust particles in Director of Facilities for his analysis. three (3) of 68 resident's rooms including rooms 4. The Director of Facilities will present the #146, #225 and #344. findings of this auditing along with any action 1/12/15 plans for improvement to the Quality 2. Fire sprinklers were soiled with dust particles in Assurance/Performance Improvement four (4) of 68 resident's rooms including rooms Committee which meets monthly and is #323, #339, #344 and #360. chaired by the Administrator.

Health Regulation & Licensing Administration							
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3) DATE COMPI				
AND PLAN C	F CORRECTION	IDENTIFICATION NOMBER	A. BUILDING:				
			D MAINIC			(0044	
		HFD02-0020	B. WING		12/09	/2014	
,,,	ROVIDER OR SUPPLIER	2425 25TH	RESS, CITY, STAT	TE, ZIP CODE		:	
TRANSIT	IONS HEALTHCARE C	ADITOL CITY	TON, DC 200	w			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE	
L 410	Continued From pag	ge 48	L 410	3256.1 Nursing Facilities (cont.)			
	bathroom of rooms	esident's call bells located in the #210, #241, #259, #328 were ilv accessible.		 Pull Cords The four pull cords found to be to at the time of survey were replaced immediately upon discovery. 		12/9/14	
	too short to be readily accessible. These observations were made in the presence of Employee #19 who acknowledged the findings.		evaluated to be acce 3. Mainter	 Pull cords throughout the facility evaluated to ensure all were long e to be accessible to the residents. Maintenance staff were inservice proper length of pull cords. The 	nough	12/9/14	
				Environmental Services Quality Imp Team will monitor the accessibility cords on a routine basis and forward the results of their auditing	of pull	1/10/15	
				Director of Facilities for his analysis 4. The Director of Facilities will pre findings of this auditing along with a plans for improvement to the Qualit Assurance/Performance Improvem Committee which meets monthly at chaired by the Administrator.	s. esent the any action ty ent	1/12/15	