Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0020	A. BUILDING: _____ B. WING _____	12/09/2014

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

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L 000	Initial Comments The annual Licensure Survey was conducted at your facility on December 1, 2014 through December 9, 2014. The following deficiencies are based on observations, record reviews, resident and staff interviews for 53 sampled residents. The following is a directory of abbreviations and/or acronyms that may be utilized in the report: Abbreviations AMS - Altered Mental Status g-tube- Gastrostomy tube EKG - 12 lead Electrocardiogram NP - Nurse Practitioner BID - Twice- a-day EMS - emergency medical services (911) HVAC - Heating ventilation/Air conditioning Neuro - Neurological B/P - Blood Pressure CRF - Community Residential Facility CNA- Certified Nurse Aide DMH - Department of Mental Health Peg tube - Percutaneous Endoscopic Gastrostomy NP - Nurse Practitioner L - Liter Dl - deciliter CMS - Centers for Medicare and Medicaid Services Lbs - pounds (unit of mass) MAR - Medication Administration Record MD- Medical Doctor MDS - Minimum Data Set Mg - milligrams (metric system unit of mass) mL - milliliters (metric system measure of volume) mg/dl - milligrams per deciliter	L 000	The filing of this Plan of Correction does not constitute an admission that the deficiencies alleged did in fact exist. The Plan of Correction is filed as evidence of the facility's desire to comply with the regulatory requirement of responding to these citations.	

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

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L 000	Continued From page 1 mm/Hg - millimeters of mercury POS - physician ' s order sheet Prn - As needed Pt- Patient TAR - Treatment Administration Record PASRR - Preadmission screen and Resident Review ARD - assessment reference date IDT - interdisciplinary team ID - Intellectual disability QIS - Quality Indicator Survey D.C. - District of Columbia D/C- discontinue Rp, R/P- responsible party PO- By Mouth	L 000		
L 001	3200.1 Nursing Facilities Each nursing facility shall comply with the Act, these rules and the requirements of 42 CFR Part 483, Subpart B, Sections 483.1 to 483.75; Subpart D, Sections 483.150 to 483.158; and Subpart E, section 483.200 to 483.206, all of which shall constitute licensing standards for nursing facilities in the District of Columbia. This Statute is not met as evidenced by: A. Based on observation, record review and staff interview for one (1) of 53 sampled residents, it was determined that facility staff failed to implement appropriate treatment and services to correct the assessed problem of Resident #160 placing nonnutritive item ' s in his/her mouth. The findings include: According to the Psychiatric Times " Pica is the pathological craving for and eating of a nonnutritive item "	L 001	**3200.1 Nursing Faculties** A. 1. Resident #160 was readmitted to the facility and his care plan was updated to address his advanced dementia He was evaluated by the facility's psychiatrist who wrote that the "Pt does not meet the criteria for Pica. It appears that he has a hyper oral fixation related to his dementia. Behavioral interventions implemented at N.H. have been effective." 2. All residents with Advanced Dementia were screened to ensure accurate information about the care and services needed by these residents is known to his/her caretakers. 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 and the clarification of terms such as "close monitoring" and "1:1." Additionally, the Inservice address the need for the accurate notification of caretakers of the care and needs for these specific residents. Compliance auditing will be conducted by the Quality Assurance Nurse on a routine basis to ensure proper communication of the residents needs, care and services as well as the prompt access of Behavioral Health evaluations. The results of those audits will be forwarded to the Director of Nurses for his evaluation. 4. The Director of Nurses will review the data from these monitoring efforts done by the Quality Assurance Nurse and present his analysis and any action plans for improvement to the	12/15/14 1/16/15 1/12/15 1/5/15 1/12/15

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L 001	Continued From page 2 " Often, the control of pica in mentally handicapped adults with complicated histories presents a clinical problem that must be approached through individualized design and the presence of aversive but not harmful consequences. " <http://www.psychiatrictimes.com/eating-disorders/update-pica-prevalence-contributing-causes-and-treatment/page/0/1> According to the History and Physical completed on September 22, 2014 the resident had the following diagnoses: End Stage Renal Disease- Dialysis Dependent, Dementia and Hypertension. The resident ' s mental status was assessed as confused. According to the Minimum Data Set completed November 12, 2014. Under Section C1000 (Cognitive Skills for Daily Decision Making), the Resident was coded as severely impaired [never/rarely made decisions]. Under Section E 0200 (Behavior), the resident was coded as physical behavioral symptoms directed towards others (e.g. hitting, kicking, pushing, scratching, grabbing ...), Section G (Functional Status), the resident was coded as requiring extensive assistance in bed mobility, and transfers; and required total assistance in toileting, dressing, eating, and personal hygiene. Section G 0400 (Functional Limitation in Range of Motion), the resident was coded as having no impairment to upper or lower extremities. Under Section K (Swallowing/Nutritional Status), the resident was coded as being on a mechanical altered diet.	L 001	**3200.1 Nursing Facilities (cont.)** Quality Assurance/Performance Improvement Committee which meets monthly and is chaired by the Administrator	1/12/15

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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 [used to treat Major Depressive Disorder] 10 mg take one tablet by	L 001		

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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.	L 001		

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L 001	Continued From page 5 A review of the Psychiatric Consults revealed that the last consult was conducted October 24, 2013. There was no evidence that the resident was seen by a psychiatrist to evaluate and address the resident's behavior of ingesting nonnutritive items. The team note dated November 21, 2014 at 11:30 PM revealed, " 911 call at 3:35 PM. Arrived at 3:45 PM. Resident was transported at 3:50 PM to [hospital name] [second] to declott of [right] upper AV (Arteriovenous) graft site. Resident is still under evaluation at the end of the shift... " A review of the " Metropolitan Washington Area Inter-Agency Referral Transfer Form " [no date indicated] and the D.C. Fire & EMS[District of Columbia Fire and Emergency Medical System] forms lacked evidence that facility staff communicated to the receiving hospital and the transport agency, the resident's behavior of ingesting nonnutritive items. Face-to-face interviews were conducted on December 8, 2014 between 10:00 AM and 4:00 PM with Employees assigned to care for Resident #160. Facility staff stated the following: Employee #27 stated, " Resident #160 talks and tries to get out of the wheelchair. At one point Resident#160 was briefly on 1:1 monitoring. He/she participates in the restraint reduction program and wears a seatbelt in the wheelchair.	L 001		

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L 001	Continued From page 6 He/she would chew on his/her shirt every chance that he/she got. " 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 he/she 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 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	L 001		

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L 001	Continued From page 7 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 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.	L 001		

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L 001	Continued From page 8 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 Resident #160. Employee #31 stated that he/she keeps an eye on Resident #160 when he/she is in the room. I feed Resident #160 because he/she is unable to feed him/herself. Sometimes when Resident #160 is being fed he/she tries to put things in his/her mouth, when 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, 2014 at approximately 10:30 AM a face-to-face interview was conducted with Employees #1, 2, 8, and 25. They stated that 1:1 monitoring means that a certified nurse aide is assigned to the resident for a defined period of time; and acknowledged the findings.	L 001		

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L 001	Continued From page 9 There was no evidence that 1:1 monitoring was implemented to address the resident ' s behavior of ingesting nonnutritive items and that facility staff communicated to the medical team regarding the resident ' s behavior of mouthing/chewing on non-food items. The care plan lacked evidence that facility staff implemented specific interventions to address the resident ' s behavior of ingesting nonnutritive items. The " Resident Care Card " for Resident #160 lacked problem identification, goals and specific interventions for the management of mouthing/chewing non-food items. The resident was admitted to the hospital, underwent diagnostic studies that determined that he/she had ingested non-food items identified as " gloves ". A face to face interview was done on December9, 2014 at approximately 3:00 PM with Employee ' s #1, and 2. The findings were reviewed and acknowledged. The record was reviewed on December 9, 2014. B. Based on record review and staff interview for one (1) of 53 sampled residents, it was determined that facility staff failed to inform one (1) resident at the time of admissions of their rights, all rules and regulations governing resident conduct and responsibilities; 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 services), as	L 001	**3200.1 Nursing Facilties (cont.)** B. 1. This resident was discharged from the facility without his/her complete admission packet being signed. 2. All new residents' admissions packets have been reviewed to ensure that all admission paperwork was completed and that each resident/Resposnible Party was informed of their rights, all rules and regulations governing resident conduct and responsibilities; their rights and benefits for Medicare and Medicaid services in writing (such as, equal access to waiving rights, written assurance of residents eligibility, and costs for services and changes in cost for services). 3. Inservice educaton was completed with the Admissions Staff to ensure their competecy and understanding of the requirements for notification of their rights, all rules and regulations governing resident conduct and responsibilities; their rights and benefits for Medicare and Medicaid services in writing (such as, equal access to waiving rights, written assurance of residents eligibility, and costs for services and changes in cost for services). To ensure on-going compliance, the Admissions Quality Improvement Team will complete a monthly audit of the admission paperwork for new residents and report their findings to the Director of Admissions and Marketing. 4. The Director of Admissions and Marketing will present the finding of the Admissions Quality Improvement Team along with any action plans for improvement to the Quality Assurance/Performance Improve-Ment Committee which meets monthly and Is chaired by the Administrator.	11/21/14 12/29/14 12/16/14 12/29/14 1/12/15

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L 001	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 services.	L 001		

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L 001	Continued From page 11 A review of the clinical record for Resident #102 lacked evidence that all forms related to the admission ' s process were signed, indicating that the resident was informed of his/her rights, and benefits for Medicare and Medicaid services. A face-to-face interview was conducted with Employee #13 on December 8, 2014 at approximately 11:30 AM. Employee #13 was queried regarding why the admissions contract was not signed. He/she stated that all contracts are to be signed by the resident or responsible party when the resident is admitted into the facility. There was no evidence that facility staff ensured that Resident #102 and/or resident ' s responsible party was informed of his/her rights, all rules and regulations governing resident conduct and responsibilities; and rights and benefits for Medicare and Medicaid services. Employees #13 and #14 acknowledged the findings on December 8, 2014. The clinical record was reviewed on December 8, 2014. C. Based on record review and staff interview for seven (7) of 17 sampled physician records, it was determined that the facility staff failed to assure that all personnel were free of communicable diseases. Physicians' # 41, 43, 44, 45, 47, 49, and 50.	L 001	**3200.1 Nursing Facilties (cont.)** C. 1. Physician's files found to be lacking an annual screening for TB have been updated. 2. All Physicians file are complete with annual TB screenings with evidence of a Chest x-ray or an annual PPD. 3. The Medical Records Quality Improvement Team will monitor Physician Credentials for completeness on a monthly basis and report their findings to the Director of Medical Records. 4. The Director of Medical Records will present her findings and any action plans for improvement to the Quality Assurance/Performance Improvement Committee which meets monthly and is chaired by the Administrator.	1/12/15 1/12/15 1/12/15 1/12/15

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L 001	Continued From page 12 The findings include: Centers for Disease Control and Prevention (CDC), Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis (TB) in Health Care Setting, 2005. Morbidity and Mortality Weekly Reports (MMWR) 2005:54(RR17); 1-141 stipulates " TB Screening Procedures for Settings Classified as Low Risk - all HCWs (health care workers) should receive baseline screening upon hire ... additional testing is not necessary unless an exposure to M. tuberculosis occurs ....HCWs (health care workers) with a baseline positive or newly positive test result ...should receive one chest radiograph result to exclude TB disease ... " TB Screening Procedures for Settings Classified as Medium Risk - all HCWs (health care workers) should receive baseline screening upon hire ... HCWs should receive TB screening annually (i.e., symptom screen for all HCWs and testing for infection with M. tuberculosis for HCWs with baseline negative test results ...HCWs with a baseline positive or newly positive ...should receive one chest radiograph result to exclude TB disease. Instead of participating in serial testing, HCWs should receive a symptom screen annually. " The facility staff failed to ensure an annual PPD [Purified Protein Derivative]/TB [Tuberculosis] Screening was performed for Physicians' #41, 43, 44, 45, 47, 49, and 50. A review of Physicians ' #41, 43, 44, 45, 49, and 50 ' s personnel records lacked documented evidence that the physicians was screened annually. A review of Physician #47's personnel record revealed that the tuberculosis skin test	L 001		

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L 001	Continued From page 13 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. D. Based on observation and staff interviews for one (1) of 53 sampled residents, it was determined that the facility staff failed to demonstrate care consistent with current infection control practices to prevent contamination and the spread of infection as evidenced by the staff ' s failure to use sanitary measures while feeding the resident; and to follow accepted standards of hand hygiene practices to help prevent the spread of infection. Resident #38. The findings include: 1. Facility staff failed to use sanitary measures while feeding Resident #38. The Annual Minimum Data Set (MDS) dated, August 25, 2014 revealed the admitting diagnoses included Cerebrovascular Accident, Hemiplegia or Hemiparesis, Hypertension, and Seizure disorder for Resident #38. Under Section G- Functional Status, it also revealed that the resident was totally dependent with Activities of Daily Living (ADL's).	L 001	**3200.1 Nursing Facilties** D. 1. Resident #38 1. The staff member involved was counsled and inserviced on proper Infection Control techniques while feeding a resident. 2. Monitoring rounds are done in the dining rooms and on the units to ensure that all staff who are feeding residents use proper Infection Control techniques. 3. Nursing staff were inserviced on Infection Control and Feeding to ensure their understanding in this area. Monitoring rounds are being done on a weekly basis by memebers of the Nursing Quality Improvement Team for on-going compliance. The results of these monitoring efforts are forwarded to the Director of Nursing for his review and analysis. 4. The Director of Nursing will present the findings of this monitoring along with any action plans for improvement to the QualityAssurance/Performance Improvement Committee which meets monthly and is chaired by the Administrator.	12/5/14 1/12/15 1/12/15 1/12/15

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L 001	Continued From page 14 On December 1, 2014 at approximately 12:55 PM, a dining observation was conducted on unit, 1 North. Resident #38 was observed being fed by Employee #39. Employee #39 was observed rubbing his/her stomach with both hands, then continuing to feed the resident without sanitizing. Additionally, he/she put both hands in his/her pocket, while the resident was chewing food. Then he/she resumed feeding the resident, without sanitizing. On December 1, 2014 at approximately 1:10PM, a face-to-face interview was conducted with Employee #39 regarding the aforementioned findings. He/she acknowledged the findings. Facility staff failed to demonstrate care consistent with current infection control practices to prevent contamination and the spread of infection. The clinical record was reviewed on December 1, 2014. 2. Facility failed to follow accepted standards of hand hygiene practices to help prevent the spread of infection. A tour of 3 South was conducted on December 1, 2014 at approximately 9:45 AM. During this time it was noted that Resident #314 was on isolation for C. Diff [Clostridium Difficile is a bacterial infection that affects the digestive system]. On December 8, 2014 at approximately 9:30 AM, Employee #37 was observed walking into room 354 [Resident #314's assigned room] with a mask on his/her face and no other PPE (personal protective equipment) donned and carrying clean linen. [PPE is equipment worn to minimize exposure to serious workplace illnesses. The equipment includes: gloves and/or gowns and/or	L 001	**3200.1 Nursing Facilties (cont.)** 2. Resident #314 1. The staff member involved was counsled and inserviced on proper Infection Control techniques/Hand Washing to prevent cross contamination and the spread of infection. 2. Monitoring rounds are done in any isolation situation to ensure the proper use of PPE and infection control techniques to prevent cross contamination and the spread of infection. 3. Nursing staff were inserviced on Infection Control/Hand Washing to prevent Cross Contamination and the Spread of Infection. Monitoring rounds are being done on a weekly basis by the Infection Control Nurse for on-going compliance. The results of these monitoring efforts are forwarded to the Director of Nursing for his review and analysis. 4. The Director of Nursing will present the findings of this monitoring along with any action plans for improvement to the QualityAssurance/Performance Improvement Committee which meets monthly and is chaired by the Administrator	12/8/14 12/8/14 1/12/15 1/12/15

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L 001	Continued From page 15 mask]. Once in the room, Employee #37 placed the clean linen in a chair, removed the mask from his/her face, placed it in the trash receptacle located underneath the hand washing sink, and left the room without first washing his/her hands. Employee #37 acknowledged the finding at the time of the observation. There was no evidence that facility staff followed acceptable standards of hand hygiene practices to help prevent potential cross contamination and spread of infection.	L 001		
L 027	3207.2 Nursing Facilities The Medical Director shall: (a)Coordinate medical care in the facility; (b)Implement resident care policies; (c)Develop written medical bylaws and medical policies; (d)Serve as liaison with attending physician physicians to ensure the prompt issuance and implementation of order; (e)Review incidents and accidents that occur on the premises to identify hazards to health and safety; (f)Ensure that medical components of resident care policies are followed; (g)Assist the Administrator in arranging twenty-four (24) hours of continuous physician services a day for medical emergencies and in developing	L 027	**3207.2 Nursing Facilities** 1. The Medical Director and the Attending Physician were counseled regarding the D.C. regulations for re-admission of a resident. 2. The admission and re-admission records of the residentsfollowed by this Attending Physician were reviewed to ensure compliance. 3. The Clinical Managers and Quality Assurance Nurse will monitor new admissions and re-admissions of residents to this facility to ensure that the resident is seen by the Attending Physician within 72 hours. The results of their monitoring will be forwarded to the Director of Nurses for his review and analysis. 4. The Director of Nursing will present the findings of this monitoring along with any action plans for improvement to the QualityAssurance/Performance Improvement Committee which meets monthly and is chaired by the Administrator.	1/12/15 1/12/15 1/12/15 1/12/15

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L 027	Continued From page 16 procedures for emergency medical care; and (h)Ensure that attending medical professionals who treat residents in the facility have current District of Columbia licenses, U.S. Drug Enforcement Agency and D.C. Controlled Substance registration on file in the facility, along with initial and annual certification of their freedom from communicable diseases. This Statute is not met as evidenced by: Based on record review and staff interview for one (1) of 53 sampled residents, it was determined that the medical director failed to ensure that the physician performed a physical assessment of the resident within 72 hours [his/her] readmission to the facility. Resident #92. The findings include: A review of the resident ' s clinical record revealed that the [he/she] was readmitted to the facility on September 26, 2014. Review of the physical assessment section of the clinical record revealed that the resident ' s last physical examination was completed on July 14, 2014. According to the District of Columbia Municipal regulations for Nursing Facilities 3207.2 subsection (h) The Medical Director shall ensure that each resident is seen by a physician within 72 hours after admission. According to a review of the physical assessments on the clinical record the first documented assessment from the physician [after the readmission] was in the form of an " Attending ' s Note " dated October 19, 2014.	L 027		

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L 027	Continued From page 17 A face-to-face interview was conducted with Employee #2 was conducted at approximately 9:30AM. The employee acknowledged the finding. The record was reviewed on December 7, 2014. The medical director failed to ensure that the physician performed a physical assessment of the resident within 72 hours [his/her] readmission to the facility.	L 027		
L 052	3211.1 Nursing Facilities Sufficient nursing time shall be given to each resident to ensure that the resident receives the following: (a)Treatment, medications, diet and nutritional supplements and fluids as prescribed, and rehabilitative nursing care as needed; (b)Proper care to minimize pressure ulcers and contractures and to promote the healing of ulcers: (c)Assistants in daily personal grooming so that the resident is comfortable, clean, and neat as evidenced by freedom from body odor, cleaned and trimmed nails, and clean, neat and well-groomed hair; (d) Protection from accident, injury, and infection; (e)Encouragement, assistance, and training in self-care and group activities; (f)Encouragement and assistance to: (1)Get out of the bed and dress or be dressed in	L 052	**3211.1 Nursing Facilities**	

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L 052	Continued From page 18 his or her own clothing; and shoes or slippers, which shall be clean and in good repair; (2)Use the dining room if he or she is able; and (3)Participate in meaningful social and recreational activities; with eating; (g)Prompt, unhurried assistance if he or she requires or request help with eating; (h)Prescribed adaptive self-help devices to assist him or her in eating independently; (i)Assistance, if needed, with daily hygiene, including oral acre; and j)Prompt response to an activated call bell or call for help. This Statute is not met as evidenced by: Based on observations, record review and staff interview for seven (7) of 53 sampled residents, it was determined that facility staff failed to ensure sufficient nursing time was given to provide care and services to attain the residents' highest practicable physical, mental, and psychosocial well-being as evidenced by failure to: clarify physician's orders for the use of multiple PRN (as needed) pain medications for one (1) resident; ensure that one (1) resident was fed in an upright position; implement measures to prevent fecal impaction for one (1) resident; ensure that appropriate treatment and services to correct and/or manage one (1) resident ' s potential for ingestion of non-food items; obtain a psychiatric consultation in accordance with physician's orders for one (1) resident diagnosed with advanced dementia and for one (1) resident	L 052		

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L 052	Continued From page 19 diagnosed with weight loss; and administer Procrit [medication used to treat Anemia] in accordance with physician ' s orders. Residents' #42, 92, 157, 160, 170, 183, and 357. The findings include: 1. Facility staff failed to ensure sufficient nursing time was given to clarify physician's orders for the use of multiple PRN (as needed) pain medications for Resident #42. A review of the resident's history and physical dated March 4, 2014 revealed the resident's admitting diagnoses included: Diabetes Mellitus with Neuropathy and Headache. A review of the Physician's Order sheet signed and dated November 28, 2014 revealed the following: "Acetaminophen tab 325 mg [milligram], take two (2) tablets (650mg) by mouth every 6 [six] hours as needed for pain/ temp [temperature] greater than 100.0 F [Fahrenheit] (use caution with APAP [acetyl-p-aminophenol, total daily dose greater than 3,000 mg] original order date September 25, 2014; Hydromorphone [analgesic] tab 4mg: take one (1) tablet by mouth every 4 hours as needed for pain, original order dated September 10, 2014;	L 052	**3211.1 Nursing Facilities (cont.)** 1. Resident #42 1. The Attending Physician for this resident has clarified the orders for the use of multiple PRN pain medications. 2. The Physician order for all residents with multiple PRN pain medications have been 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. 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 Director of Nurses for his review. 4. The Director of Nurses will review the data 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 chaired by the Administrator.	1/12/15 1/12/15 1/12/15 1/12/15

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L 052	Continued From page 20 Lidocaine patch 5% [analgesic]: Apply one (1) patch daily, original order date September 9, 2014." A face-to-face interview was conducted on December 9, 2014 with Employee #7 at approximately 1:00 PM. After review of the above physician ' s orders, Employee #7 acknowledged that the PRN pain medications, noting that the original orders lacked evidence of parameters for pain [mild, moderate, or severe]. Facility staff failed to ensure sufficient nursing time was given to clarify physician's orders for the use of multiple PRN pain medications for one (1) resident. 2. Facility staff failed to ensure sufficient nursing time was given to implement measures to prevent fecal impaction for Resident #92. A review of the clinical record revealed that the resident was readmitted to the facility on September 27, 2014. A hospital discharge summary dated September 24, 2014 revealed; "GI [Gastro Intestinal] performed a colonoscopy today, which was unremarkable other than some stool impaction." Another colonoscopy report dated 9/25/2014 [September 25, 2014] revealed the following, " Hard impacted clay stool found in the rectum. Underlying stercoral ulcer can't be ruled out in rectum. Petechiae mucosa found in the	L 052	**3211.1 Nursing Facilities (cont.)** 2. Resident #92 1. A Bowel Protocol was implemented for Resident #92 due to the history of fecal impaction. 2. All resident who have a history of fecal impaction have been evaluated for the need for a bowel protocol. 3. Inservice education was conducted for the Licensed Nurse Staff regarding the need to implement the facility's bowel protocol for any resident with a history of bowel impaction. 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 Director of Nurses for his review. 4. The Director of Nurses will review the data 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 chaired by the Administrator.	1/12/15 1/12/15 1/12/15 1/12/15

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L 052	Continued From page 21 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. Facility staff failed to ensure sufficient nursing time was given to implement measures to prevent fecal impaction. 3. Facility staff failed to give sufficent nursing time to ensure that Resident #157 was fed in an upright position. The Quarterly Minimum Data Set (MDS) dated September 24, 2014 revealed the admitting diagnoses under Section I (Active Diagnoses) included Cerebrovascular Accident, Hemiplegia or Hemiparesis, and Parkinson's disease for Resident #157. Under Section G- Functional Status, it also revealed that the resident was totally dependent with Activities of Daily Living (ADL's). On December 1, 2014 at approximately 12:50 PM, a dining observation was conducted on unit, 1 North. Resident #157 was observed sitting in a reclining position in a geriatric chair, near a dining	L 052	**3211.1 Nursing Facilities (cont.)** 3. Resident #157 1. The staff member was inserviced immediately upon discovery of the proper positioning of a resident while feeding. 2. All dining rooms are monitored to promote care in a manner that maintains or enhances the residents' dignity and respect by ensuring their proper position while being fed. 3. Inservices have been done to emphasize the need to properly position our residents while they are being fed their meals. Compliance auditing will be conducted by the Quality Assurance Nurse on a routine basis. The results of those audits will be forwarded to the Director of Nurses for his evaluation. 4. The Director of Nurses will review the data from these monitoring efforts done by the Quality Assurance Nurse and present his analysis and any action plans for improvement to the Quality Assurance/Performance Improvement Committee which meets monthly and is chaired by the Administrator.	12/1/14 12/1/14 1/9/15 1/12/15

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L 052	Continued From page 22 table. Employee #32 was observed feeding Resident #157, while in a reclining position. On December 1, 2014 at approximately 1:05 PM, a face-to-face interview was conducted with Employee #32 regarding the resident's position, while eating. He/she said, "I should get some help to sit him/her up." He/she requested the assistance of a nearby employee who assisted him/her to reposition the resident in an upright position. Facility staff failed to give sufficient nursing time to ensure that Resident #157 was fed in an upright position. The clinical record was reviewed on December 1, 2014. 4. Facility staff failed to ensure sufficient nursing time was given to ensure that appropriate treatment and services were provided to correct and/or manage Resident#160 ' s potential for ingestion of non-food items. According to the History and Physical completed on September 22, 2014 Resident #160 ' s diagnoses included: End Stage Renal Disease- Dialysis Dependent, Dementia and Hypertension. Under the section labeled " mental status, " the physician recorded " confused. " According to the Minimum Data Set completed November 12, 2014. Under Section C1000 (Cognitive Skills for Daily Decision Making), the Resident was coded as severely impaired [never/rarely made decisions]. Under Section E 0200 (Behavior), the resident was coded as physical behavioral symptoms directed towards others (e.g. hitting, kicking, pushing, scratching, grabbing ...), Section G (Functional Status), the resident was coded as requiring extensive assistance in bed mobility, and transfers; and	L 052	**3211.1 Nursing Facilities (cont.)** 4. Resident #160 1. Resident #160 was readmitted to the facility and his care plan was updated to address his advanced dementia He was evaluated by the facility's psychiatrist who wrote that the "Pt does not meet the criteria for Pica. It appears that he has a hyper oral fixation related to his dementia. Behavioral interventions implemented at N.H. has been effective." All residents with Advanced Dementia were screened to ensure accurate information about the care and services needed by hese residents is known to his/her caretakers. 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 and the clarification of terms such as "close monitoring" and "1:1." Additionally, the Inservice address the need for the accurate notification of caretakers of the care and needs for these specific residents. Compliance auditing will be conducted by the Quality Assurance Nurse on a routine basis to ensure proper communication of the residents needs, care and services as well as the prompt access of Behavioral Health evaluations. The results of those audits will be forwarded to the Director of Nurses for his evaluation. 4. The Director of Nurses will review the data from these monitoring efforts done by the Quality Assurance Nurse and present his analysis and any action plans for improvement to the Quality Assurance/Performance Improvement Committee which meets monthly and is chaired by the Administrator	12/15/14 1/16/15 1/5/15 1/12/15 1/12/15

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L 052	Continued From page 23 required total assistance in toileting, dressing, eating, and personal hygiene. Section G 0400 (Functional Limitation in Range of Motion), the resident was coded as having no impairment to upper or lower extremities. Under Section K (Swallowing/Nutritional Status), the resident was coded as being on a mechanical altered diet. A review of Resident #160 ' s care plan revealed the interdisciplinary team assessed the following problem: " 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	L 052		

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L 052	Continued From page 24 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.	L 052		

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L 052	Continued From page 25 A review of consulting specialists ' notes revealed a Psychiatric Consult was most recently conducted October 24, 2013. There was no evidence that the psychiatrist was aware and/or evaluated Resident #160 for behavior of mouthing/chewing non-food items. A nurse ' s note dated November 21, 2014 at 11:30 PM revealed, " 911 call at 3:35 PM. Arrived at 3:45 PM. Resident was transported at 3:50 PM to [hospital name] [second] to declott of [right] upper AV (Arteriovenous) graft site. Resident is still under evaluation at the end of the shift... " A review of the forms utilized by the facility to communicate to a receiving provider/facility (hospital) entitled " Metropolitan Washington Area Inter-Agency Referral Transfer Form " [no date indicated] and the D.C. Fire & EMS[District of Columbia Fire and Emergency Medical System] lacked evidence that facility staff communicated to the receiving hospital and the transport agency, the resident's behavior of [potential for] ingesting non-food items. Face-to-face interviews were conducted on December 8, 2014 between 10:00 AM and 4:00 PM with Employees assigned to care for Resident #160. Facility staff stated the following: Employee #27 stated, " Resident #160 talks and tries to get out of the wheelchair. At one point Resident#160 was briefly on 1:1 monitoring. He/she participates in the restraint reduction program and wears a seatbelt in the wheelchair. He/she would chew on his/her shirt every chance that he/she got. "	L 052		

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L 052	Continued From page 26 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	L 052		

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L 052	Continued From page 27 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	L 052		

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L 052	Continued From page 28 Resident #160. Employee #31 stated that he/she keeps an eye on Resident #160 when he/she is in the room. I feed Resident #160 because he/she is unable to feed him/herself. Sometimes when Resident #160 is being fed he/she tries to put things in his/her mouth, when 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, 2014 at approximately 10:30 AM a face-to-face interview was conducted with Employees #1, 2, 8, and 25. They stated that 1:1 monitoring means that a certified nurse aide is assigned to the resident for a defined period of time; and acknowledged the findings. There was no evidence how staff implemented the management of Resident #160 ' s behavior of [potential] " intake of foreign objects " [per care plan]. According to the aforementioned staff interviews, there were inconsistencies in the knowledge of and/or interventions related to the resident ' s behavior of [potential] " intake of foreign objects. " There was no evidence that [potential] " intake of foreign objects " was identified, tracked and/or monitored as a targeted behavior. There was no evidence that facility staff communicated to the medical team regarding the resident ' s behavior of mouthing/chewing on non-food items. The " Resident Care Card " for Resident #160 lacked problem identification, goals and specific interventions for the management of mouthing/chewing non-food items.	L 052		

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L 052	Continued From page 29 According to the nurse ' s note (noted above) dated November 21, 2014, Resident #160 was transported to an acute care facility secondary to a clotted graft site. A review of hospital records revealed Resident #160 was admitted to the hospital on November 22, 2014. An Endoscopy [diagnostic procedure to visually examine the upper digestive system] was performed on December 2, 2014 [10 days post hospital admission]. A specimen was obtained during the procedure and labeled " stomach, foreign body removal. " A review of the pathology report read: " a tan black disrupted plastic foreign body measuring 14.5x7x2 cm [centimeters]. A Gastroenterology progress note dated December 3, 2014 8:32 AM read: " ...EGD [Endoscopy] 12/2/14 revealed hardened plastic objects in the stomach which turned out to have the appearance of gloves ... " Facility staff failed to implement appropriate treatment and services to correct and/or manage Resident #160 ' s assessed problem of potential ingestion of non-food items. There was no evidence that the medical team was informed about the resident ' s assessed behaviors and the record lacked evidence that the behaviors [potential " ingestion of foreign objects "] were communicated to the receiving hospital. The resident was diagnosed with foreign object(s) in the stomach during an Endoscopy procedure conducted 10-days post hospitalization. A face-to-face interview was done on December 9, 2014 at approximately 3:00 PM with Employees #1 and # 2. The findings were reviewed and acknowledged. The record was reviewed on December 9, 2014.	L 052		

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L 052	Continued From page 30 5. Facility staff failed to ensure sufficient nursing time was givent to obtain a Psychiatric consult in accordance with the physician's order for one (1) resident diagnosed with weight loss. Resident #170. A review of the Nutrition Quarterly notes dated August 29, 2014 - 12 PM revealed, " ...Resident being seen by SLP [speech language pathology] for tx [treatment] for oropharyngeal dysphasia per St [speech therapist] order 8/20/14. Per SLP comments and discussion with writer, resident was refusing Puree solids and diet was changed to mechanical soft on 8/28/14. SLP reported to this writer that resident has exhibited episodes of speaking about various things which seem " paranoia" in nature. Resident with dx [diagnosis] of dementia and may benefit from psych consult to evaluate resident especially in light of recent weight loss. Recommend (1) psych [psychiatric] consult - evaluate resident R/T [related to] h/o [history of] dementia, recent sig. [significant] wt [weight] decrease and lab refusals. " Physician's Interim Orders dated August 29, 2014 at 4:40 PM directed, "Psych consult - evaluate Resident R/T [related to] H/O [history of] dementia, recent significant weight loss." A review of the clinical record lacked evidence that 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	L 052	**3211.1 Nursing Facilities (cont.)** **5. Resident #170** 1. The resident was seen by the Consultant Psychiatrist per Physician orders. 1/12/15 2. All medical records were audited to ensure all Physician orders to obtain a Psychiatric consultation was followed. 1/12/15 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. 1/5/15 1/12/15 4. The Director of Nurses will review the data from these monitoring efforts done by the Quality Assurance Nurse and present his analysis and any action plans for improvement to the Quality Assurance/Performance Improvement Committee which meets monthly and is chaired by the Administrator 1/12/15	

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L 052	Continued From page 31 was no evidence of a psychiatric consult. The record was reviewed on December 9, 2014. Facility staff failed to ensure sufficient nursing time was given to obtain a Psychiatric consult in accordance with the physician's order for one (1) resident diagnosed with weight loss. 6. Facility staff failed ensure sufficient nursing time was given to administer Procrit in accordance to physician's orders A review of the November 2014 Physician's Order, with an original order date of August 5, 2014, directed " Procrit INJ (injection) 40,000 units/M inject 1 ML [milliliter] (40,000 units) SUB Q [subcutaneous] every month on the 8th to keep HB [hemoglobin] between 10 and 11 gm/d [gram/deciliter]." A review of the MAR for November 8, 2014, timed 10:00 AM, revealed the allotted signature space was blank; which indicated the Procrit was not administered. A face-to-face interview was conducted with Employee #7 on December 1, 2014 at approximately 11:30 AM. After reviewing the clinical record, he/she acknowledged the aforementioned findings. The record was reviewed on December 1, 2014. There was no evidence that facility staff administered Procrit to Resident #183 in accordance with physician's orders.	L 052	**3211.1 Nursing Facilities (cont.)** **6. Resident #183** 1. Procrit order was obtained from the Attending Physician and administered immediately. Subsequent orders for Procrit have been administered per the Attending Physician's orders. 2. the medical records for Residents with a Procrit order were evaluated to ensure the medication was administered according to the Attending Physician's orders. 3. Inservice training was provided to the Nursing Staff regarding the need to following the Attending Physician orders in an effort to provided necessary care/services to our residents. Clinical Managers along with the Nursing Quality Improvement Team will monitor the administration of Procrit on a frequent basis and submit the results of their audit to the Director of Nurses for his analysis. 4. The Director of Nurses will review the data from these monitoring efforts done by the Quality Assurance Nurse and present his analysis and any action plans for improvement to the Quality Assurance/Performance Improvement Committee which meets monthly and is chaired by the Administrator.	12/1/14 1/12/15 1/9/15 1/9/15 1/12/15

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L 052	Continued From page 32 Facility staff failed to ensure sufficient nursing time was given to administer Procrit in accordance to physician's orders. 7. Facility staff failed to obtain a Psychiatric consultation in accordance with physician's orders for one (1) resident diagnosed with advanced dementia. Resident #357. A review of the clinical record revealed a physician's order dated September 17, 2014 for a psychiatrist consult for inappropriate behavior (urinating in public). A face to face interview with Employee #3 was conducted on December 8, 2014, at approximately 10:00 AM. He/she was queried regarding the written physician's order for a psychiatric consult. He/she responded that the psychiatrist was at the facility once a week and had been busy with residents who required immediate attention. He/she admitted that the psychiatric consult for Resident #357 had not been scheduled. There was no evidence that facility staff followed the physician's order for a psychiatric consultation for Resident #357. The clinical record was reviewed on December 8, 2014.	L 052	**7. Resident #357** 1. The resident was seen by the Consultant Psychiatrist per Physician orders. 1/15/15 2. All medical records were audited to ensure all Physician orders to obtain a Psychiatric consultation were followed 1/12/15 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. 1/5/15 1/12/15 4. The Director of Nurses will review the data from these monitoring efforts done by the Quality Assurance Nurse and present his analysis and any action plans for improvement to the Quality Assurance/Performance Improvement Committee which meets monthly and is chaired by the Administrator. 1/12/15	
L 099	3219.1 Nursing Facilities Food and drink shall be clean, wholesome, free from spoilage, safe for human consumption, and	L 099		

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L 099	Continued From page 33 served in accordance with the requirements set forth in Title 23, Subtitle B, D. C. Municipal Regulations (DCMR), Chapter 24 through 40. This Statute is not met as evidenced by: Based on observations made in the main kitchen on December 1, 2014 at approximately 10:00 AM and on December 3, 2014 at approximately 2:00 PM, it was determined that the facility failed to store, prepare, distribute and serve food under sanitary conditions as evidenced by four (4) of seven (7) soiled cutting boards, one (1) of three (3) soiled sheet pan, one (1) of five (5) dented cans of applesauce and one (1) of 14 dented cans of red peppers in dry food storage, one (1) of six (6) torn splash curtain from the dishwashing machine, uncovered pans (19) of turkey burgers in the walk-in refrigerator, one (1) of one (1) torn air curtain in the walk-in refrigerator and in the walk-in freezer and a soiled and discolored kitchen floor. The findings include: 1. Four (4) of seven (7) cutting boards were soiled. 2. One (1) of three (3) sheet pans was soiled. 3. One (1) of five (5) large cans of applesauce stored in the dry storage room was dented and one (1) of 14 large cans of red peppers stored in the dry food storage room was also dented. 4. One (1) of six (6) splash curtains from the dishwashing machine was torn. 5. 19 pans of uncooked turkey burgers were stored in the walk-in refrigerator uncovered.	L 099	**3219.1 Nursing Facilities** **1. & 2 Cutting Boards and Sheet Pans** 1. Cutting Boards and Sheet Pans found soiled at the time of the survey were cleaned immediately upon discovery. 2. All Cutting Boards and Sheet Pans were inspected to insure all were free of stains and carbon build-up. Those which could not be cleaned or destained were discarded. 3. Inservices were given to the Dietary Staff regarding the proper cleaning and maintenance of Cutting Boards and Sheet Pans. The Dietary Supervisors and the Dietary Quality Improvement Team will the cleanliness of the cutting boards and sheet pans on a monthly basis and report their findings to the Director of Nutritional Services. 4. The Director of Nutritional Services will present the findings of this monitoring along with any action plans for improvement to the QualityAssurance/Performance Improvement Committee which meets monthly and is chaired by the Administrator. **3. Dented Cans** 1. All dented cans found in the dry storage room were removed immediately upon discovery. 2. All cans were reviewed to ensure any cans with dents were stored appropriately. 3. Inservices were given to the Dietary Staff regarding the proper storage of dented cans. The Dietary Supervisors and the Dietary Quality Improvement Team will monitor the storage of dented cans on a monthly basis and report their findings to the Director of Nutritional Services. 4. The Director of Nutritional Services will present the findings of this monitoring along with any action plans for improvement to the QualityAssurance/Performance Improvement Committee which meets	12/1/14 12/3/14 1/9/15 1/12/15 12/1/14 12/1/14 1/9/15 1/12/15

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L 099	Continued From page 34 6. One (1) of one (1) air curtain from the walk-in refrigerator was torn and one (1) of one (1) air curtain from the walk-in freezer was also torn. 7. The kitchen floor was soiled in numerous areas with discoloration. These observations were made in the presence of Employee #19 who acknowledged the findings.	L 099	**3219.1 Nursing Facilities (cont.)** monthly and is chaired by the Administrator. **4. & 6.Splash Curtain and Air Curtain** 1. The torn air curtain and splash curtains have been replaced. 2. All air curtains and splash curtains were inspected to insure there were no further 3. Inservices were given to the Dietary Staff regarding the inspection and care of the splash curtain in the dishwasher and the air curtain in the refrigerator. The Dietary Supervisors and the Dietary Quality Improvement Team will monitor these specialty curtains on a monthly basis and report their findings to the Director of Nutritional Services. 4. The Director of Nutritional Services will present the findings of this monitoring along with any action plans for improvement to the QualityAssurance/Performance Improvement Committee which meets monthly and is chaired by the Administrator.	1/12/15 12/5/14 1/9/15 1/12/15
L 141	3226.1 Nursing Facilities Unless administered under a self-administer order, all medication shall be prepared and administered only by a licensed physician or by a licensed nurse. This Statute is not met as evidenced by: Based on observation, record review and staff interviews for one (1) of 53 sampled residents, it was determined that the interdisciplinary team failed to assess one (1) resident's ability to self administer medications in a safe manner. Resident #116. The findings include: During a medication observation conducted on December 1, 2014 at approximately 10:00 AM, Resident #116 was observed administering his/her Flovent inhaler (Inhaled Corticosteroid) and Flonase (Nasal Steroid) nasal spray. The resident shooked his/her container of Flovent inhaler; positioned the inhaler in his/her mouth and administered one (1) puff; waited for three (3) seconds, and administered a second (2) puff, proceeded to administer one (1) spray of Flonase in each nostril.	L 141	**5. Turkey Burgers** 1. Turkey burgers were immediately covered upon discovery. 2. All other food in the refrigerator was inspected to ensure their proper storage. 3. Inservices were given to the Dietary Staff regarding the proper storage of prepped food. . The Dietary Supervisors and the Dietary Quality Improvement Team will monitor the storage of prepped foods on a monthly basis and report their findings to the Director of Nutritional Services. 4. The Director of Nutritional Services will present the findings of this monitoring along with any action plans for improvement to the QualityAssurance/Performance Improvement Committee which meets monthly and is chaired by the Administrator.	12/1/14 12/1/14 1/9/15 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." 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." A review of the November and December 2014 Medication Administration Records lacked evidence that the resident was self-administering [his/her] medications. The aforementioned medications were administered daily at 10:00 AM.	L 141	**3219.1 Nursing Facilities (cont.)** **7. Kitchen Floor** 1. The areas of the kitchen floor found to be discolored were attended to upon discovery. 2. All areas of the kitchen floor were evaluated to ensure no further areas of discoloration. **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 medication and report their findings to the Director of Nurses. 4. The Director of Nurses will review the data from these monitoring efforts done by the Clinical Managers and present his analysis and any action plans for improvement to the Quality Assurance/Performance Improvement Committee which meets monthly and is chaired by the Administrator.	12/1/14 1/9/15 1/9/15 1/9/15 1/12/15

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L 141	Continued From page 36 There was no evidence in the clinical record that the Interdisciplinary Care Team (IDT) determined that it was safe for Resident #116 to self administer medications. Additionally, it was observed that there were no instructions provided to Resident #116 when he/she self administered medications on December 1, 2014 at approximately 11:00 AM. A face-to-face interview was conducted with Resident #116 on December 3, 2014 at approximately 11:30 AM regarding the aforementioned observation. He/she stated that [he/she] had been self-administering the Flovent inhaler and Flonase spray since it was first ordered. Further stated, the doctor demonstrated to him/her how to use the inhaler and nasal spray in his/her office and no one has instructed [him/her] since that time. However; sometimes [he/she] " does not feel the inhaler go to his/her lungs." A face-to-face interview was conducted on December 3, 2014 at approximately 12:00 PM with Employees #5 and #55. Both stated, "[Resident #116] self administers his/her Flonase nasal spray and Flovent inhaler. We observe [him/her] take the medications." The interdisciplinary team failed to assess Resident #116's ability to self administer medications in a safe manner. The observation and clinical record was reviewed on December 1,	L 141		

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L 141	Continued From page 37 2014.	L 141		
L 152	3227.3 Nursing Facilities Proper storage temperature shall be maintained for each medication according to the manufacturer's direction. This Statute is not met as evidenced by: Based on an observation and staff interview of one (1) of two (2) medication storage refrigerators, it was determined that facility staff failed to store medications in accordance with the manufacturer's specifications. Unit 3 South. The findings include: According to the monograph for drugs manufacturer specifications, the following medications were 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,	L 152	**3227.3 Nursing Facilities** 1. Temperatures were adjusted upon discovery. 2. All medication refrigerators were inspected to ensure their proper temperature. 3. Inservice was given to the licensed nursing staff regarding the appropriate temps of med refrigerators. The Clinical Managers and the Nursing Quality Improvement Team will monitor the temperature of medication refrigerators on a monthly basis and report their findings to the Director of Nursing. 4. The Director of Nursing will present the findings of this monitoring along with any action plans for improvement to the QualityAssurance/Performance Improvement Committee which meets monthly and is chaired by the Administrator.	12/1/14 12/1/14 1/12/15 1/12/15

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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.	L 152		
L 153	3227.4 Nursing Facilities Medication that is dispensed by a pharmacy within the facility for use within the facility shall be labeled to identify the generic chemical or brand name, strength, lot number and expiration date. This Statute is not met as evidenced by: Based on observation, record review and staff	L 153	**3227.4 Nursing Facilities** 1. The medication was returned to the pharmacy upon discovery of the absence of an expiration date on the label. 2. All other medications were reviewed to ensure that each label had an expiration date. There were no other occurrences.	12/1/14 12/1/14

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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 printed on the package/label. 3 South Unit. The findings include: During a 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 and failed to locate the expiration date of the medication. Facility staff failed to ensure that medications, when received from pharmacy, had an expiration date printed on the package/label. 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 ensure that medications, when received from pharmacy, had an expiration date printed on the package/label.	L 153	**3227.4 Nursing Facilities (cont.)** 3. Inservice was given to the Licensed Nursing Staff to ensure the return of medications without labels with expiration dates on them. Monitoring will be done on a monthly basis by the Clinical Managers and Quality Assurance Nurses. The results of their monitoring will be forwarded to the Director of Nurses for his review and analysis. 4. The Director of Nurses will present the findings of this monitoring along with any action plans for improvement to the QualityAssurance/Performance Improvement Committee which meets monthly and is chaired by the Administrator.	1/12/15 1/12/15

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L 161	Continued From page 40	L 161		
L 161	3227.12 Nursing Facilities Each expired medication shall be removed from usage. This Statute is not met as evidenced by: Based on an observation of one (1) of two (2) medication storage refrigerators, it was determined that facility staff failed to label and store medications in accordance with accepted professional principles as evidenced by: medications stored beyond the expiration date. Unit 3 South. The findings include: 1. Facility staff failed to ensure that medications were not stored beyond the expiration date. 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.	L 161	**3227.12 Nursing Facilities** 1. Medication with an expiration date of 11/30/14 was destroyed upon discovery. 2. All medications were reviewed to ensure any medication due to expire on 11/30/14 was destroyed. 3. Inservice was given to the licensed nursing staff regarding the timely destruction of expired medication. The Clinical Managers and the Nursing Quality Improvement Team will monitor the destruction of expired medication on a monthly basis and report their findings to the Director of Nursing. 4. The Director of Nursing will present the findings of this monitoring along with any action plans for improvement to the QualityAssurance/Performance Improvement Committee which meets monthly and is chaired by the Administrator.	12/1/14 12/1/14 1/12/15 1/12/15

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L 161	Continued From page 41 Based Facility staff failed to ensure that medications were not stored beyond the expiration date: 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 December 1, 2014.	L 161	**3229.4 Nursing Facilities** 1. This resident was discharged from the facility without his/her complete admission packet being signed. 2. All new residents' admissions packets have been reviewed to ensure that all admission paperwork was completed and that each resident/Responsible Party was informed of their rights, all rules and regulations governing resident conduct and responsibilities; their rights and benefits for Medicare and Medicaid services in writing (such as, equal access to waiving rights, written assurance of residents eligibility, and costs for services and changes in cost for services). 3. Inservice education was completed with 12/16/14 the Admissions Staff to ensure their competency and understanding of the requirements for notification of their rights, all rules and regulations governing resident conduct and responsibilities; their rights and benefits for Medicare and Medicaid services in writing (such as, equal access to waiving rights, written assurance of residents eligibility, and costs for services and changes in cost for services). To ensure on-going compliance, the Admissions Quality Improvement Team will complete a monthly audit of the admission paperwork for new residents and report their findings to the Director of Admissions and Marketing. 4. The Director of Admissions and Marketing will present the finding of the Admissions Quality Improvement Team along with any action plans for improvement to the Quality Assurance/Performance Improve-Ment Committee which meets monthly and Is chaired by the Administrator.	11/21/14 12/29/14 12/29/14 1/12/15
L 182	3229.4 Nursing Facilities In conjunction with the resident's admission, stay, and discharge, the functions of the social services program shall include the following: (a)Direct service, including therapeutic interventions, casework and group work services to residents, families and other persons considered necessary by the social worker; (b)Advocacy on behalf of residents;	L 182		

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L 182	Continued From page 42 (c)Discharge planning; (d)Community liaison and services; (e)Consultation with other members of the facility's Interdisciplinary Care Team; (f)Safeguarding the confidentiality of social service records; and (g)Annual in-service training to other staff of the facility on subjects including, but not limited to, resident's rights, psychosocial aspects of aging and confidentiality. This Statute is not met as evidenced by: Based on family and staff interviews, and record review for one (1) of 53 sampled residents, it was determined that facility staff failed to provide medically related social services to ensure one (1) resident maintained physical, mental and psychosocial well being as evidenced by failing to implement discharge planning services and assess the resident's individual needs in that the resident departed the facility against medical advice in response to a call received from facility staff that the resident would be responsible for incurring costs associated with his/her continued stay at the facility. The findings include: Resident #102 was admitted to the facility on October 13, 2014 for sub acute rehabilitation status post inpatient admission for " Fatigue, Urinary Retention, and Urinary Tract Infection." Interim physician's orders revealed the following:	L 182		

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L 182	Continued From page 43 "October 14, 2014- 12:30 PM- [Occupational Therapy Clarification]: (1) Evaluate patient, (2) Treat (five) 5 [times a] week [for] 12 weeks; POC (Plan of Care)- Therapeutic Exercises, Therapeutic Activity, Neuro (neurological) rehabilitation and Neural Repair, Activities of Daily Living and Modality Application [as needed] and Cognition Training. October 14, 2014-12:45 PM- [Physical Therapy Clarification]- Physical Therapy to see patient for evaluation and treatment for gait training, strengthening, transfer, transfer and standing balance activities." An " Initial Social Service Assessment " dated October 14, 2014 revealed; "Discharge Plan: Resident have a plan to return to the community as soon as possible. Additional Comments: Resident is oriented [times] 3 (three), and [his/her] long/short term memory appears to be moderately intact. .. Resident is here to receive rehab [rehabilitation] services. ... Resident is here on a short term basis." A " Transitions Healthcare Activity Report " revealed; " November 19, 2014; Time 15:21 (3:21 PM); Type-Call; Status: Closed; Note: Called and spoke to the [gender] about completing a Medicaid application. [He/she] said that [he/she] would not qualify for Medicaid ... [He/she] said [he/she] would have to leave from the facility because [he/she] could not pay." Employee #19 was asked if the social worker or anyone was alerted that the responsible party was considering removing the Resident #102 from the facility. He/she stated, " No. " A review of the clinical record "Team Notes" revealed the following:	L 182		

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L 182	Continued From page 44 "November 21, 2014- 1:05 PM- Focus: Discharged Against Medical Advice- Resident's RP (Responsible Party)/ and family decided to discharge resident home (resident's address documented) against medical advice on November 21, 2014 around 12:10 PM. RP and family said they were not notified of insurance lapse in a timely fashion so we are taking him home. SW (Social Worker) tried to persuade RP and resident's [resident's relative] to give us a day at least so the facility can order medications for the resident, but they insisted on taking the resident home on November 21, 2014. November 24, 2014- 1:10 PM- Focus: Discharge Note- Resident's RP and his [resident's relative] read the form used to discharge a resident against medical advice and know that there are risks involved when discharging their loved one against medical advice." A "Leaving Facility Against Medical Advice" form dated November 21, 2014 revealed; "Comments: (explanation of circumstances behind resident leaving facility)- Family was not notified of insurance lapse in a timely fashion and decided to take resident home. " A face-to-face interview was conducted with Employee #54 on December 8, 2014 at approximately 9:53 AM regarding the aforementioned concern. He/she stated; "It was something regarding the business office and the insurance lapsing. I tried to get them to stay, but the [resident's responsible party] was rushing [him/her] out. I did not know anything about the resident/responsible party planning to take [him/her] out of the facility until the day it occurred." When queried if a comprehensive	L 182		

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L 182	Continued From page 45 assessment was conducted with resident/responsible party related to his/her prior living status, including assistive devices for mobility? He/she stated, "No, I coordinate the resident ' s needs with the doctors, physical therapists and occupational therapist before discharge. I make referrals to obtain PCA (Patient Care Assistants) and any medical equipment if needed." A telephone interview was conducted with the [resident's family member] on December 8, 2014 at approximately 12 Noon. He/she stated they (resident/ responsible party) were not informed of what was covered or the cost of anything. Further stated; "No admission packet was signed. We hired a private nurse to help when [he/she] came home. He/she comes in twice a week. We are paying for this out of our pockets." A face-to-face was conducted with Employee #17 on December 9, 2014 at approximately 12:50 PM. When queried about Resident #102's discharge plans; he/she stated that the discharge plan would have been to refer the resident to Occupational and Physical Therapy services at home. Facility staff failed to implement discharge planning services and assess Resident #102's individual needs prior to resident's departure from the facility against medical advice. The clinical record was reviewed on December 9, 2014.	L 182		

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L 214	Continued From page 46	L 214	**3234.1 Nursing Facilities**	
L 214	3234.1 Nursing Facilities Each facility shall be designed, constructed, located, equipped, and maintained to provide a functional, healthful, safe, comfortable, and supportive environment for each resident, employee and the visiting public. This Statute is not met as evidenced by: Based on observations made on December 5, 2014 at approximately 12:30 PM, it was determined that the facility staff failed to maintain resident environment free of accident hazards as evidenced by loose surge protectors observed on the floor of two (2) of 68 resident's rooms. The findings include: 1. Surge protectors were observed in use, on the floor of resident's rooms #253 and # 258, two of 68 resident's rooms surveyed. These observations were made in the presence of Employee #19 who confirmed the findings.	L 214	1.The two surge protectors noted on the floor at the time of the survey were immediately secured upon discovery. 2. A review of the facility found no other surge protectors on the floor. 3. Maintenance Staff was inserviced on the proper way to install a surge protector. The Maintenance Quality Improvement Team will inspect the facility for the proper mounting of surge protectors on a monthly basis. The results of their inspections will be forwarded to the Director of Facilities for his review and analysis. 4. The Director of Facilities will present the findings of this auditing along with any action plans for improvement to the Quality Assurance/Performance Improvement Committee which meets monthly and is chaired by the Administrator.	12/5/14 12/5/14 12/12/14 1/9/15 1/12/15
L 297	3245.1 Nursing Facilities A nursing station space shall be provided on each unit for the supervision and care of each resident. This Statute is not met as evidenced by: Based on observations made on December 1, 2014 at approximately 10:00 AM and on December 5, 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 alarm when tested. The findings include:	L 297	**3245.1 Nursing Facilities** 1. The call bell in room 103B was repaired immediately upon discovery. 2. All call bells on that unit were tested to ensure proper working order. 3. Maintenance staff was inserviced on the proper techniques for call bell maintenance and repair. The Maintenance Supervisors and Maintenance Quality Improvement Team will monitor the proper functioning of the call bell system on a monthly basis. They will report their findings to the Director of Facilities for his analysis. 4. The Director of Facilities will present his findings and any action plans for improvement to the Quality Assurance/Performance Improvement Committee which meets monthly and is chaired by the Administrator.	12/5/14 12/5/14 1/12/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0020	A. BUILDING: _____ B. WING _____	12/09/2014

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

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L 297	Continued From page 47 1. The call bell in resident room #103 (B) did not function as intended, one (1) of 68 resident's rooms surveyed. These observations were initially made in the presence of Employee #3 on December 1, 2014 at approximately 10:00 AM and confirmed by Employee #19 on December 5, 2014 at approximately 12:30 PM.	L 297	**3256.1 Nursing Facilities** **1. Exhaust Vents** 1. The three exhaust fans found soiled with dust particles at the time of survey were cleaned upon discovery. 2. Exhaust fans throughout the facility were evaluated to ensure all were without dust particles. 3. Housekeeping staff were inserviced on the proper cleaning of exhaust vents. The Environmental Services Quality Improvement Team will monitor the cleanliness of the exhaust vents on a routine basis and forward the results of their auditing to the Director of Facilities for his analysis. 4. The Director of Facilities will present the findings of this auditing along with any action plans for improvement to the Quality Assurance/Performance Improvement Committee which meets monthly and is chaired by the Administrator. **2. Fire Sprinklers** 1. The four fire sprinklers found soiled with dust particles at the time of survey were cleaned upon discovery. 2. Fire sprinklers throughout the facility were evaluated to ensure all were without dust particles. 3. Housekeeping staff were inserviced on the proper cleaning of fire sprinklers. The Environmental Services Quality Improvement Team will monitor the cleanliness of the fire sprinklers on a routine basis and forward the results of their auditing to the Director of Facilities for his analysis. 4. The Director of Facilities will present the findings of this auditing along with any action plans for improvement to the Quality Assurance/Performance Improvement Committee which meets monthly and is chaired by the Administrator.	12/9/14 12/9/14 1/10/15 12/9/14 12/9/14 1/10/15 1/12/15
L 410	3256.1 Nursing Facilities Each facility shall provide housekeeping and maintenance services necessary to maintain the exterior and the interior of the facility in a safe, sanitary, orderly, comfortable and attractive manner. This Statute is not met as evidenced by: Based on observations made on December 1, 2014 at approximately 10:00 AM and on December 5, 2014 at approximately 12:30 PM, it was determined that the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior as evidenced by soiled exhaust vents in three (3) of 68 residents' rooms, soiled fire sprinklers in four (4) of 68 resident's rooms and short call bell cords in four (4) of 68 residents' rooms. The findings include: 1. Exhaust vents were soiled with dust particles in three (3) of 68 resident's rooms including rooms #146, #225 and #344. 2. Fire sprinklers were soiled with dust particles in four (4) of 68 resident's rooms including rooms #323, #339, #344 and #360.	L 410		

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	HFD02-0020	A. BUILDING: _____ B. WING _____	12/09/2014

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

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L 410	Continued From page 48 3. Pull cords from resident's call bells located in the bathroom of rooms #210, #241, #259, #328 were too short to be readily accessible. These observations were made in the presence of Employee #19 who acknowledged the findings.	L 410	**3256.1 Nursing Facilities (cont.)** **3. Pull Cords** 1. The four pull cords found to be too short at the time of survey were replaced immediately upon discovery. 2. Pull cords throughout the facility were evaluated to ensure all were long enough to be accessible to the residents. 3. Maintenance staff were inserviced on the proper length of pull cords. The Environmental Services Quality Improvement Team will monitor the accessibility of pull cords on a routine basis and forward the results of their auditing to the Director of Facilities for his analysis. 4. The Director of Facilities will present the findings of this auditing along with any action plans for improvement to the Quality Assurance/Performance Improvement Committee which meets monthly and is chaired by the Administrator.	12/9/14 12/9/14 1/10/15 1/12/15