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 _____	12/14/2018

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 Transitions Center from December 3, 2018 through December 14, 2018. Survey activities consisted of a review of 90 sampled residents. The following deficiencies are based on observation, record review and resident and staff interviews. After analysis of the findings, it was determined that the facility is not in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The resident census during the survey was 347. An immediate jeopardy (IJ) was identified at 42 CFR§ 483.25 Quality of Care; F689 Free of Accident Hazards/Supervision/Devices on December 10, 2018 at 6:01 PM. The facility's Administrator provided a letter with supportive documentation (to include revising the smoking policy, reassessing and updating the care plan for all residents who smoke, offering residents who smoke a cessation program, staff education, and resident supervision) noting a corrective action plan. The IJ was removed on December 21, 2018, at 3:25 PM. An immediate jeopardy (IJ) was identified at 42 CFR§ 483.12, Freedom from Abuse, Neglect, and Exploitation, F600 on December 11, 2018 at 6:25 PM. The facility's Administrator provided a letter with supportive documentation (to include: one-to-one monitoring of several residents, follow up review of incidents specific residents identified by the State Agency, review of resident-to-resident altercations reported to the State Agency within the last 30 days, revision of	L 000	A 1. Resident #319, #26, #63 have consented to the new smoking policy and acknowledged understanding the policy. They agreed to be searched for smoking paraphernalia in their respective rooms and person. Their care plans have been updated with new smoking assessments and signed acknowledgements of the policy. B. 1. Resident #53's care plan for elopement was revised with appropriate interventions 1/8/19 to prevent recurrence. C. 1. Resident #112 is refusing any and all recommendations for professional help regarding his alcohol consumption. A care plan meeting was held with him, including the Regional Director Social Service, The Administrator and the Ombudsman in attendance 1/11/19. Resident admits drinking and that he enjoys drinking as this been part of his family living all his life, and that he will continue to drink. He agreed that he will not drink while in the facility premises, as well as allowing staff to search him and his room randomly. He also stated that he will allow staff to assist him back to his room to keep him safe when he knows that he has been drinking while in the community. He realizes that he can hurt himself or someone else when he is inebriated, but his care plan will allow staff to closely monitor and even provide 1-on-1 supervision when necessary. 2. **Residents with the potential to be affected**	1/28/19 1/8/19 1/11/19

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Nora J. Weyan — TITLE: Administrator — (X6) DATE: 2/5/19

(CONTINUATION)
The smoking policy of the facility has been changed. All smokers have been assessed and will continued to be assessed and will be considered "Dependent Smokers" and will not be able to carry either tobacco and/or incendiary devices at any time. All smoking is being supervised as determined by the facility.

3.Systemic changes to be implemented

- The smoking policy was revised as of December 21, 2018.
- All smokers are now considered Dependent Smokers and will not be able to carry either tobacco or incendiary devices at any time.
- All smoking will be supervised as determined by the facility.
- All smokers and/or their responsible party are required to acknowledge and sign off on the new smoking policy.
- With residents permission as evidenced by the signed acknowledgement, residents, will be searched each shift and upon return from outing/LOA from the facility for smoking materials.
- Failure to abide by the new smoking policy will result in Notice of Infraction which will allow 7 day grace period to comply with the smoking policy.
- If a resident continue to be non-compliant the resident will be issued a 30-day involuntary discharge notice.
- The new Smoking Policy will be included in the facility's admission package and reviewed with each resident upon admission.
- Staff was in-serviced on this policy and completed 12/14/18.
- Care plan meetings will be held to address any violation of the policy and to assist with resident(s) understanding of the expectation of the smoking policy.

4. To sustain and maintain compliance

- The Clinical Managers will present the results of their daily auditing to the Director of Nursing.
- The Director of nursing will report results of this audit and monitoring to the QAPI Committee that meets every month, and is chaired by the Nursing Home Administrator.
- The Director of Nursing will present this
- report to QAPI for three (3) consecutive months, and Quarterly thereafter.
- The QAPI committee will determine compliance.

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L 000	Continued From page 1 the Abuse policy and staff education) noting a corrective action plan and the IJ was removed on December 21, 2018, at 3:25 PM. A complaint investigation (DC00004200, C-19-010) was also conducted during the survey period of December 3, 2018 through December 14, 2018. A complaint investigation (DC00004200, C-19-010) was also conducted during the survey period of December 3, 2018 through December 14, 2018. The following is a directory of abbreviations and/or acronyms that may be utilized in the report: Abbreviations AMS - Altered Mental Status ARD - Assessment Reference Date AV- Arteriovenous BID - Twice- a-day B/P - Blood Pressure cm - Centimeters CFR- Code of Federal Regulations CMS - Centers for Medicare and Medicaid Services CNA- Certified Nurse Aide CRF - Community Residential Facility CRNP- Certified Registered Nurse Practitioner D.C. - District of Columbia DCMR- District of Columbia Municipal Regulations	L 000		

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L 000	Continued From page 2	L 000		

D/C Discontinue
Dl - deciliter
DMH - Department of Mental Health
EKG - 12 lead Electrocardiogram
EMS - Emergency Medical Services (911)
G-tube Gastrostomy tube
HR- Hour
HSC - Health Service Center
HVAC - Heating ventilation/Air conditioning
ID - Intellectual disability
IDT - interdisciplinary team
LPN- Licensed Practical Nurse
L - Liter
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
mm/Hg - millimeters of mercury
MN midnight
Neuro - Neurological
NP - Nurse Practitioner
O2- Oxygen
PASRR - Preadmission screen and Resident Review
Peg tube - Percutaneous Endoscopic Gastrostomy
PO- by mouth
POA - Power of Attorney
POS - physician ' s order sheet
Prn - As needed
Pt - Patient
Q- Every
QIS - Quality Indicator Survey
RD- Registered Dietitian
RN- Registered Nurse
ROM Range of Motion

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L 000	Continued From page 3 Rp, R/P - Responsible party SCC Special Care Center Sol- Solution TAR - Treatment Administration Record	L 000	1. All previously reported incidents involving residents cited (Residents #s, 10, 24, 32, 62, 63, 89, 103, 104, 151, 159, 164, 235, and 297) for possible abuse in October and November 2018 were investigated and the care plans updated with the specific interventions. The incidents will be reviewed and thoroughly completed reflecting root cause analysis and appropriate plans to prevent future recurrence. Resident #24 and Resident #104 were placed on one-to-one. All the incidents related to resident-to-resident altercations and allegations of abuse that were reported to the DOH Department of Health) in the last 30 days were reviewed thoroughly, investigated, documented appropriately, presented to the Interdisciplinary Team for root-cause analysis, and finalized with the results of the investigation including conclusions, and how residents involved will be protected from future incidents, and appropriate update to resident care plan. During survey visit of 12/21/18, all of the residents were reviewed and found to be in compliance.	
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: The facility failed to comply with 42 CFR§ 483.12, Freedom from Abuse, Neglect, and Exploitation. Based on review of clinical records, facility documentation, facility policy, residents and staff interviews, it was determined that the facility failed to identify and conduct thorough investigations of resident-to-resident altercations as a potential for abuse; the facility failed to implement measures to protect each resident involved in the incidents; and failed to substantiate or un-substantiate whether the residents were physically or verbally abused for 13 of 87 sampled residents (Residents' #10, #24, #32, #62, #63 #89, 103, #104, #151, #159, 164, #235 and #297). Based on the facility's failures, the Administrator was informed that the facility was in Immediate Jeopardy (IJ)-"L" was identified at 42 CFR§ 483.10 Abuse, Neglect, and Exploitation on December 11, 2018 at 6:35 PM.	L 001	**2. To identify residents with the potential to be affected** Residents involved in verbal resident-to-resident altercations and other alleged abuse incidents within the last 30 days were reviewed and investigated as allegations abuse, with recommendations for new interventions as appropriate. Other reports of alleged abuse were investigated, with appropriate documentation, interviews and witness statements obtained as part of the process, presented to the Interdisciplinary Team for root-cause analysis, and finalized results of the investigation including conclusions drawn. A new system of reporting incidents have been implemented to ensure that resident to resident verbal altercations are reported as abuse, and investigated appropriately.	12/21/18 12/14/18

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L 001	Continued From page 4 The findings included: On December 11, 2018, at 6.35 PM an Immediate Jeopardy (IJ)-"L" was identified at 42 CFR§ 483.10 Abuse, Neglect, and Exploitation. On December 11, 2018 at 7:05 PM, the facility's Administrator provided a letter to the State Agency Survey team documenting the corrective action plan, which included investigations of previously reported incidents involving Residents' # 10, #24, #32, #89, #104, #151, #159, #235 and #297 for possible abuse in October and November 2018. The incidents will be reviewed and thoroughly completed reflecting root cause analysis and appropriate plans to prevent recurrence. Resident # 24 and Resident #104 were placed on one-to-one. All incidents related to resident-to-resident altercations and allegations of abuse that have been reported to the Department of Health in the last 30 days will be review thoroughly, investigated, documented appropriately, presented to the Interdisciplinary Team for root-cause analysis, and finalized with the results of the investigation including conclusions from the process, how resident(s) involved will be protected from future incidents, and appropriate update to resident care plans. The facility's Abuse Policy was updated and submitted to the survey team on December 10, 2018. All incidents occurring within the facility will be reviewed, analyzed, and completed according to the Incident Reporting and Abuse policies. Department Heads, IDT [interdisciplinary team] Members and nursing staff will be in-serviced on this updated policy by 12/14/18. The Nursing	L 001	**3. Systemic Changes to be implemented** • Facility staff was in-serviced on the definition of Abuse to include resident to resident verbal altercations, per CMS. • Abuse policy has been updated • Assistant Directors of Nursing, Clinical Managers and Nursing Supervisors will review incident reports daily and start the investigation process. The results of findings will be reported to the Director of Nursing and Administrator. • An Incident Log was developed to review incidents daily for previous 24 hours, to identify root-cause analysis and to validate for accuracy and completeness of the incident reported. • Director of Nursing, Clinical Managers, and other members of the IDT team provide input, recommendations and identify new interventions to be implemented. • Clinical managers or designee will audit • Incident log daily to ensure compliance with facility policy. • The result of their findings will be reported to the DON, and Administrator. **4. To maintain and sustain for compliance** • The facility Abuse Coordinator, who is the Director of Nursing will report the results of this findings/audit on allegations of abuse monthly to the QAPI Committee, which is chaired by the Nursing Home Administrator monthly. • The Director of Nursing will present the audit report at the QAPI Committee meeting for three (3) consecutive months for compliance. • The QAPI committee will determine compliance.	12/14/18 & Ongoing 2/7/19 Monthly & Quarterly

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L 001	Continued From page 5 Quality Improvement Committee will maintain a log of the review of the incidents to identify trends and patterns of care issues and report their findings to the Director of Nurses. The Director of Nurses will review the log and present his findings with any action plans for Improvement to the Quality Assurance and Performance Committee ..." The IJ was abated after the team verified that the plan of correction was in place on December 21, 2018, at 3:25 PM, the Immediate Jeopardy was removed. Consequently, the State Agency amended the scope and severity of the deficient practice to an "F." Facility Policy Policy Title: OPS-346 Abuse, Neglect, Mistreatment, Exploitation, and Misappropriation of Resident Property Revised 10/27/17 stipulates, "A. This facility upholds resident rights to be free and strictly prohibits and prevents verbal, sexual, physical, and mental abuse of residents ... B. Residents shall not be subject to abuse by anyone including but not limited to facility staff, other residents... C. It is the policy of the facility to immediately report and thoroughly investigate all allegations of mistreatment, neglect, abuse, misappropriation of resident's property or any injury of unknown origin. Definition of Abuse: 1.Abuse means the willful infliction of injury, measurable unreasonable confinement,	L 001		

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L 001	Continued From page 6 intimidation, or punishment with resulting physical harm or pain or mental anguish or deprivation by an individual, including caretaker, of goods or services that are necessary to attain or maintain physical, mental and psychosocial well-being... 4. Physical abuse includes hitting, slapping, pinching, kicking, etc. It also includes controlling behavior through corporal punishment. Identification: A. Facility staff will be trained to report any oral or written reports of alleged neglect, abuse, mistreatment, and misappropriation of resident's property. Facility staff must also report injuries of unknown etiology. Investigation: A. The administrator of designee person will report alleged incident immediately to the regulatory agency of that Facilities respective jurisdiction. B.A thorough investigation will be initiated immediately for all alleged incidents of abuse involving staff members, residents, family and/or visitors who have potential knowledge of the incident or its circumstances ...D. The Administrator/designee will make all reasonable efforts to thoroughly investigate and address all alleged reports, concern and grievances presented to them, and prevent further potential abuse, neglect ...while the investigation is in process .... 2. Upon receiving reports of physical or sexual abuse, the supervising nurse shall immediately examine the resident ...3. The supervisor or charge nurse must report the incident to the Administrator, and Director of Nursing Services and/or Social Worker immediately. 5. Written	L 001		

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L 001	Continued From page 7 statements from all staff present during and/or involved in the incident will be submitted to the nursing supervisor ... Resident-to-Resident Interaction If a resident is observed being aggressive or exhibiting any form of verbal, physical, or sexual abuse behavior toward another resident, immediate action will be taken to stop alleged abuse and remove the resident from danger. LPN or RN in charge will assess the residents for injury and record findings of the examination. "In the event, upon investigation, it is determined that the incident is the result of [inappropriate behavior] from a facility resident, the resident's behavior will be discussed with the resident's family/responsible party, attending physician, and other members of the health care team. Alternate measures to reduce inappropriate behavior such as counseling, medication, or psychiatric evaluations the will be followed as recommended. Note: It is the responsibility of the facility to report such incidents and it is the responsibility of the local and state agencies to determine if actual abuse, neglect or mistreatment of each individual has occurred. Protection of the Resident A. The resident will receive measures to ensure his or her immediate safely ...C. Means of providing protection include, but are not limited to: Move resident to another room or unit. Provide one to one monitoring as appropriate. Suspension of staff members as indicated pending investigation ...monitor of the resident's physical environment ..."	L 001		

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L 001	Continued From page 8 The following are examples of residents involved in a physical altercation(s) documented by the facility: 1. Resident #89 slapped Resident #10 A review of the Facility Reported Incident (FRI) on 12/4/2018, at 11:00 AM showed: "At 2:40 PM, Resident #10 was sitting in the hallway in front of 3N nurses station, Resident #89 was passing by Resident #10 grabbed her hand and refused to let go, so Resident #89 slapped her." There were no investigation statements present with FRI, the resident's care plans were not updated to include interventions regarding this incident, the resident's behaviors and not care planned for abuse. A review of Resident # 89's Quarterly MDS (Minimum Data Set) dated 9/25/18 showed the resident has diagnoses which include manic depression, end-stage renal disease, diabetes mellitus, and hypertension. Under Section C (Cognitive Patterns) the resident's Brief Interview for Mental Status was "15" indicating the resident is cognitively intact. Under Section E0200 (Behavioral Symptom Presence and Frequency the resident had verbal behavior symptoms directed towards others (e.g., threatening others, screaming at others, cursing at others) and other behavioral symptoms not directed toward others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual, acts disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal	L 001		

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L 001	Continued From page 9 symptoms like screaming disruptive sounds). Under Section G (Functional Status), the resident required supervision and set up help (no supervision to go off unit). A review of Resident # 10's Quarterly MDS dated 8/21/18 showed the resident has diagnoses which included Dementia, Cerebral Vascular Accident, Traumatic Brain Injury and Schizophrenia. Under Section C (Cognitive Patterns) the resident's Brief Interview for Mental Status was "99" indicating resident was unable to complete assessment. The resident had no behavioral symptom present under Section E0200. Under section G (Functional Status) the resident was coded for extensive assistance with one to two-person assistance required for all Activities of Daily Living and required supervision for locomotion on unit -oversight, encouragement or cueing one person assist. There was no evidence facility appropriately intervened to prevent future episodes of abuse occurring. 2. Resident #24 punched Resident #151 in her chest. Resident #24 was admitted to the facility on March 04, 2010, with diagnoses which included Anemia, Hypertension, Gastroesophageal Reflux Disease, Diabetes, Thyroid Disorder and Dementia, Psychotic Disorder, Anxiety Disorder and Obsessive Compulsive Disorder. A review of Resident #24's Annual Minimum Data Set dated March 1, 2018, under Section C	L 001		

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L 001	Continued From page 10 (Cognitive Patterns) showed a Brief Interview for Mental Status Score of "14" which is an indication that the resident is cognitively intact and able to make decisions. Under Section G0110 Activities of Daily Living (Functional Status) the resident is coded as needing no assistance for bed mobility or transfer. She needs physical assistance from one person in the form of supervision/oversight, encouragement or cueing for walking in her room, supervision in toilet use, limited assistance in personal hygiene and extensive assistance in dressing. She eats independently but requires physical help in bathing and ambulates with a walker. Under Section E100 Behavior (Potential behaviors of Psychosis) the resident is coded as displaying verbal behavioral symptoms (threatening, screaming, cursing at others) to others and also displaying disruptive behaviors. Review of Resident #24's care plans failed to reveal any evidence of care plans with goals and interventions to protect the resident from resident-to-resident abuse and deter future altercations. Resident #151 was admitted to the facility on December 7, 2012 with diagnoses which included Coronary Artery Disease, Hypertension, Diabetes Mellitus, Chronic Obstructive Pulmonary Disease and Respiratory Failure. A review of Resident #151's Annual Minimum Data Set (MDS) dated July 20, 2018 showed a Brief Interview for Mental Status (BIMS) score of 15 which is an indication that the resident is cognitively intact and able to make decisions. Under Section G0110 Activities of Daily Living (Functional Status) the resident is coded as	L 001		

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L 001	Continued From page 11 needing extensive physical assistance from one (1) person for bed mobility, transfer, walking in room, dressing, personal hygiene and limited assistance for toilet use. The resident is totally dependent on staff for bathing. She needs setup help for eating but eats independently. She uses a wheelchair and is independent with locomotion on the unit but requires supervision oversight and set up assistance when off the unit. Review of Resident #151's care plans failed to reveal any evidence of care plans with goals and interventions to protect the resident from resident-to-resident abuse and deter future altercations. Review of the facility's incident report showed that on November 17, 2018, Resident #24 punched Resident #151 (an elderly woman who sits in a wheelchair) in her chest because she did not give her a cigarette. During a face-to-face interview with Resident #151 on December 12, 2018 at 11:00 AM. The resident explained that the incident was unprovoked. She stated that while she was sitting in her wheelchair in the hallway Resident #24 walked over and said, 'Give me a cigarette.' and when she responded that she did not have a cigarette, Resident #24 struck her in the chest with her fist. A face-to-face interview was also conducted with Employee #4 at approximately 3:00 PM on December 12, 2018. The employee acknowledged that most of the residents usually	L 001		

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L 001	Continued From page 12 have misunderstandings with each other but he never thought of them as abuse because they are usually friendly with each other shortly after the altercations. The facility staff failed to identify the altercation as a form of resident-to-resident abuse. Employee #4 acknowledged the finding. 3. Resident #297 and Resident #24 Resident #297 had a physical altercation with Resident #24 on October 02, 2018. The Resident #297 grabbed the resident's walker and pushed her to the ground. Resident #297 told the staff that Resident #24 kept following him and asking for cigarettes. Resident #297 was admitted to the facility on June 24, 2013, with diagnoses which included Dementia, Depression and Schizophrenia. A review of Resident #297's Annual Minimum Data Set dated May 17, 2018 showed a Brief Interview for Mental Status score of "13" which is an indication that the resident is an indication that the resident is cognitively intact and able to make decisions. Under Section G0110 (Functional Status) the resident is coded as independent for bed mobility, transfer, walking in the room and in the corridor, locomotion on the unit. The resident requires extensive physical assistance from one person for personal hygiene and physical support from one person for bathing. According to the MDS the resident displays aggressive and threatening behavior and screams and curses at	L 001		

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L 001	Continued From page 13 others. Review of Resident #297's care plans failed to reveal any evidence of care plans with goals and interventions to protect the safety of all residents and prevent further incidents of verbal and/or physical abuse. On December 12, 2018 at 3:00 PM, Employee #4 acknowledged that facility staff failed to identify the resident-to-resident incident as an altercation and develop strategies to prevent further episodes. 4. Resident #63 and Resident #164 According to Facility Reported Incident Resident #63 was involved in a verbal altercation with another resident (Resident #164) on March 15, 2018. One of the two residents called Metropolitan Police. The police arrived at the facility, interviewed both residents and left without filing any charges on either resident. No information was given to the facility. Resident #63 was admitted to the facility on March 20, 2017 with diagnoses which included Anemia, Chronic Obstructive Pulmonary Disease, and Psychotic Disorder. A review of Resident #63's Annual Minimum Data Set (MDS) dated March 15, 2018 showed a Brief	L 001		

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L 001	Continued From page 14 Interview for Mental Status score of "13" which is an indication that the resident is cognitively intact and able to make decisions. Under Section G0110 Activities of Daily Living (Functional Status) the resident is coded as independent and not requiring any assistance in performing the following activities of daily living: Bed Mobility, Transfer, Walk in the room and/or corridor, Locomotion off unit, dressing and eating. He does however, require set up help from staff when he uses the toilet and requires extensive physical assistance from one person (providing weight bearing support) during personal hygiene, (bathing, shaving, brushing teeth etc.) Review of Resident #63's care plans showed no evidence that the incident was identified as abuse or the development of plans with goals and interventions to prevent further episodes in the future. A face-to-face interview was conducted with Resident #63 at approximately 2:00 PM on December 12, 2018. When asked about the incident with the police the resident said he did not want to talk about but added that he has known the Resident (Resident #164) for a long time and "Now she is funny." Resident #164 was admitted to the facility on June 27, 2018, with diagnoses which included GERD (Gastroesophageal Reflux Disease), Hyperlipidemia and DM (Diabetes Mellitus). A review of Section C400 of the annual Minimum	L 001		

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L 001	Continued From page 15 Data Set (MDS) with an admission Assessment Reference Date of July 04, 2018 showed a Brief Interview for Mental Status (BIMS) score of "14" which is an indication that the resident is cognitively intact and able to make decisions. Under Section G0110 Activities of Daily Living (Functional Status) the resident is coded as requiring extensive assistance in performing the following activities of daily living: Bed Mobility, Transfer, dressing, personal hygiene and toileting; requires supervision and set up for Locomotion and uses a wheelchair, hygiene and toileting and needs physical help and support for bathing. Resident #164 refused to be interviewed by this Surveyor. Review of Resident #164's care plans showed no evidence that the incident was identified as abuse or the development of plans with goals and interventions to prevent further episodes in the future. During a face-to-face interview with Employee #4 at approximately 3:00 PM on December 12, 2018, the employee stated that the residents have arguments and disagreements one day and get friendly the next day. The employee acknowledged that the facility staff failed to identify the altercation as a form of resident-to-resident abuse. 5.Residents' #62 and #103 According to the facility's report Resident #62 and Resident #103 were involved in a verbal	L 001		

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L 001	Continued From page 16 altercation on September 10, 2018. Both residents were residents were heard yelling and shouting expletives at each other and threatening to fight. Resident #62 was admitted to the facility on October 02, 2014 with diagnoses which included DVT (Deep Vein Thrombosis), Hypertension, GERD (Gastroesophageal Reflux Disease, Arthritis, Depression, COPD (Chronic Obstructive Pulmonary Disease) and Respiratory Failure. A review of Section C400 of Resident #62's annual MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of April 05, 2018 showed a BIMS (Brief Interview for Mental Status) score of "15" which is an indication that the resident is cognitively intact and able to make decisions. Under Section G0100 Activities of Daily Living (Functional Status) the resident is coded as needing extensive physical from two or more persons for bed mobility. She is totally dependent on two or more staff for transferring. She needs extensive assistance from one staff for dressing, bathing and personal hygiene and is totally dependent on two or more staff for toileting. The resident eats independently and uses a wheelchair. No behavior issues were coded on the MDS. Resident #103 was admitted to the facility on April 14, 2011 with diagnoses which included BPH (Benign Prostatic Hypertrophy), Depression and Manic Depression. A review of Section C400 of Resident #103's annual MDS (Minimum Data Set) with an ARD	L 001		

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L 001	Continued From page 17 (Assessment Reference Date) of July 12, 2018, showed a BIMS (Brief Interview for Mental Status) score of "15" which is an indication that the resident is cognitively intact and able to make decisions. Under Section G0100 Activities of Daily Living (Functional Status) the resident is coded as independent in all areas. He is classified as being unsteady on transferring, turning, walking and getting on and off toilet but stabilizes self without assistance. The resident eats independently and uses a wheelchair. Under Section E Behavioral Symptoms the resident classified as directing symptoms toward self rather than towards others and rummaging. Nursing notes describes the resident as hoarding food and other items. Review of the documentation on the incident report and on the Progress Notes indicated that both residents were in the hallway verbally abusing each other. Upon observation the residents reside in adjacent rooms and both are wheelchair bound. The psychologist and family members were notified but no care plans with goals and approaches were implemented to decrease and/or prevent future episodes. A face-to-face interview was conducted with Employee #4 at approximately 3:00 PM on December 12, 2018. The employee acknowledged that the facility failed to classify and treat the resident-to-resident altercation as an abuse. 6. Resident #104	L 001		

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L 001	Continued From page 18 Resident# 104 was admitted to the facility on 3/13/18 with diagnoses which include Unspecified Dementia without Behavioral Disturbance, Major Depressive Disorder, Essential (Primary) Hypertension, Peripheral Vascular Disease and Acquired Absence of Left Leg above the Knee and Other Psychoactive Substance Abuse, Uncomplicated. Review of the Comprehensive Minimum Data Set [MDS] dated 9/18/18 on 12/11/18 at 11:00 AM showed Section C [Cognitive Patterns] Brief Interview for Mental status [BIMS] was scored as "13" which indicate cognitively intact. Review of the Resident #104 care plan showed focus: "Resident has a behavior problem r/t (related to) cursing, yelling and using profane language on staff and residents; goal Resident#104 will have fewer episodes of refusal x 90 days, will have fewer episodes of disagreement with his roommate during the next 90 days." Interventions include: "Anticipate and meet needs, monitor the relationship between resident and his roommate, educate family/caregivers on successful coping and interaction strategies encouragement and active support by family/caregivers when resident use these strategies, explain all procedures to before starting to adjust to changes, intervene as necessary to protect the rights and safety of others. Approach/speak in a calm manner, resident was instructed to stay away from the other resident by police officer, offered a room/unit change but he declined, resident verbalized that he will stay away from the other resident." Resident #104 was involved in physical or verbal altercations with the following residents:	L 001		

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L 001	Continued From page 19 Resident #159 was admitted to the facility on 6/24/13, with diagnoses which include Parkinson's Disease, Anxiety Disorder, Peripheral Vascular disease, Schizophrenia, Unspecified, Restlessness and Agitation. Review of the Comprehensive Minimum Data Set [MDS] dated 10/9/18 on 12/11/18 showed Section C [Cognitive Patterns] Brief Interview for Mental status [BIMS] was scored as "8" which indicated cognition moderately impaired. Resident #235 was admitted to the facility on 8/7/14 with diagnoses which include Chronic Obstructive Pulmonary Disease, Edema, Allergic Rhinitis, Major Depressive Disorder, Dyspnea, and Hyperlipidemia. Review of the Comprehensive Minimum Data Set [MDS] dated 10/9/18 on 12/11/18 showed Section C [Cognitive Patterns] Brief Interview for Mental status [BIMS] was scored as "99", indicating the interview could not be completed. Resident #32 was admitted to the facility on 8/27/18 with diagnoses to included Bipolar Disorder, Hyperlipidemia, Cerebral Infarction (Unspecified). Review of the Comprehensive Minimum Data Set [MDS] dated 9/18/18 AM showed Section C [Cognitive Patterns] Brief Interview for Mental status [BIMS] was scored as "13" which indicate cognitively intact. Review of the facilities investigative reports showed Resident #104 was involved in multiple	L 001		

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L 001	Continued From page 20 resident-resident altercations to include physical or verbal abusive with Resident# 32, #159 and Resident #235. A review of the facility investigative report dated 10/3/18 showed "at about 3:10 PM it was reported by Assistant Director of therapy, that Resident #104 had physical altercation with Resident #235 while they were in the elevator, Resident was asked what happened while they were in the elevator and the resident said "I am not allowed to talk to other people, you want to start some s ...with me now." Another facility investigative report dated 10/15/18 showed "at 1:45 PM, it was reported the Resident# 104 got in to physical altercation with his roommate [Resident# 159], he was on top of him grabbing and hitting him. Resident #104 verbalized being taken by surprise and verbalized they were both using profanity towards each other." Behavior note dated 11/27/18 showed Resident #104 was noted "cursing Resident #32 in the hall way, both were screaming, yelling at each other, they were separated and redirected." Review of Resident #235 medical record identified the following the following dates of physical/verbal abuse to residents and staff: Incident note dated 10/3/18, Assistant Director of therapy reports" resident was involved in a verbal altercation with Resident# 104, while they were in the elevator." Behavior note dated 10/6/18, "Resident refused care and assign Certified Nursing Assistant (CNA) attempted X3, resident was cursing saying	L 001		

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L 001	Continued From page 21 f ...you go clean yourself." Verbally abusive note dated 10/18/18, "Resident was heard yelling and cursing to the CNA, while the CNA was passing the snack, Resident stated f ...that food." Verbally abusive noted dated 10/20/18," Resident was sitting in the hallway in front of the nurse's station and heard saying get this stinking s ...from here she has to go back to her floor. Resident was redirected and told not to insult other residents and he responded I don't care." A further review of the medical record showed an Interdisciplinary note dated 10/30/18, "resident has behavior of noncompliance with medication and behavior of verbally abusive to staff." A review of the care plan failed to show physical/verbal abuse as an area of focus, hence there were no listed goals, approaches or specific interventions to address the resident's physical/verbal behavior toward other residents and staff. There were no investigative statements present with Facility Reported Incidents [FRI's], the resident behaviors were not care planned as abuse. Interview with the Facility's Investigator (Employee #2, Director of Nursing) During a face-to-face-interview on 12/11/18 at 1:45 PM, Employee #2 (the Facility's Abuse Investigator and Director of Nursing Services) who stated, "I investigated all incidents as	L 001		

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L 001	Continued From page 22 resident-to-resident abuse. I talk to the residents, I am not writing down the conversations, we do not write down the resident's statement, I do no write if the investigation was substantiated or unsubstantiated, the grievance form was not used." Based on record and policy review and staff interview, there is no evidence that after the facility recorded resident-to-resident altercations that a documented thorough investigation was completed related to the potential for abuse. In addition, there is no evidence that staff implemented measures to protect each resident involved in the incident or developed person-centered care plans with specific interventions for residents involved in the incidents of abuse or alleged abuse; and there is no evidence facility staff substantiated or unsubstantiated if residents where physically or verbally abused by other residents. During a face-to-face interview on December 11, 2018, at 1:45 PM, Employees #1 and #2 acknowledged the findings.	L 001		
L 012	3203.2 Nursing Facilties A list of all employees, with the appropriate current license or certification numbers, shall be on file at the facility and available to the Director. This Statute is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure that persons in charge, who are certified food protection managers, obtained a District of Columbia issued Food Protection Manager Identification Card as evidenced by four (4) of	L 012	1. The four (4) employees are Always complemented by a Manager with certification intact And current.	

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L 012	Continued From page 23 seven (7) persons in charge who did not have a District of Columbia issued Certified Food Protection Manager Identification Card. Findings included ... During record review in Dietary Services on December 3, 2018, at approximately 10:40 AM, four (4) of seven (7) Persons in Charge did not possess a District of Columbia issued Food Protection Manager Identification Card. The 2012 District of Columbia Food Code, section 203.3 of chapter 2 states the following: 2012 District of Columbia Food Code 203 CERTIFICATION AND DISTRICT-ISSUED ID REQUIREMENTS ? FOOD PROTECTION MANAGER, PERSON IN CHARGE 203.3 A person in charge who is a certified food protection manager as required in §203.1 shall obtain a District-issued Food Protection Manager Identification Card (ID Card), issued by the Department, and shall renew the District-issued ID Card every three (3) years. During a face-to-face interview on December 3, 2018, at approximately 10:40 AM, Employee #10 acknowledged the findings.	L 012	2. No residents were affected by this finding. 3. The four (4) employees have been given instruction to apply and Obtain current certification within the next thirty days. The Food Service Manager will ensure all Food Service Supervisors maintain up to date certification. 1/28/19 4. The Food Service Manager will report on current certification of all supervisory staff to the QAPI committee monthly until all certifications are up to date. 2/7/19 Monthly and Quarterly	
L 051	3210.4 Nursing Facilities A charge nurse shall be responsible for the following:	L 051		

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L 051	Continued From page 24 (a)Making daily resident visits to assess physical and emotional status and implementing any required nursing intervention; (b)Reviewing medication records for completeness, accuracy in the transcription of physician orders, and adherences to stop-order policies; (c)Reviewing residents' plans of care for appropriate goals and approaches, and revising them as needed; (d)Delegating responsibility to the nursing staff for direct resident nursing care of specific residents; (e)Supervising and evaluating each nursing employee on the unit; and (f)Keeping the Director of Nursing Services or his or her designee informed about the status of residents. This Statute is not met as evidenced by: A. Based on record review and staff interview for one (1) of 90 sampled residents the charge nurse failed to obtain a physician's order and consent from the resident's Power of Attorney (POA) prior to placing the resident into physical restraints. Resident #348. Findings included . . . Resident #348 was admitted to the facility on August 12, 2016, with diagnoses which include Hypertension, Paraplegia, Quadriplegia, Gastroesophageal Reflux Disease, Depression,	L 051	1.A Physician order and consents from The resident's representative for the Hand mitten and abdominal binder were Obtained upon discovery 2. An audit of residents in the facility identified as having restraints was performed by the DON. Physician orders and consents were obtained for all residents with restraints. 3. The Regional Nurse Consultant in-serviced MDS coordinators and Clinical Managers on what constitutes a "restraint" and the process by which restraint are obtained (e.g., physician orders, signed consents, and proper MDS coding of restraints). Residents with restraints will be reviewed every care plan meeting by IDT to ensure that the restraint is still appropriate for the resident. Findings will be reported to the DON after care plan meetings.	1/1/19 1/22/19

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L 051	Continued From page 25 Manic Depression, Psychotic Disorder and Schizophrenia. A review of Section C400 of the annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of February 05, 2018, showed a Brief Interview for Mental Status (BIMS) score of 04 which is an indication that the resident is not cognitively intact and able to make decisions. Under Section G0110 Activities of Daily Living (Functional Status) the resident is totally dependent on physical assistance from two or more persons for all aspects of care: for bed mobility, transfer, dressing, toilet use, personal hygiene and bathing. She receives all nutrition and medication via tube feeding. The resident was observed lying in bed with hand mittens on both hands and an abdominal binder around the abdomen on December 05, 2018, at 3:19 PM. A review of the clinical record failed to show either a physician's order or consent from the resident's POA. A face-to-face interview was conducted with Employee #5 at approximately 2:00 PM on December 6, 2018. When asked about the physician's order and the consent from the POA for the use of the restraint the employee responded that the mittens and the binder were not restraints but were used to prevent the resident from pulling out her Gastrostomy tube and added that the resident has a history of pulling the tube out. The employee	L 051	4.The DON will report the results of this audit to the QAPI Committee that meets every month, and is chaired by the Nursing Home Administrator.	2/7/19 Monthly and Quarterly

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L 051	Continued From page 26 acknowledged the finding during the interview. B. Based on record review and staff interview for three (3) of 90 sampled residents, the charge nurse staff failed to develop and implement base-line care plans for three (3) residents' within 48-hours of the resident's admission to the facility. Residents' #66, #120 and #405. Findings included... 1. Resident #66 was admitted to the facility on November 23, 2018, with diagnoses which included Dry Gangrene, Atrial Fibrillation, Hyperlipidemia, Anemia, Congestive Heart Failure, Arthritis, Vascular Dementia, and Leukocytosis. Review of electronic clinical record showed that a 48-Hour Baseline Care Plan Assessment was completed by a facility staff member on November 23, 2018, at 12:50 PM. Review of the resident's clinical record failed to show any evidence that the facility developed a baseline care plan with input from the resident and family members that included instructions needed to provide person-centered care to meet professional standards and to address specific goals for the resident's care. Also, there was no evidence that facility staff provided the resident or her representative with a written summary of the baseline care plan in a language that they can understand.	L 051		

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L 051	Continued From page 27 During a face-to-face interview with Employee #9 at approximately 3:00 PM on November 9, 2018, the employee after failing to present a 48-hour base-line care plan acknowledged that the facility staff failed to develop a base-line care plan for Resident #66. 2. Resident #120 was admitted to the facility on September 21, 2018, with diagnoses which included Arthritis, Depression, Bipolar Disorder and Seizure Disorder. Review of Resident #120's clinical record failed to show any evidence that the facility developed a baseline care plan with input from the resident and family members that included instructions to provide person-centered care to address specific goals to meet the resident's needs. Facility staff also failed to provide the resident and/or the representative with a written summary of the care plan in a language that they could understand. A face-to-face interview was conducted with Employee #6 on December 10, 2018, at 12:00 PM. During the interview the employee acknowledged that facility failed to develop the baseline care plan for Resident #120. 3. Resident #405 was admitted to the facility on December 6, 2018, with complaints of generalized weakness and diagnoses of Small Bowel Obstruction and Peritoneal Carcinoma with Metastasis to the Liver.	L 051		

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L 051	Continued From page 28 Review of the clinical record showed that the facility completed a comprehensive assessment of the resident. However, there was no evidence to show that the facility developed a baseline care plan with input from the resident and family members that included instructions to provide person-centered care to address specific goals to meet the resident's needs. Facility staff also failed to provide the resident and/or the representative with a written summary of the care plan in a language that they can understand. A face-to-face interview was conducted with Employee #8 on December 10, 2018, at 12:00 PM. During the interview the employee acknowledged that facility failed to develop the baseline care plan for Resident #405. C. Based on record review and staff interview for two (2) of 90 sampled residents, the charge nurse failed to revise/update care plan after a fall for one (1) resident and failed to update a care plan to include interventions for one (1) resident with Depression. Residents' #14 and # 31. Findings included ... 1.Resident #14 was admitted to the facility on 2/19/18, with diagnoses which include Chronic Venous Hypertension, Hyperlipidemia, Schizophrenia, Muscle Weakness, History of Falling and Restlessness and Agitation. Review Resident #14's Quarterly Minimum Data	L 051		

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L 051	Continued From page 29 Set [MDS] dated 8/22/18, on 12/13/18, at 1:00 PM showed Section C [Cognitive Patterns] a Brief Interview for Mental Status [BIMS] with a score of "15" which indicate cognitively intact. Section G [Functional Status] resident is coded as "1" supervision (oversight, encouragement or cueing) for locomotion on and off the unit. Section J1800 [Falls] is coded as "1" which indicate resident had a fall since admission, entry or reentry whichever is more recent. A further review of Resident #14's medical record showed an Incident Note dated 10/18/18, "residents' roommate called at the nursing station saying resident was on the floor, writer went into the room and found resident sitting on the floor between both beds, no injury noted." Review of the care plan showed focus Resident is a high risk for falls related to Confusion and Gait/balance Problems dates of falls are recorded as: 4/30/18 5/11/18 6/4/18 8/2/18 10/5/18 During an interview on 12/13/18, at 1:00 PM, Employee #7 stated we document all the resident's falls and update the care plan, we missed that fall it's not on the care plan. Facility staff failed to revise/update care plan with goals and approaches after resident sustained a fall with no injury.	L 051		

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L 051	Continued From page 30 During a face-to-face interview on 12/13/18, at 1:00 PM, Employee #7 acknowledged the finding. 2. Resident #31 was admitted to the facility on 12/13/17, with diagnoses which include Major Depressive Disorder, Hypotension, Unspecified, Ascites, Hyperparathyroidism, Unspecified, Insomnia. During a resident interview on 12/13/18 at 10:30 AM, observed resident sitting on the bed in a dimly lit room, looking downward resident stated, I used to participate in activities but not anymore, I mostly stay in my room. Review of Resident #31 Quarterly Minimum Data Set [MDS] dated 9/1/18 on 12/13/18 at 11:00 AM showed Section C [Cognitive Patterns] Brief Interview for Mental status [BIMS] was scored as "15" which indicate cognitively intact. Section D [Mood] D0200. Resident Mood Interview showed over the past two weeks resident did not exhibit any problems related to mood, total severity score was "00." Review of Resident #31 Behavior Assessment notes dated 1/19/18 showed "resident experiences psychotic symptoms and depressed mood symptoms, psychologists recommends reduced stimulation from environment such as lower and softer sounding music, traditional television programming for her age, also bright rather than dim lighting to avoid pseudohallucinations (an imaginal experience) or hallucinations related to dark areas in her vision field, recommends soothing and softer communication form staff and reduced social interaction in the milieu may be indicated	L 051		

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L 051	Continued From page 31 especially if over stimulated". A further review of the therapy note showed "care coordination, plan to assist staff and her providers in the provision of treatment as the patient's mental health issues are chronic and requiring of continued care". Review of Behavior Assessment noted dated 8/10/18 showed recommendations/plan: pt. (resident) reported significant stressors in her life, coping skills are not sufficient to manage current stressors, she (resident) becomes frustrated, depressed, irritable. Review of Behavior Assessment note dated 9/14/18 showed she (resident) reported feeling depressed, denied suicidal ideation, Recommendations/plan: cognitive therapy to address coping strategies, supportive therapy. Review of Behavior Assessment notes dated 11/5/18, care coordination: "plan to continue to assist staff and her prescriber in the provision of treatment to truncate severity of symptoms and duration so that chronicity can be avoided." A review of Resident #31 behavior modification sheets for the months of July, August, September 2018 showed a behavior code of "7" which indicate "continuous crying", and October and December 2018, showed a behavior code of "12" which indicate "Depressed, withdrawn." During an interview on 12/13/18, at 11:00 AM, Employee #6 states the resident is depressed and staff are to record the president's behavior and document how often the resident is crying or appears depressed, I don't see the sheet for November [2018].	L 051		

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L 051	Continued From page 32 A review of the medical record did not show a care plan for Depression with goals, approaches or specific interventions to address the resident's Depression. Facility staff failed to update care plan to include goals and approaches with specific interventions for resident with Depression. During a face-to-face interview on 12/13/18, at 11:00 AM, Employee #6 acknowledged the finding.	L 051		
L 052	3211.1 Nursing Facilities Sufficient nursing time shall be given to each resident to ensure that the resident receives the following: (a)Treatment, medications, diet and nutritional supplements and fluids as prescribed, and rehabilitative nursing care as needed; (b)Proper care to minimize pressure ulcers and contractures and to promote the healing of ulcers: (c)Assistants in daily personal grooming so that the resident is comfortable, clean, and neat as evidenced by freedom from body odor, cleaned and trimmed nails, and clean, neat and well-groomed hair; (d) Protection from accident, injury, and infection; (e)Encouragement, assistance, and training in self-care and group activities;	L 052	1.Resident #151's concern was addressed immediately. This resident was not scheduled for Physical Therapy at the time she verbalized this concern to the surveyor. She however was receiving Restorative Nursing Care and did not miss her Restorative session 12/6/18. Resident has received her permanent battery 1/8/2019, from the vendor to charge her motorized wheelchair.	

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L 052	Continued From page 33 (f)Encouragement and assistance to: (1)Get out of the bed and dress or be dressed in his or her own clothing; and shoes or slippers, which shall be clean and in good repair; (2)Use the dining room if he or she is able; and (3)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: A.Based on observation, resident and staff interview for one (1) of 90 sampled residents, sufficient nurse staffing was not given to accommodate the resident's need for an operable wheel chair in order to attend physical therapy and participate in activities. Resident #151. Findings included . . . Resident # 151 was admitted to the facility on December 7, 2012, with diagnoses which	L 052	**2. To identify other resident with the potential to be affected.** The facility nevertheless reviewed the list of residents with motorized wheelchairs to determine if any other residents could be affected. No other resident was identified as having a need for wheelchair maintenance. This list will be maintained in the Rehab and Maintenance departments so that any residents needing repairs of their wheelchairs will be addressed and documented immediately. **3. Systemic changes to be implemented** • Nursing leadership team, including assistant directors of nursing, clinical managers, nursing supervisors, will update the list of residents who have wheelchairs needing repairs and report findings to Director of Nursing. • Nursing staff have been in-serviced to report wheelchair malfunctioning to the Rehab and Maintenance departments.	

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L 052	Continued From page 34 included Coronary Artery Disease, Hypertension, Diabetes Mellitus, Chronic Obstructive Pulmonary Disease and Respiratory Failure. A review of Section C400 of the Annual Minimum Data Set (MDS) dated July 20, 2018 showed a Brief Interview for Mental Status score of "15" which is an indication that the resident is cognitively intact and able to make decisions. Under Section G0110 Activities of Daily Living (Functional Status) the resident is coded as needing extensive physical assistance from one (1) person for bed mobility, transfer, walking in room, dressing, personal hygiene and limited assistance for toilet use. The resident is totally dependent on staff for bathing. She needs setup help for eating but eats independently. She uses a wheelchair and is independent with locomotion on the unit but requires supervision oversight and set up assistance when off the unit. During a face-to-face interview with Resident #151 on December 6, 2018, at approximately 11:30 AM the resident stated that she has not attended physical therapy for two days because she does not have a battery to charge her motorized wheelchair. She further stated she has not had a battery for her chair for about a week and staff has been borrowing chargers from other residents to charge her chair. However, today (other residents) refused to loan their battery. Face-to-face interviews were conducted with the Social Worker and Manager at approximately	L 052	**4. To sustain and maintain compliance** • The Director of Nursing will report the results of the audit to the QAPI Committee monthly at the QAPI meetings for three (3) consecutive months. QAPI committee is chaired by the Nursing Home Administrator. • QAPI will determine compliance and audit will be presented Quarterly by the Director of Nursing thereafter.	2/7/19 Monthly and Quarterly

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L 052	Continued From page 35 December 12, 2018, at 11:00 AM. Both employees confirmed the resident's account and stated that they have spoken with the Rehabilitation Department and are in the process of ordering a charger for the resident. In the meantime a loaner has been obtained for the resident's use until the permanent charger is obtained. Employees' #17 and #4 (Social Worker and Manager) both acknowledged that facility staff failed to accommodate the resident's need for an operable wheel chair in order to attend physical therapy and participate in activities. B. Based on observation, medical record review, resident and staff interviews for three (3) of 90 residents identified as a "Dependent Smokers", sufficient nursing time shall be given to ensure measures were implemented to prevent Resident #319 from keeping in his possession smoking material (cigarettes, lighter) after he was observed smoking in his resident room; and two (2) residents identified as dependent smokers from maintaining smoking materials on their person. The facility staff failed to identify one (1) of 87 residents as an elopement risk, therefore a plan of care was not implemented to help prevent him from eloping. Subsequently, the resident eloped from the facility on September 9, 2018. Also, the facility staff failed to implement a recommendation from the Behavioral Health Specialist to have one (1) of 87 residents attend psychotherapy to address his behavior (drinking alcohol). Subsequently, the resident was found lying on the floor several times related to intoxication and ultimately sustaining harm (Subarachnoid Hemorrhage, Left Supracondylar Fracture and laceration below left eyebrow). Residents' #319, #26, #63, #53 and #112.	L 052		

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L 052	Continued From page 36 Findings included... A. On December 10, 2018, at 6:01PM an Immediate Jeopardy (IJ)-"L" was identified at 42 CFR§ 483.25 (d)(1) Accidents -The environment remains as free of accident hazards as is possible; and 483.25 (d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. On December 10, 2018 at 6:35 PM, the facility's Administrator provided a letter to the State Agency Survey team documenting the corrective action plan, which included: The family of Resident #319 was contacted and it was enforced that he is not to have either cigarettes or incendiary devices on his person or in his room. They acknowledged understanding. The Smoking Policy was revised as of December 21, 2018, (to clarify information related to resident's discharge). All smokers are now considered Dependent Smokers and will not be able to carry either tobacco or incendiary devices at any time. All smoking will be supervised as determined by the facility. The Director of Social Workers, and Administration met with each smoker, their responsible party/guardian to inform them of the new policy, and their acknowledgement and sign off was required. Failure to abide by the facility's policy will result in a Notice of Infraction which will allow a 7 day grace period to comply with the Smoking Policy. If a resident continues to be non-compliant, the resident will be issued a 30-day involuntary discharge notice. All safe smoking recommendations will be included in the care plan process. The Smoking Policy will be included in the admissions packet and reviewed	L 052		

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L 052	Continued From page 37 with each resident upon admission. The resident will be required to sign the acknowledgement of Smoking Policy document. Information in respect to smoking cessation will be provided to encourage wellbeing. The IJ was removed after the State Agency Survey team verified that the plan of correction was in place and being implemented on December 21, 2018, at 3:25 PM, the Immediate Jeopardy was removed. Smoking Policy effective 11/26/18, stipulates, "It is the policy of the Facility to allow Residents the privilege to smoke in a safe manner while restricting smoking to designated areas of the facility grounds, and in compliance with applicable laws. Smoking is prohibited in all enclosed areas of the Facility. The Facility's primary obligation is to provide a safe environment for all residents. Therefore, any resident that does not comply with the facility's smoking rules may be asked to forfeit smoking privileges. If the danger or lack of compliance is serious enough, it may warrant consideration to discharge in accordance with state and federal law." 1.The Resident #319 was admitted to the facility on 8/11/2018, with diagnoses which include Diffuse Traumatic Brain Injury, Other Seizures, Shared Psychotic Disorder, Alcohol Abuse, and Mood Affective Disorder. Review of the Quarterly Minimum Data Set dated November 13, 2018, showed the resident has a BIMS score of "10" indicating he has moderate	L 052		

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L 052	Continued From page 38 cognitive impairment. Section E (Behaviors) showed the resident had no behavioral symptoms, but was coded for wandering. Under Section G (Functional Status), the resident was coded as requiring supervision in bed mobility, transfers, walk-in corridor, dressing and personal hygiene. He had no impairment to his upper and lower extremities and required no mobility devices for ambulation. Review of the medical record showed the following progress noted: October 13, 2018 at 22:22 incident note at 9:23 PM showed, "The facility's fire alarm came on; it was further traced to room 215, where the smoking alarm had triggered. Upon entering the room, nurse could perceive strong cigarette odor and cigarette ashes we noted in the trashcan [flammable receptacle] beside resident. During interview resident denied smoking cigarette resident refused assessment and denied smoking and no obvious injuries noted ..." Transitional Care Center Capital City "Smoking Rules acknowledgement form(s) was signed by the Resident on August 13, 2018 and August 14, 2018. Assessments: "Smoking assessment- August, 11, 2018 -can light his own cigarette, no adaptive equipment needed-does the resident store lighter and cigarette "Smoking assessment - October 16, 2018 - resident caught smoking in room; now not able to light own cigarette and requires supervision- the facility now stores and lights the resident cigarette.	L 052		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 39 Observation and interview with Resident #319 (Room #215B) On December 10, 2018 at approximately 3:20 PM during a tour of 2 North, room 215B, Resident #319 was asked if he still smoked and he said "yes". He was asked if he had any cigarettes or lighter with him and he said "yes" and he pulled out of his coat pocked a pack of Newport 100's and a red lighter. At 3:45 PM on December 10, 2018, a follow up interview was conducted with the Resident in the presence of Employee #2 (DON). At this time, this surveyor observed Resident #319 in the hallway on 2 North. Employee #2 asked him if he had a lighter and Resident #319 nodded his head and showed Employee #2 a red lighter. When asked by Employee #2 where he got the lighter, Resident #319 said that he bought it for a dollar or two yesterday (Sunday, December 9, 2018) when he was out with his niece. When this surveyor asked Resident #319 if he was searched by staff when he returned to the facility he said "no". When Employee #2 told Resident #319 that he had signed a letter saying that he should not have a lighter, Resident #319 said that he was not aware that he was not supposed to have a lighter. Resident #319 also denied that he ever smoked in his room. A face-to-face interview was conducted on 12/10/18, at 5:30 PM with the Administrator, Director of Nursing (DON), Assistant Director of Nursing, and the Clinical Manager. During this time, DON stated the resident is challenge and he is non-compliant with the smoking policy. The	L 052		

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L 052	Continued From page 40 Clinical Manager, present during the interview stated, the social worker has the lighter; we search him at night. Because he is able to go out and his brother takes him out this is how he gets a new lighter. The Clinical Manager and Director of Nursing were asked based on the resident's care plan, how does the facility ensure the resident does not have smoking materials in his possession? The Clinical Manager stated the resident goes to the smoking area and the attendant lights the cigarettes. The Assistant Director of Nursing stated, we search his room when he goes out of the facility. He does not go out [on leave of absence] by himself. The last time he was out of the building was on December 9, 2018, with his brother. The facility failed to show evidence of their approach to monitoring the resident for the possession of smoking materials. Review of Resident #319's care plan last revised on October 15, 2018, showed, "Focus- [Resident #319] is a current smoker. [He] was caught smoking in his room over the weekend. He is considered a dependent smoker. Interventions: SW (social worker) has spoken to [Resident #319] about the episode of smoking in his room. He gave me his lighter and I will be calling his guardian ...to tell him not to bring him any more lighting material in the facility he will now be considered a dependent smoker ...Staff will light [Resident #319's] cigarettes." Review of the Smoker List dated December 10, 2018, Resident #26 in Room #154 and Resident #63 in room #112A were identified as "Dependent Smokers", Per the Facility's "Smoking Rules" the "Dependent Smoker -requires staff, family/friends or physical support or supervision to smoke safely. May need to	L 052		

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L 052	Continued From page 41 wear protective safety equipment when necessary". These residents were observed on December 10, 2018, at approximately 3:30 PM to be in possession of cigarettes and a lighter. Facility staff were not aware that the residents were in possession of these items (cigarettes and lighter). 2.Resident #26 was admitted to the facility on February 16, 2017, with diagnoses which included Acute Kidney Failure, Obesity, Rhabdomyolysis, Unspecified Cerebral Infarct and Cerebrovascular Accident with right sided weakness and identified by the facility as "Dependent Smokers". A review of Section C400 of the annual Minimum Data Set (MDS) with an Assessment Reference Date of November 30, 2018, showed a Brief Interview for Mental Status (BIMS) score of "15" which is an indication that the resident is cognitively intact and able to make decisions. Under Section G0110 Activities of Daily Living (Functional Status) the resident is coded as totally dependent and needing physical assistance from two (2) persons for bed mobility, transfer, toilet use, personal hygiene and bathing. She is able to eat with supervision and support and also manages her motorized wheelchair with supervision and support. During a face-to-face interview with the resident on December 10, 2018, at approximately 3:30 PM the resident informed this surveyor that she had a lighter and two (2) cigarettes in her possession. Employee #4 retrieved the cigarettes and the lighter from the resident.	I. 052		

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L 052	Continued From page 42 The resident signed her acknowledgement of the Smoking Policy on February 16, 2017, (on admission to the facility) and December 18, 2017. Review of the "Smoking Assessment" dated November 19, 2018, showed the resident was assess as a dependent smoker r/t (related to) right side weakness/right arm paralysis and according to the assessment the Resident does need the facility [staff] to store the lighter and cigarettes. Review of the care plan showed that the resident was described as a "Dependent Smoker". The initiation date on the care plan was December 11, 2018, and the focus was that the resident as a dependent smoker would not be able to carry either tobacco or incendiary devices at any time. The goal is that the resident will practice safe smoking while in the facility by abiding with the facility's smoking policies. The interventions included the following: that the resident was to hand over all smoking paraphernalia, submit to searches of person and room every shift, will be given the option of attending smoking cessation classes and may be discharged from the facility if she refuses to adhere to the facility's policies. During a face-to-face interview with Employee #4 at approximately 11:00 AM on December 12, 2018. The employee was asked whether he was aware that the resident had smoking paraphernalia either in her room or on her person. The employee acknowledged that he was unaware that the resident kept smoking paraphernalia in her room and/or her person. Employee #4 also acknowledged at that time that sufficient nursing time shall be given to ensure that Resident #26's environment was free of	L 052		

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L 052	Continued From page 43 cigarettes and other incendiary devices. 3. Resident #63 was admitted to the facility on March 20, 2017, with diagnoses which included Anemia, Chronic Obstructive Pulmonary Disease, and Psychotic Disorder and identified by the facility as "Dependent Smokers" A review of Section C400 of the annual Minimum Data Set dated March 15, 2018, showed a Brief Interview for Mental Status score of '13' which is an indication that the resident is cognitively intact and able to make decisions. Under Section G0110 Activities of Daily Living (Functional Status) the resident is coded as independent and not requiring any assistance in performing the following activities of daily living: Bed Mobility, Transfer, Walk in the room and/or corridor, Locomotion off unit, dressing and eating. He does however, require set up help from staff when he uses the toilet and requires extensive physical assistance from one person (providing weight bearing support) during personal hygiene, (bathing, shaving, brushing teeth etc...) During a face-to-face interview with Resident #63 on December 10, 2018, at approximately 4:00 PM this surveyor asked the resident whether he has cigarettes and/or a lighter. The resident responded "yes" and explained that he had cigarettes and a lighter; but refused to show the items. Employee #4 (The Manager) entered the room and retrieved six cigarettes and a lighter from the resident. The employee was asked whether the resident was allowed to keep cigarettes and/or incendiary devices. The employee responded "No" and added that he was not aware that the resident had cigarettes and/or	L 052		

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L 052	Continued From page 44 incendiary devices. Review of a care plan for the resident with a documented start date of September 23, 2018, showed that the resident is identified as a "dependent smoker" and will not be able to carry either tobacco or incendiary devices at any time." The goal was documented that the resident would practice safe smoking by abiding with the facility's smoking policies; with interventions which included the following: that the resident was to hand over all smoking paraphernalia, submit to searches of person and room every shift, will be given the option of attending smoking cessation classes and may be discharged from the facility if he refuses to adhere to the facility's policies. Employee #4 acknowledged that facility staff failed to ensure that Resident #63's environment was free of cigarettes and other incendiary devices during an interview at 11:00 AM on December 12, 2018. The resident signed his acknowledgement of the Smoking Policy on March 22, 2017 (two days after admission to the facility). Review of "Smoking Assessment" dated September 11, 2018, showed the resident was assessed as a Dependent Smoker r/t (related to) impaired cognition/impulsive behavior/in house; and according to the assessment the Resident does need the facility [staff] to store the lighter and cigarettes. Sufficient nursing time shall be given to assess the effectiveness of the smoking plan implemented for Resident #319 who was noted to be smoking in his room and discarded the ashes	L 052		

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L 052	Continued From page 45 in a flammable trash receptacle. Resident #319 was then assessed to be a Dependent Smoker, yet on December 10, 2018, he was found to have cigarettes and a lighter on his person which is a direct violation of the Facility's smoking rules. In addition, Residents' #26 and#63 who were deemed Dependent Smokers were also found to be in possession of smoking materials on December 10, 2018. There was no evidence that facility staff provided sufficient supervision to each resident deemed as a "Dependent Smoker" to ensure they are not in possession of smoking material as resident smoking in the build presents as a potential for harm to the dependent resident who is smoking, other residents, staff and visitors. On December 10, 2018, at 5:30 PM, during the face-to-face interview with the Administrator, Director of Nursing, Assistant Director of Nursing, and the Clinical Manager acknowledged the findings. B. Sufficient nursing time shall be given to identify Resident #53 as an elopement risk, therefore a plan of care was not implemented to help prevent him from eloping. Subsequently, the resident eloped from the facility on September 9, 2018. Resident #53 was admitted to the facility on 8/30/2018, with diagnoses which include Hypertension, Non-Alzheimer's Dementia, and Alcohol Abuse.	L 052		

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L 052	Continued From page 46 Review of the Quarterly Minimum Data Set dated September 6, 2018, showed the resident has a BIMS score of "05" indicating he has severely impaired cognition. Section E (Behaviors) showed the resident displayed verbal behavioral symptoms directed towards others and other behavioral symptoms not directed at others and the resident was coded for wandering. Under Section G (Functional Status), the resident was coded as independent in bed mobility, transfers, walk-in corridor, and locomotion on and off the unit. Under Section 0300 (Balance During Transitions and Walking) the resident was coded as not steady, but able to stabilize without staff assistance. Under Section G0400 (Functional Limitation in Range of Motion) the resident had no impairment to his upper and lower extremities and required a cane for ambulation under section G0600 (Mobility Devices). Review of the Elopement/Wandering Assessment dated August 30, 2018, the resident was assessed to have verbalize about wanting to leave the facility. Review of the progress notes showed the following: September 9, 2018, at 4:28 AM "During routine rounds at 11:15 PM, resident was not found in bed. Evening nurse stated, resident is in the building that he did not signed out on LOA (Leave of Absence). At 12 AM call was made to front desk if resident signed out of the facility, they stated that he didn't sign out as per their records. Then we began a search of the building and he was nowhere to be found. A call was made to the police at around 1:30 AM and was informed that they have the Resident at 7 District. He was brought back to the facility at 2:30 AM [on September 10, 2018] by [Name of Police Officer]	L 052		

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L 052	Continued From page 47 On assessment , resident received in stable condition, unharmed alert and oriented x 1 to person with intermittent confusion ...He is now being monitored closely for elopement risk". According to a Physician's order dated September 13, 2018, the resident had Wander Guard (Protects residents with dementia against elopement risk) applied to be worn at all times ... every shift for elopement risk. Review of the care plan initiated on October 22, 2018, "Focus area- ...at risk for elopement r/t (related to) confusion and diagnosis of Dementia. Interventions: Check Wander Guard functioning every evening by the supervisor. Do elopement checks every one hour as necessary and document as indicated ...monitor Wander Guard q (every) shift ..." There was no evidence that after facility staff identified the resident as an elopement risk, a plan of care was implemented to help prevent him from eloping. Subsequently, the resident eloped from the facility on September 9, 2018. During a face-to-face interview on December 11, 2018, at 11:45 AM with Employees' #2 and #6, they acknowledged the findings. C. Sufficient nursing time shall be given to implement a recommendation from the Behavioral Health Specialist to have Resident #112 attend psychotherapy to address his behavior (drinking alcohol). Subsequently the resident was found lying on the floor several	L 052		

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L 052	Continued From page 48 times and ultimately sustaining harm (Subarachnoid Hemorrhage, Left Supracondylar Fracture and laceration below left eyebrow). Resident #112 was re-admitted to the facility on April 4, 2017, with diagnoses which included, Fracture of Nasal Bones, Alcohol Abuse with Intoxication, Difficult Walking, Major Depressive Disorder, and Unspecified Mood Disorder. Review of the Quarterly Minimum Data Set dated August 7, 2018, showed the resident has a BIMS of "13" indicating he is cognitively intact. Section E (Behaviors) showed the resident was coded as having verbal behavioral symptoms. Under Section G (Functional Status), the resident was coded as requiring supervision in bed mobility, transfers, walk-in room, dressing, toilet use and personal hygiene. He had no impairment to his upper and lower extremities and required a walker for mobility. Care plan last updated on November 21, 2018, with a focus area of " ...has history of alcohol abuse" list the following interventions: Document any abuse of substance in resident's chart, educate resident on the importance of not drinking alcohol beverage while medication, labs as ordered, medication as ordered- 2/1/2016. Alcohol intoxication, allow resident to rest, safety and fall precautions maintained, [Behavior Health Specialist Company]-3/10/2017. Re-educate [Resident] about the risk and implications of taking alcohol while connected with his behavior of always being intoxicated and it was explained to him that it could lead to causing harm and injury to himself- initiated 1/1/2018. Care plan last updated November 4, 2018, with a	L 052		

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L 052	Continued From page 49 focus area of " ...at risk for falls" listed the following interventions: a working reachable call light, bed in low position, personal items within reach-2/1/2016. He was advised to stop drinking and consider support service for help - 8/6/2018. Re-emphasized and educate [Resident] about all of his fall is connected with his behavior of being intoxicated and it was explained to him that it could lead to causing harm and injury to himself- initiated 1/1/2018. Review of the Resident's medical record shows the following notes: August 3, 2018, at 15:01 [PM] Resident signed out on pass ... August 3, 2018, at 21:46 [PM] Resident returned from LOA (Leave of absence) at 4:15 PM resident was noted verbally abusive to staff and smelling of alcohol ...On August 4, 2018, at 16:50 [PM] resident was found on the floor crying for help in between the two beds, with the face on the floor, the left side of his eyes was noted with hematoma ...breath smells of alcohol ...[Attending] made aware and said to transfer resident to the nearest ER (emergency room) ..." August 5, 2018, at 05:09 [AM] "Post ER visit ...ER diagnosis: Facial Contusion and alcohol intoxication ..." Note written by Certified Registered Nurse Practitioner (CRNP) from [Behavioral Health Services Company] on August 6, 2018, showed, "On August 4, 2018 [Resident #112] had a fall in his room, reportedly was intoxicated with alcohol, he was sent to the ER (emergency room) ... but was brought back same day, no serious injury noted. Resident was re-educated on the negative effects of alcohol, he still resists alcohol treatment program outside the facility ... Recommendations/Continue to monitor mood	L 052		

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L 052	Continued From page 50 and behavior Supportive care. Resident was formerly on psychotherapy, will recommend he re-start psychotherapy as he had consistently decline drug treatment program. Care Coordination: Discussed with nursing team/nurse mgr (manager)." Note written by CRNP from [Behavioral Health Services Company] on September 6, 2018, showed, "Assessment: resident seen, negative effects of alcohol reiterated, ...he still resists alcohol treatment program outside the facility ... Recommendations/Continue to monitor mood and behavior Supportive Care. He will benefit from psychotherapy. Care Coordination: Discussed with nursing team/nurse mgr (manager)." October 6, 2018 at 16:29 [PM] "Resident observed lying on his back on the floor at hallway nearby room 326 door ....His walker rollator was noted with 3 bottles of vodka in a black plastic bag, one of them almost finished ....Resident refused assessment ...refused no one to touch him ...[Attending Physician] was on the unit and he made aware no new order given ..." November 3, 2018, at 11:21 AM "Resident was noted to be drunk with strong odor of alcohol smell coming of his mouth on taking over the shift. Resident weak, staggering while walking and stated, "this is the effect of the alcohol I drank yesterday night. One bottle of vodka was also found under the pillow, same removed and discarded. Fall and safety precaution maintained ..." November 4, 2018, at 15:56 [PM] "At around 2:30 PM, ...I found [Resident] lying down on his left	L 052		

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L 052	Continued From page 51 side with the left face on the floor. Resident disoriented and talking incoherently. Resident noted with strong smell of alcohol ...Upon assessment, resident is disoriented , weak confused, intoxicated with scant bleeding on the left side of the face, laceration on the left eye brow ....resident observed with right side twitching ...Unable to move left hand...[Attending Physician] made aware who gave order to transfer resident to ER for evaluation." November 5, 2018, at 07:59 [AM] "Resident admitted at [Hospital] with undisclosed dx [diagnosis]." November 8, 2018, at 22:11[PM] "Resident was readmitted to the unit at 4:45 PM ....with the following diagnosis of Subarachnoid Hemorrhage, Left Supracondylar Fracture ETOH (alcohol) intoxication ...laceration below left eye brow with 8 stiches ..." Note written by CRNP from [Behavioral Health Services Company] on November 12, 2018, showed, "Assessment: Facility request to re-evaluate resident who recently returned from hospital due to alcohol induced fall, with fracture of LF (left) hand ...Reportedly resident was intoxicated, lost control and fell with fracture. He claimed he was in pain, and had to drink alcohol to numb his pain ... Recommendations/Plan: Health teaching related to consequences of abuse was reiterated ...not ready to take responsibility for his actions. He will benefit from psychotherapy. Continue to provide health teaching ...Care Coordination: Discussed with nursing team/nurse mgr (manager)." Review of the record showed that on August 3, 2018, the resident stained a fall with injury, on	L 052		

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L 052	Continued From page 52 October 6, 2018, the resident sustained a fall without injury and on November 4, 2018, the resident sustained a fall with injury. Each time the resident was found lying on the floor, facility staff noted the resident to smell of alcohol or the resident was intoxicated. Although the resident was seen by a Behavioral Health Specialist, there is no evidence that the recommendation from the Behavior Health Specialist to receive psychotherapy was ever carried out to address the residents use of alcohol which the facility has correlated to the resident being found lying on the floor and subsequently lead to the resident sustaining harm (Subarachnoid Hemorrhage, Left Supracondylar Fracture and laceration below left eye brow). During a face-to-face interview on December 14, 2018, at approximately 9:30 AM with the Psycologist #24 from [Behavioral Health Services Company], he stated, the company does not offer psychotherapy and he has not seen or treated this resident before. During a face-to-face interview on December 14, 2018, at approximately 4:00 PM with the Employee #9, she acknowledged the findings.	L 052		
L 056	3211.5 Nursing Facilities Beginning January 1, 2012, each facility shall provide a minimum daily average of four and one tenth (4.1) hours of direct nursing care per resident per day, of which at least six tenths (0.6) hours shall be provided by an advanced practice registered nurse or registered nurse, which shall	L 056	1. The staffing deficit could not be corrected for the eight (8) days cited	

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L 056	Continued From page 53 be in addition to any coverage required by subsection 3211.4. This Statute is not met as evidenced by: Based on record review and staff interview, during a review of staffing [direct care and advanced practiced registered nurse per Resident per day hours], it was determined that facility failed to provide a minimum daily average of four and one-tenth (4.1) hours of direct care per Resident per day for eight (8) of eight (8) days reviewed in accordance with Title 22 DCMR Section 3211, Nursing Personnel and Required Staffing Levels. The findings included: According to the District of Columbia Municipal Regulations for Nursing Facilities: 3211.5 Beginning January 1, 2012, each facility shall provide a minimum daily average of four and one-tenth (4.1) hours of direct nursing care per resident per day, of which at least six tenths (0.6) hours shall be provided by an advanced practice registered nurse or registered nurse, which shall be in addition to any coverage required by subsection 3211.5. A review of the Nurse Staffing was conducted on December 14, 2018, at approximately 1:00 PM. Of the eight (8) days reviewed, Eight (8) of the eight (8) days failed to provide a minimum daily average of four and one-tenth (4.1) hours of direct care per resident per day as follows:	L 056	**2. Residents with the potential to be affected** The facility also acknowledge that all the residents have the potential to be affected. **3. Systemic changes to be implemented** • The facility is has increased our efforts to recruit licensed nursing staff through the use of Career Builder Website, Indeed Website, The Washington Post, Ward 8 Job posting Board, UDC Community College Division of Workforce Development, Lifelong Learning Program, VMT, and the Transitions Healthcare Website. • The candidates from the search efforts are presented o the DON for interview and potential hire. All the Clinical Mangers and Supervisors are engaged in the hiring process. All walk-in candidates are interviewed on the spot same day. **4. To sustain and maintain compliance** • The DON will present the result of recruitment efforts along with the Human Resource Director during the monthly QAPI meeting that is held monthly and is chaired by the Nursing Home Administrator. • The Director of Nursing will present this report to QAPI for three (3) consecutive months, and Quarterly thereafter. • The QAPI Committee will determine compliance.	2/7/19 Monthly and Quarterly

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L 056	Continued From page 54 Hours of Direct Care per resident per day Thursday, August 30, 2018, showed that the facility provided direct nursing care per resident at a rate of 3.49 hours. Friday, August 31, 2018, showed that the facility provided direct nursing care per resident at a rate of 3.60 hours. Wednesday, September 5, 2018, showed that the facility provided direct nursing care per resident at a rate of 3.48 hours. Thursday, September 6, 2018, showed that the facility provided direct nursing care per resident at a rate of 3.49 hours. Friday, September 7, 2018, showed that the facility provided direct nursing care per resident at a rate of 3.58 hours. Wednesday, September 12, 2018, showed that the facility provided direct nursing care per resident at a rate of 3.55 hours. Saturday, September 15, 2018, showed that the facility provided direct nursing care per resident at a rate of 3.00 hours. Sunday, September 16, 2018, showed that the facility provided direct nursing care per resident at a rate of 2.79 hours. A face-to-face interview conducted with the Staffing Coordinator at the time of the staffing review and he acknowledged the findings.	L 056		

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L 080	Continued From page 55	L 080	1. Physician order and consents from the resident's representative for the hand mitten and abdominal binder were obtained upon discovery for resident #348.	12/14/18
L 080	3216.1 Nursing Facilities Each resident has the right to be free from physical and chemical restraints. This Statute is not met as evidenced by: Based on record review and staff interview for one (1) of 90 sampled residents facility staff failed to obtain a physician's order and consent from the resident's Power of Attorney (POA) prior to placing the resident into physical restraints. Resident #348. Findings included . . . Resident #348 was admitted to the facility on August 12, 2016, with diagnoses which include Hypertension, Paraplegia, Quadriplegia, Gastroesophageal Reflux Disease, Depression, Manic Depression, Psychotic Disorder and Schizophrenia. A review of Section C400 of the annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of February 05, 2018, showed a Brief Interview for Mental Status (BIMS) score of 04 which is an indication that the resident is not cognitively intact and able to make decisions. Under Section G0110 Activities of Daily Living (Functional Status) the resident is totally dependent on physical assistance from two or more persons for all aspects of care: for bed	L 080	2. An audit of residents in the facility identified as having restraints was performed by the DON. Physician orders and consents were obtained for all residents with restraints. 3. The Regional Nurse Consultant in-serviced MDS coordinators and Clinical Managers on what constitutes a "restraint" and the process by which restraint are obtained (e.g., physician orders, signed consents, and proper MDS coding of restraints). Residents with restraints will be reviewed every care plan meeting by IDT to ensure that the restraint is still appropriate for the resident. Findings will be reported to the DON after care plan meetings. 4. The DON will report the results of this audit to the QAPI Committee that meets every month, and is chaired by the Nursing Home Administrator.	1/1/19 1/22/19 2/7/19 Monthly and Quarterly

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L 080	Continued From page 56 mobility, transfer, dressing, toilet use, personal hygiene and bathing. She receives all nutrition and medication via tube feeding. The resident was observed lying in bed with hand mittens on both hands and an abdominal binder around the abdomen on December 05, 2018, at 3:19 PM. A review of the clinical record failed to show either a physician's order or consent from the resident's POA. A face-to-face interview was conducted with Employee #5 at approximately 2:00 PM on December 6, 2018. When asked about the physician's order and the consent from the POA for the use of the restraint the employee responded that the mittens and the binder were not restraints but were used to prevent the resident from pulling out her Gastrostomy tube and added that the resident has a history of pulling the tube out. The employee acknowledged the finding during the interview.	L 080		
L 091	3217.6 Nursing Facilities The Infection Control Committee shall ensure that infection control policies and procedures are implemented and shall ensure that environmental services, including housekeeping, pest control, laundry, and linen supply are in accordance with the requirements of this chapter. This Statute is not met as evidenced by: Based on observation, medical record review, resident and staff interview for one (1) of 90 sampled residents, facility staff failed to maintain infection control standard of practice as	L 091		

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L 091	Continued From page 57 evidenced by a soiled gown, gloves and diaper left on the floor of resident's room[Resident #104]; and failed to ensure a resident's room identified as an isolation room, had working trash receptacles and hand soap in one (1) of one (1) isolation room within the facility; and failed to identify catheter-associated infections of residents within the facility on the October 2018 surveillance line listing. Findings included ... 1. Resident# 104 was admitted to the facility on 3/13/18, with diagnoses which include Unspecified Dementia without Behavioral Disturbance, Major Depressive Disorder, Essential (Primary) Hypertension, Peripheral Vascular Disease and Acquired Absence of Left Leg above the Knee and Other Psychoactive Substance Abuse, Uncomplicated. Review of the Comprehensive Minimum Data Set [MDS] dated 9/18/18 on 12/13/18, at 11:00 AM showed Section C [Cognitive Patterns] Brief Interview for Mental status [BIMS] was scored as "13" which indicate cognitively intact. During a resident interview on 12/13/18, at 12:30 PM, observed soiled gown, gloves and diaper on the floor of the room next to beige trash can lined with a clear bag. Resident #104 was asked how long has the soiled gown, diaper and gloves been on the floor? Resident#104 responded "all morning." Employee# 6 was asked to come to the resident's room and she observed the soiled items on the floor and she placed the gloves and diaper in the	L 091	1.The gown, gloves, linen, and diaper found on the floor of Resident #104s room were removed immediately during the survey. The trash receptacle and hand soap were also replaced immediately for Resident #29 and Resident #54's rooms and the soap dispenser was replenished. The catheter-associates urinary trach infection (CAUTI) was entered on the infection control line listing to appropriately identify Resident #TF3's infection. In-service for nurses has been provided on minimizing the spread of the infections related to catheter associated infections, urinary tract infections and wound infections **2. Residents with the potential to be affected** A review of the infection control log for the month of November/December, 2018 showed that no other resident was affected by this omission. Also residents' rooms were observed to ensure that no linen, diaper, gloves and gown were left on the floor. Resident rooms were also checked for soap dispensers and proper trash receptacles.	12/13/18 12/3/18 12/13/18 12/13/18

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L 091	Continued From page 58 trash can and the gown was placed in a separate bag and was transported to the soiled utility room. During an interview on 12/13/18, at 12:45 PM with Employee#21 in the presence of Employee#6. Employee# 21 responded yes, that was not my resident, I was helping another Certified Nursing Assistant (CNA) and I was rushing, and I left the soiled linen, gloves and diaper on the floor. Facility staff failed to maintain infection control standard of practice by failing to properly dispose of soiled gloves, diaper and linen to prevent the spread of infection. During a face-to face interview at the time of the observation Employees# 6 and #21 acknowledged the finding. 2. Facility staff failed to ensure a resident's room identified as an isolation room, had working trash receptacles and hand soap in one (1) of one (1) isolation room within the facility. During a tour of the nursing unit on December 3, 2018, at 4:10 PM, it was noted that Residents' #29 and #54, occupying room 332 were on isolation precautions for Carbapenem-resistant Enterobacteriaceae (CRE). At this time, a tour of the room showed that one (1) of two (2) red receptacles used for soiled linen had a broken foot pedal caused staff, resident or visitor to open the lid with their hand which potentially puts them in contact with soiled linen. One (1) of one (1) soap dispenser was absent of soap for staff, residents or visitor to wash their	L 091	**3. Systemic changes to be implemented** • Nurses have been in-serviced by the Infection Control Preventionist on the new updated infection control log that includes a column of CAUTI infections; also on minimizing the spread of the infections related to catheter associated infections, urinary tract infections and wound infections. • The Infection Preventionist will monitor for compliance on a daily basis to ensure compliance and report findings to the Director of Nursing. **4. To sustain and maintain compliance** • The Director of Nursing will report the results of this audit to the QAPI Committee which meets monthly, and is chaired by the Nursing Home Administrator. • The Director of Nursing will present this audit to QAPI Committee for three (3) consecutive months for compliance. • The QAPI Committee will determine compliance	1/10/19 2/7/19 Monthly and **Quarterly**

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L 091	Continued From page 59 hands to be germ free. There was no evidence that facility staff maintained appropriate transmission-based precautions to help prevent the spread of infection. Employee # 9 was present at the time of the observation acknowledged the findings. 3. Failed to identify catheter-associated infections of residents within the facility on the October 2018 surveillance line listing. On December 13, 2018, at approximately 3:15 PM, a review the facility's infection control program was conducted with Employee #23. At this time, it was noted that surveillance data related to infection control for October 2018, list Resident #TF3 as having a facility acquired urinary tract infection. However, the October 2018 Surveillance line listing did not reflect the resident having an indwelling catheter. Review of the facility's infection control report for the months of October 2018, conveys that in-services included perineal care, helping residents increase their fluid intake, the importance of handwashing as the first line in the prevention of infection. Employee #23 was asked to show the sign-in sheets for the in-services. She was unable to show documented evidence that staff attended	L 091		

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L 091	Continued From page 60 the in-services or received education related to help minimize the spread of the infections related to catheter associated infections, urinary tract infections and wound infections. During a face-to-face interview with Employee #23 on December 13, 2018, at approximately 3:15 PM, she acknowledged the findings.	L 091		
L 099	3219.1 Nursing Facilities Food and drink shall be clean, wholesome, free from spoilage, safe for human consumption, and 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, and interview, it was determined that the facility failed to maintain food equipment in safe condition and failed to store utensils in a manner as to prevent contamination as evidenced by exposed electrical wires from one (1) of one (1) food shredder and one (1) of one (1) heavy duty blender, five (5) of eight (8) soiled fire sprinkler heads and eleven (11) of eleven (11) hotel pans, four (4) of four (4) half pans and nine (9) of nine (9) meat loaf pans that were improperly stored. Findings included ... During a tour of the Dietary Services on December 3, 2018 at approximately 9:05 AM: 1. Electrical wires from both ends of the power cord attached to the Robot Coupe food shredder were exposed and accessible, possibly subjecting staff to	L 099	1 .Electrical wire from both end of the power cord attached to the Robot Coupe food shredder which were exposed have been repaired by an electrical technician. The electrical wires from the power cord to the Heavy Duty Blender that was exposed was also repaired by an electrical technician. The five (5) fire sprinkler heads located. 2. Residents with the potential to be Affected All small appliances were reviewed by the Technician an no other issues were found. Sprinkler heads in the kitchen were Reviewed and observed for dust and no Other issues were found; hotel pans meat Loaf and half pans were observed to make Sure they were air dried before they were Stored. **3. Systemic changes to be implemented** The opening and closing checklist was Amended to be checked twice a day. In-service was provided to staff on observing areas in the kitchen and	12/14/18

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L 099	Continued From page 61 electrical hazards. 2. Electrical wires from the power cord to the Heavy Duty Blender (Waring Commercial) were exposed and accessible, a potential for electrical shock to staff. 3. Five (5) of eight (8) fire sprinkler heads located above two (2) of two (2) grease fryers and one (1) of one (1) gas stove were soiled with dust. 4. Eleven (11) of eleven (11) hotel pans, four (4) of four (4) half pans and nine (9) of nine (9) meat loaf pans were stored wet on the clean, ready for use shelf. Employee #10 on December 3, 2018, at approximately 11:30 AM acknowledged the findings.	L 099	Maintaining the checklist of small appliances For proper and safe condition; and Observation of kitchen to prevent dust build up on Sprinkler heads; and on making sure hotel pans Are dried before stored. Nutrition Service Assistant Director and supervisor will monitor to make sure Checklist is completed as required. **4. To sustain and maintain compliance** • The Director of Nursing will report results of this audit to the QAPI Committee that meets monthly and is chaired by the Nursing Home Administrator. • The Director of Nursing will present this report to QAPI for three (3) consecutive months, and Quarterly thereafter. • The QAPI Committee will determine compliance.	2/7/19 Monthly & Quarterly
L 190	3231.1 Nursing Facilities The facility Administrator or designee shall be responsible for implementing and maintaining the medical records. This Statute is not met as evidenced by: Based on record review and staff interview for two (2) of 90 sampled residents facility staff failed to maintain a complete and accurate medical record by failing to include the residents' advance directive form in the active medical record for one (1) resident and by including a physician's order for medication in the wrong medical record for one (1) resident. Residents' # 189 and # 14. Findings included...	L 190	The Advance Directive for Resident #189 was immediately placed in the resident's chart. The physician order that was erroneously placed in Resident #14's chart was immediately removed and placed in the correct chart for Resident #205. **2. Residents with the potential to be affected** A review of residents' medical records	12/13/18 12/13/18 1/10/19

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reflected no other resident was affected by

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L 190	Continued From page 62 Record review of the facility's policy titled "Advance Directive and Advanced Care Planning (End of Life) dated 11/23/16 showed "It is the policy and intent of the Facility to inquire, obtain or provide, the completion of advanced directive for the purpose of prospectively identifying a healthcare decision maker, clarifying treatment preferences and developing individualized goals of care near the end of life." Procedure: "Advanced care planning will begin when the Resident is admitted to the Facility a copy of the Resident's Advanced Directive/Living Will should be placed in the Resident's chart (if completed)." 1. Resident##189 was admitted to the facility on 4/7/18 with diagnoses which include Chronic Obstructive Pulmonary Disease (COPD), Morbid (Severe) Obesity due to Excess Calories, Schizophrenia, Unspecified, Essential (Primary) Hypertension and Edema. Review of the Comprehensive Minimum Data Set [MDS] on 12/13/18 at 10:00 AM showed Section C [Cognitive Patterns] Brief Interview for Mental status [BIMS] was scored as "15 " which indicate cognitively intact. During a staff interview with Employee# 18, it should be in the chart, but she is a full code because the chart is a blue color. Employee# 6 stated no, it's not in the chart the Social Worker must have it, I will make a call. Facility staff failed to maintain a complete medical record by failing to include the residents' advance directive in the medical record in accordance with facility's policy.	L 190	reflected no other resident was affected by these errors. **3. Systemic changes to be implemented** • All Unit secretaries have been in-serviced to perform monthly chart audits to ensure Advance Directives are included in the appropriate medical record as well as placing physician orders in the right chart. • The Unit Secretaries will perform a monthly chart audit and provide the information for the Medical Records Director for his/her review. • The Medical Records Director or designee will perform a review of the results of the monthly audit for accuracy and corrective action will be taken as needed.	1/28/19

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L 190	Continued From page 63 During a face-to-face interview on 12/13/18 at 10:00 AM, Employees # 6 and #18 acknowledged the finding. Facility staff failed to maintain an accurate and complete medical record by including physician order for medication in the wrong medical record. 2. Resident# 205 was admitted to the facility on 10/18/18 with diagnoses which include Type II Diabetes Mellitus, Hyperlipidemia, Essential (Primary) Hypertension, Acute Kidney Failure and Cerebral Infarction. During a review of Resident #14 medical record on 12/13/18 at 1:00 PM showed a physician's order for Resident# 205 which reads "Pregabalin (Lyrica) 75 mg twice daily and Gabapentin 300 mg three times daily for Neuropathy. These two medications are structurally similar and therefore represent duplication in therapy. Please consider discontinuing one of the above medications." During an interview on 12/13/18 at 2:00 PM, Employee#7 stated this does not belong in this resident's chart; this order is the wrong chart. Facility staff failed to maintain a complete and accurate record by placing a physician's order in the wrong medical record. During a face-to-face interview on 12/13/18 at 2:00 PM Employee#7 acknowledged the finding at the time of the review.	L 190	**4. To sustain and maintain compliance** • The Medical Records Director will present the monitoring audit and findings at the QAPI Committee meeting, that is chaired by the Nursing Home Administrator. • The Medical Records Director will present the monitoring audit to the QAPI Committee for three (3) consecutive months and Quarterly thereafter for compliance. • The QAPI Committee will determine compliance.	2/7/19 Monthly and Quarterly

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 214	Continued From page 64 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 and interview, the facility failed to provide an environment that is free from accident hazards as evidenced by exposed electrical wires from one (1) of one (1) food shredder and one (1) of one (1) heavy duty blender, and frayed call bell cords in two (2) of 73 resident's rooms. Findings included ... During observations in Dietary Services on December 3, 2018, at approximately 9:05 AM: 1. Electrical wires from both ends of the power cord attached to the Robot Coupe food shredder were exposed and accessible. 2. Electrical wires from the power cord to the Heavy Duty Blender (Waring Commercial) were exposed and accessible. 3. During observations throughout the facility on December 3, 2018, at approximately 2:30 PM, and on December 4, 2018, at approximately 11:00 AM, call bell cords were frayed in two (2) of 73 resident's rooms (#121A and 319A). These deficiencies potentially present electrical	L 214 L 214	1. Electrical wires from both end of the power cord attached to the Robot Coupe food shredder which were exposed have been repaired by an electrical technician. The electrical wires from the power cord to the Heavy Duty Blender that was exposed was also repaired by an electrical technician. Maintenance staff repaired the call bells in rooms #121A and #319A. **2. Residents with the potential to be affected** All small appliances were checked and reviewed by the technician and no other issues were found. Call bells throughout the facility were checked and repairs provided as necessary. All call bells were in compliance. **3. Systemic changes to be implemented** • The opening and closing checklist was amended to be checked twice a day. • In-service was provided to staff on observing areas in the kitchen and maintaining the checklist of small appliance for proper and safe condition. • Nutrition Service Assistant Director and Supervisor will monitor to make sure checklist is completed as required. • The Maintenance staff was in-serviced on the repair and upkeep of the call bells. • Maintenance staff will continue to monitor residents rooms daily for call bells and the results of the monitoring will be provided to the Director of Facilities	

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L 214	Continued From page 65 shock and fire hazards to staff members, residents and visitors. These observations were acknowledged by Employee #10 on December 3, 2018, at approximately 11:30 AM and by Employee #3 on December 4, 2018, at approximately 11:00 AM.	L 214	**4. To sustain and maintain compliance** The Director of Nutritional Service and the Director of Facility will report results of the audits and monitoring to the QAPI Committee that meets monthly and is chaired by the Nursing Home Administrator. The Director of Nutritional Services e and the the Director of Facility will present this report to QAPI for three consecutive Months and Quarterly thereafter.	
L 306	3245.10 Nursing Facilities A call system that meets the following requirements shall be provided: (a)Be accessible to each resident, indicating signals from each bed location, toilet room, and bath or shower room and other rooms used by residents; (b)In new facilities or when major renovations are made to existing facilities, be of type in which the call bell can be terminated only in the resident's room; (c)Be of a quality which is, at the time of installation, consistent with current technology; and (d)Be in good working order at all times. This Statute is not met as evidenced by: Based on observations and staff interview, the facility failed to maintain the call bell system in good working condition as evidenced by call bells in six (6) of 73 resident's rooms that failed to alarm when tested and a call bell without a pull cord in one (1) of 73 resident's rooms. Findings included...	L 306	1. Maintenance staff repaired the call bells in six (6) of the seventy-three (73) rooms #139A, 229B, 238A, 305A, 338B, where the call bell did not activate properly and the room #238 with the missing cord. Repairs were done immediately upon discovery. 2. Residents with the potential to be affected Call bells throughout the facility were checked and repairs provided. All call bells were in compliance. **3. Systemic changes to be implemented** • Maintenance staff was in-serviced on the repair and upkeep of the call bells. • Maintenance staff will continue to monitor residents rooms daily. monitoring will be provided to the Director of Facilities for his review. **4. To sustain and maintain compliance** • The Director of Facilities will report results of the audits and monitoring and any action plan for improvements to the QAPI Committee that meets monthly and is chaired by the Nursing Home Administrator. • The Director of Facilities will present this	12/3/18 12/12/18 12/12/18 2/7/19 & Monthly & Quarterly

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L 410	Continued From page 67 An environmental tour of the facility was conducted on December 3, and December 4, 2018, and water temperatures were tested on the third floor on December 13, 2018, at approximately 11:30 AM. The following observations were made: 1. Bathroom vents were soiled with dust in four (4) of 73 resident's rooms (#109, 344, 352, 357). 2. Ceiling tiles were stained in 13 of 73 resident's rooms #114, 115, 122, 148, 202, 204, 218, 221, 230, 232, 245, 246, 257. 3. Water temperatures in shower rooms located on 1 North, 2 North, and 2 South failed to reach a minimum temperature of 95 degrees Fahrenheit. On 1 North, the maximum temperature from the shower room was 94.2 degrees Fahrenheit. On 2 North, the water temperature at the hand sink was 98. 4 degrees Fahrenheit but from the showerhead, it measured 85.4 degrees Fahrenheit ten minutes after it was activated. On 2 South, the water temperature at the shower room was 94.2 degrees Fahrenheit. During a face-to-face interview on December 4, 2018, at approximately 4:00 PM, Employee #3 acknowledged the findings. During observations on December 13, 2018, at approximately 11:30 AM, water temperatures in	L 410		

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L 410	Continued From page 68 the shower room on 3 South tested at 87. 0 degrees Fahrenheit from the hand sink and 80.1 degrees Fahrenheit from the showerhead. On 3 North, the water temperature from the shower room tested at 78.0 degrees Fahrenheit. During a face-to-face interview on December 13, 2018, at approximately 3:30 PM, Employee #3 acknowledged the findings.	L 410		
L 442	3258.13 Nursing Facilities The facility shall maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This Statute is not met as evidenced by: Based on observations and interview, the facility failed to provide an environment that is free from accident hazards as evidenced by exposed electrical wires from one (1) of one (1) food shredder and one (1) of one (1) heavy duty blender. Findings included ... During observations in Dietary Services on December 3, 2018, at approximately 9:05 AM: 1. Electrical wires from both ends of the power cord attached to the Robot Coupe food shredder were exposed and accessible. 2. Electrical wires from the power cord to the Heavy Duty Blender (Waring Commercial) were	L 442	1. Electrical wires from both end of the power cord attached to the Robot Coupe food shredder which were exposed have been repaired by an electrical technician. The electrical wires from the power cord to the Heavy Duty Blender that was exposed was also repaired by an electrical technician. Maintenance staff repaired the call bells in rooms #121A and #319A. **2. Residents with the potential to be affected** All small appliances were checked and reviewed by the technician and no other issues were found. Call bells throughout the facility were checked and repairs provided as necessary. All call bells were in compliance.	

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L 442	Continued From page 69 exposed and accessible. These deficiencies potentially present electrical shock and fire hazards to staff. These observations were acknowledged by Employee #10 on December 3, 2018 at approximately 11:30 AM.	L 442	**3. Systemic changes to be implemented** • The opening and closing checklist was amended to be checked twice a day. • In-service was provided to staff on observing areas in the kitchen and maintaining the checklist of small appliance for proper and safe condition. • Nutrition Service Assistant Director and Supervisor will monitor to make sure checklist is completed as required. • The Maintenance staff was in-serviced on the repair and upkeep of the call bells. • Maintenance staff will continue to monitor residents rooms daily for call bells and the results of the monitoring will be provided to the Director of Facilities **4. To sustain and maintain compliance** • The Director of Nutritional Service and the Director of Facility will report results of the audits and monitoring to the QAPI Committee that meets monthly and is chaired by the Nursing Home Administrator.	12/4/18 12/14/18 2/7/19 Monthly and Quarterly