STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	07/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON CTR FOR AGING SVCS	2601 18TH STREET NE WASHINGTON, DC 20018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Long Term Care Survey was conducted at Washington Center for Aging Services from July 17, 2019 through July 30, 2019. Survey activities consisted of a review of 56 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 243. An immediate jeopardy (IJ) was identified at 42 CFR§ 483.12(c)(2)-(4), Investigate/prevent/correct alleged violation, F610 on July 23, 2019, at 11:09 AM. The facility's Administrator provided a letter with supportive documentation (to include: termination of the employee involved in the incident, evidence of Abuse Training (Training for leadership, managers, and staff on abuse, residents with combative behaviors and residents rights; all units were checked to determine if other residents had preference as it pertains to the sexuality of the caregiver; the managers will monitor the care of residents who are combative using the behavioral monitoring tool; and the nurse managers and supervisors will continue to monitor the staffs that provide care to residents who exhibit combative behaviors noting a corrective action plan and the IJ was removed on July 24, 2019, at 4:07 PM.	F 000	Stoddard Baptist Global Care makes its best effort to operate in substantial compliance with both Federal and State Laws. Submission of this Plan of Correction (POC) does not constitute an admission or agreement by any party, its officers, directors, employees or agents as to the truth of the facts alleged of the validity of the conditions set forth of the Statement of Deficiencies. This Plan of Correction (POC) is prepared and/or executed solely because it is required by Federal and State Law.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: CNHA — (X6) DATE: 9/4/19

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	07/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON CTR FOR AGING SVCS	2601 18TH STREET NE WASHINGTON, DC 20018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 1 A complaint investigation (C-19-067, DC00004836) was also conducted during the survey period of July 17, 2019, through July 30, 2019. 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 BIMS - Brief Interview for Mental Status 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 D/C- Discontinue Dl- Deciliter DMH - Department of Mental Health DOH- Department of Health EKG - 12 lead Electrocardiogram EMS - Emergency Medical Services (911) F - Fahrenheit G-tube- Gastrostomy tube HR- Hour HSC - Health Service Center HVAC - Heating ventilation/Air conditioning	F 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	07/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON CTR FOR AGING SVCS	2601 18TH STREET NE WASHINGTON, DC 20018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 2	F 000		

ID - Intellectual disability
IDT - Interdisciplinary team
IPCP- Infection Prevention and Control Program
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
NFPA - National Fire Protection Association
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
RP R/P - Responsible party
SCC Special Care Center
Sol- Solution
TAR - Treatment Administration Record
Ug - Microgram

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	07/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON CTR FOR AGING SVCS	2601 18TH STREET NE WASHINGTON, DC 20018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 3 UR- Urinary Retention	F 000		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1,	F 584	**1.** The Bathroom vents in rooms #159, 160, 208 and 237 were cleaned immediately. The expired Boost in the pantry was removed and discarded on the day identified. **2.** A review of the bathroom vents in the facility was conducted, no other vents were identified. A review of the Boost was conducted; no other expired cans of Boost were noted. **3.** The Housekeeping staff were re-educated regarding the inspection and cleaning of vents. The nursing staff and central supply staff were re-educated regarding the checking of supplemental feeding and of ensuring that the First In First Out project is in place. **4.** As a component of the Quality Assurance/Improvement Program the checking of Vents will be added to Engineering Quality tool. The monitoring of supplemental feeding i,e Boost will be added to the monitoring of the nursing environment, including the pantry. This information will be presented to the QA/QI	9-30-19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	07/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON CTR FOR AGING SVCS	2601 18TH STREET NE WASHINGTON, DC 20018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 4 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and interview, the facility failed to provide housekeeping services necessary to maintain a safe, clean, comfortable environment as evidenced by soiled bathroom vents in four (4) of 65 residents' rooms and ten (10) of ten (10) containers of Boost nutritional drinks that were stored for use beyond their expiration date. Findings included... During an environmental tour of the facility on July 18, 2019 between 10:00 AM and 3:30 PM the following observations were made: 1. Bathroom vents in Resident rooms' #159, #160, #208 and #237 were soiled with dust, four (4) of 65 resident's rooms. 2. Ten (10) of ten (10) eight-ounce carton containers of Boost nutritional supplement drinks, stored in the pantry on Unit 2 Blue, were expired as of May 30, 2019. Employee #9 acknowledged the above findings during a face-to-face interview on July 18, 2019 at approximately 3:00 PM.	F 584		
F 610 SS=L	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4)	F 610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	07/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON CTR FOR AGING SVCS	2601 18TH STREET NE WASHINGTON, DC 20018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 5 §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to: thoroughly investigate an incident of abuse and/or neglect for Resident #164, implement measures to prevent potential abuse and/or neglect to other residents within the facility; and take appropriate corrective actions to keep other residents safe from possible abuse and/or neglect in one (1) of 56 sampled residents. The census on the first day of survey was 243. Findings included ... On July 23, 2019, at 11:09 AM an Immediate Jeopardy (IJ)-"L" was identified at 42 CFR§ 483.12 (c)(2)-(4), F610. On July 25, 2019 at 3:13 PM, the facility's Administrator provided a letter to the State Agency Survey team	F 610	Immediate Jeopardy - Removal Plan **1. Immediate Action Taken – CNA care of resident** CNA failed to stop caring for resident and failed to call for assistance for a resident who was combative I. The CNA identified in the complaint survey is no longer employed as of 7/16/2019 II. All resident were checked and three residents who are combative and/or exhibit combative behavior were identified; additional training was provided on the spot for those staff members on 7/22/2019. III. A meeting was conducted with the Administrator and the DON on 7/23/2019 and 7/24/2019. Root cause analysis and investigation principles as it pertains to Abuse were addressed. All components of abuse were discussed including the interpretation of "willful" and its relationship to abuse. Abuse training and care of combative resident (training) was started on 7/21/2019 for all staff and currently in progress.	9-30-19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	07/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON CTR FOR AGING SVCS	2601 18TH STREET NE WASHINGTON, DC 20018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 6 documenting the corrective action plan, as follows: "The CNA identified in the complaint survey is no longer employed as of 7/16/2019. All residents were checked and three residents who are combative and/or exhibit combative behaviors were identified. Additional training was provided on the spot for those staff members on 7/22/2019. A meeting was conducted with the Administrator and the DON [Director of Nursing] on 7/23/2019 and 7/24/2019. Root cause analysis and investigation principles as it pertains to Abuse were addressed. All components of abuse were discussed including the interpretation of "willful" and its relationship to abuse. Abuse training and care of combative resident (training) was started on 7/21/2019 for all staff and is currently in progress. The managers will monitor the care of residents who are combative using the behavioral monitoring tool (see audit tools). The nurse managers and supervisors will continue to monitor the staff that provide care to residents who exhibit combative behaviors. Interventions will be implemented as indicated. The information will be provided to the DON who will provide this information to the QAPI committee quarterly and/or more frequently as indicated. Family request female: The Unit Manager received individual counseling and training on 7/23/2019. Unable to retrospectively correct the occurrence.	F 610	IV. The managers will monitor the care of residents who are combative using the behavioral monitoring tool (see audit tools). The nurse managers and supervisors will continue to monitor the staffs that provide care to residents who exhibit combative behaviors. Interventions will be implemented as indicated. The information will be provided to the DON who will provide this information to the QAPI committee quarterly and/or more frequently as indicated. **2. Immediate Action Taken - Resident and Family Wishes; specifically requesting for a female care giver** Family request female – Manager not including in care plan resident preference as it pertains to care giver/Care Plan I. The Unit Manager received individual counselling and training on 7/23/2019. Unable to retrospectively correct the occurrence. II. A counselling form has been developed for the unit manager and has received training, and counselling.	9-30-19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	07/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON CTR FOR AGING SVCS	2601 18TH STREET NE WASHINGTON, DC 20018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 7 All Unit Managers received training on 7/23/2019 and 7/24/2019 as it pertains to resident's rights, specifically their wish as it pertains to the caregiver. All Units were checked on 7/23/2019, via the nursing management team to determine if other residents had preference as it pertains to the sexuality of the caregiver. One resident was identified on 7/23/2019 and the Unit manager ensured that it was incorporated in the care plan on 7/23/2019. The Interdisciplinary team was re-educated on care planning and updating the care plan as the resident's conditions changes following detailed assessment of the resident on 7/23/2019. Upon admission and care plan meeting/conferences, the managers will determine the needs of the residents, specifically if a resident request a female and/or male care giver. The resident who expresses the female/male will be checked to ensure that this request was honored. This will be done via the assignment sheet every shift and reported to the QAPI [Quality Assurance and Performance Improvement) committee quarterly and/or more frequently as indicated. The nursing management audits the care plan monthly (see audit tool). When a care plan has not been updated the appropriate discipline is notified. This information is provided to the DON who presents this information to the QAPI committee quarterly and/or more frequently as necessary." In-service/Training: " Training of the Administrator and DON regarding Root Cause Analysis and Investigation	F 610	III. All Unit Managers received training on 7/23/2019 and 7/24/2019 as it pertains to resident's rights, specifically their wish as it pertains to the care giver. IV. All Units were checked on 7/23/2019 via the nursing management team to determine if other residents had preference as it pertains to the sexuality of the care giver. One resident was identified on 7/23/2019 and the Unit manager ensured that it was incorporated in the care plan on 7/23/2019. The Interdisciplinary team was re-educated on care planning and updating the care plan as the resident's conditions changes following detailed assessment of the resident on 7/23/2019.	9-30-19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	07/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON CTR FOR AGING SVCS	2601 18TH STREET NE WASHINGTON, DC 20018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 8 Principles as it pertains to Abuse (training completed on July 24, 2019) " Training of the Clinical Leadership Team (Training completed July 19, 2019) " Evidence of Abuse Training (Training for leadership, managers, and staff on abuse, residents with combative behaviors done on July 19 2019- July 24, 2019) " Training on assignment of male/female CNA per resident's wishes (Training completed July 24, 2019) The IJ was abated after the team verified that the plan of correction was in place on July 25, 2019, at 4:07 PM, the Immediate Jeopardy was removed. Consequently, the State Agency amended the scope and severity of the deficient practice to an "F." Policy Title: Prohibition of Abuse; ADM01-003; Revised January 2019 stipulates, "A. Stoddard Baptist Global Care, Inc. promotes the residents rights to be free from abuse, neglect, misappropriation of resident property and exploitation ...No abuse or harm of any type will be tolerated and residents and staff will be monitored for protection ... Prevention: 4. The identification, ongoing assessment, care planning for appropriate interventions, and monitoring of resident with needs and behaviors which might lead to conflict or neglect. Identification: ...Because some cases of abuse are not directly observed, understanding resident outcomes of abuse could assist in identifying	F 610	V. Upon admission and care plan meeting/conferences, the managers will determine the needs of the residents, specifically if a resident request a female and/or male care giver. This information would be communicated to the interdisciplinary team including the weekend supervisors. The resident who expresses the female/male will be checked to ensure that this request was honored. This will be done via the assignment sheet every shift and reported to the QAPI committee quarterly and/or more frequently as indicated. The nursing management audits the care plan monthly (see audit tool). When a care plan has not been updated the appropriate discipline is notified. This information is provided to the DON who presents this information to the QAPI committee quarterly and/or more frequently as necessary.	9-30-19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	07/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON CTR FOR AGING SVCS	2601 18TH STREET NE WASHINGTON, DC 20018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 9 whether abuse is occurring or has occurred. Possible indicators include, but are not limited to: 1) an injury that is suspicious because the source of the injury is not observed or the extent or location of the injury is unusual, or because of the number of injuries either at a single point in time or over time. Investigation: 4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witness, and others who might have knowledge of the allegations; 6. Providing complete and thorough documentation of the investigation." Protection: 1. In the interim of the investigation process, the alleged abuser may be suspended from work until an official notice is issued for clearance to return to work or otherwise by Human Resources. 6. Protection from retaliation. Reporting: ...The results of all investigations are reported to the administrator or his or designated representative ...and if the alleged violation is verified appropriate correction action must be taken. ...2. Resident abuse is a ground for immediate termination refer to Employee Handbook". Employee Handbook revised January 2015, page 5, stipulates, "Abuse Prohibition policy: Actions of such may result in immediate termination ..." Record Review Review of Resident #164's medial record showed	F 610	3.**INVESTIGATION – Decision Making** Facility Administration – identification of Abuse and actions taken during/following an investigation I. Meeting held with Administrator and DON by the Corporate Clinical and Administrative Team on 7/23/2019 and 7/24/2019. II. Reviewed other residents and/or unusual occurrences that involved an investigation. One case identified and leadership implementing new investigation process. III. We developed a new Investigation Protocol on 7/21/2019. The Administrative and Nursing Management team were educated regarding the new process. The Corporate office developed with conjunction of Senior Leadership team the Adult Protection Statement. This document will be utilized to ensure that residents with allegations of abuse and/or evidence abuse will be thoroughly evaluated. The Administrator and DON were re-educated regarding Abuse and it was determined that the clinical leadership team, Human Resource Manager, Director of Social Services, DON, QAPI, Director, Staff development and the Administrator would be involved in the decision making process.	9-30-19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	07/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON CTR FOR AGING SVCS	2601 18TH STREET NE WASHINGTON, DC 20018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 10 she was admitted to the facility on November 29, 2016. The Quarterly Minimum Data Set (MDS) dated June 3, 2019, under Section A1000 (Race/Ethnicity) the resident was coded as Asian, Native Hawaiian or other Pacific Islander. Under Section A1100 (Language) the resident was coded as needing and wanting an interpreter to communicate with a doctor or health care staff and preferred language Chinese. She was assessed with severely impaired cognitive skills for daily decision making in Section C (Cognitive Patterns). She was assessed as requiring extensive assistance of two (2) persons for bed mobility, transfers, dressing, toileting, personal hygiene and totally dependent for bathing under Section G (Functional Status). Disease diagnoses listed in Section I include: Diabetes Mellitus, Dementia, Chronic Kidney Disease, Urinary Incontinence, Deficiency in Vitamin D, and Restlessness and Agitation. Further review of the record showed a nurse's note dated June 16, 2019, at 12:30 PM: "Writer was called by CNA [Certified Nursing Assistant/Employee #4] to come to resident room, when asked CNA said, "He was trying to give care to resident when she became combative and in the process of turning, resident hit her head on the side rail of the bed. Happened at 11:35 am. Writer went and assessed resident and noted a swelling on her left face. Supervisors were informed. [Nurse Practitioner- Name] was called, who gave orders for resident to be transported via EMR [emergency response]/911. To the nearest ER [emergency room]. [Resident #164] is alert and unable to explain what happened. Her diagnosis include but not limited to Dementia, with behavioral disturbance, HTN [hypertension], DM [diabetes mellitus] agitation	F 610	III. Cont. Any employee who has been reported and/or suspected of abuse and/or neglect will be removed from the schedule until the detailed report has been completed. IV. Any investigations conducted during the month will be reviewed by the Investigation Committee. This committee ensures that all aspects of the Investigation is complete. This is reported to the QAA Committee Quarterly and/or more often as needed.	9-30-19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	07/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON CTR FOR AGING SVCS	2601 18TH STREET NE WASHINGTON, DC 20018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 11	F 610		

and aggression. On assessment resident noted with swelling of the left fore head near the left eye with a cut on the left upper lip with minimal bleeding which was cleansed with normal saline. Ice pack applied to the left forehead swelling. V/S [vital signs] laying 138/69, P [pulse] 74, T [temperature] 97.7, Sp02 [peripheral capillary oxygen saturation] 98% on room air. V/S [vital signs] sitting B/P [blood pressure] 157/80, P 77, T [temperature] 98.2, R [respirations] 18. Pulse ox [oximetry] room air 97% FS [finger stick] 142 mg/dl [milligrams per deciliter]. Tylenol 2 tabs 325 mg [milligrams] was administered for pain 4/10 and was very effective. Neuro [neurological] check initiated. RP [Responsible Party] made aware."

Continued review of the record showed the [Hospital Name], computed tomography report dated June 16, 2019, showed Resident #164 sustained trauma, Left periorbital soft tissue swelling. Associated displaced fracture lamina papyracea (orbital fracture). Minimal blood in the left ethmoid sinuses.

Resident #164 was discharged from the facility on June 26, 2019.

Review of Employee #4's Personnel Record

" Review of Employee #4's statement dated June 20, 2019 showed, " Incident report on the 16th of June. I went into [Resident #164] room to clean her up, in the process of cleaning her, she became combative and hit her face on the bedrail which caused swelling on her face. So I decided to report the situation to the charge nurse

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	07/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON CTR FOR AGING SVCS	2601 18TH STREET NE WASHINGTON, DC 20018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 12 immediately. I was not contacted on this during the week." " Review of Employee #4's time card showed he arrived at work on June 16, 2019 at 9:29 AM, punched out at 1:30 PM punched back in at 2:00 PM and punched out for the shift at 3:48 PM. " The "Personnel Report of Change" dated June 21, 2019 showed, the Employee #4 was suspended for three (3) days (6/21/19, 6/22/19, and 6/23/19). " In-service records showed Employee #4 attended in-services on "Prohibition of Resident Abuse and Neglect, Managing Resident with Dementia and Aggressive Behavior, Cultural Competency, and Resident Safety during ADL (activities of daily living) care" on June 25, 2019, (five days after the incident). " The "Personnel Report of Change" dated July 16, 2019 showed, the Employee #4 was terminated from the facility on July 16, 2019. There was no evidence facility staff failed to immediately remove Employee #4 from the facility after the incident to ensure the safety of all residents, as evidence below: " The incident occurred at approximately 11:35 AM on June 16, 2019. According to the Employee's time card, he worked the duration of the shift (until 3:48 PM). " There was no documentation of Employee #4's suspension until June 21, 2019 (five days after the incident occurred. (The Employee did not work during this period.) " On June 27, 2019, Employee #4 was allowed to return to work, and assume his duties as a	F 610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	07/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON CTR FOR AGING SVCS	2601 18TH STREET NE WASHINGTON, DC 20018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 13 CNA. Interviews: During a face-to-face interview with the Unit Manager (assigned to the unit of Resident #164) on July 19, 2019, at 2:13 PM, she stated, "I was the manager at the time of the incident with the CNA, it was a weekend on Sunday .... the supervisor called me there was an incident that occurred on your floor and we called 911. The CNA take took care of her an abrasion during care, the face is swollen and we put on ice packs we have to send her out 911. I do not know why Employee #4 was taking care of her because the family requested that they did not have a male they told this to me. The family requested to have another [Employee Name] and that weekend she was off. Employee # 4 knew he was not supposed to take care of the resident. Employee #4 came in late and the other CNA switched [the resident assignment] ...the charge nurse did not know that he switched the resident [assignment]. She [the resident] is always is agitated ..." The surveyor asked, "What do you do when a family make a request regarding patient care?" Most of the time we have an in-service to let them know what the family is requesting. I care plan it so everyone will know /they are well-informed so that the message is passed on ... Resident #1 is an unusual incident I don't tolerate abuse, why should I want to be abused, this is something I will regret. " During a face-to-face interview with Employees' #1 and #2 on July 19, 2019 they stated, "We conducted the investigation of [Resident #1]. He	F 610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	07/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON CTR FOR AGING SVCS	2601 18TH STREET NE WASHINGTON, DC 20018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 14	F 610		

[Employee # 4] was the only person involved in the incident. There were no witnesses. The Employee was suspended immediately. He was sent for education/in-services and returned to work on June 27, 2019 at 7:28 AM. We believe what he [Employee #4] said about what happened. He probably could have called for additional help. We maintain the actions of Employee #1 (CNA) were not abusive (willful) but a care issue. We still believe it's a care issue."

The writer asked, is it my understanding that the Resident only wanted female CNAs? Employees' #1 and #2 stated, "The unit manager got the note [from the family], the note was received before this incident requesting that the resident [Resident #164] not have a male CNA."

The writer asked, what was the outcome of the investigation? Employees' #1 and #2 stated, "The Employee needed further education on combative residents and dignity and monitoring during care."

The writer asked, how were they monitoring Employee #4? Employees' #1 and #2 stated, "They were asking the charge nurses how the employee was doing. The monitoring started immediately [upon his return to work on June 27, 2019]. There was no monitoring tool. They would touch basis on the days he worked to ensure he was fine."

The writer asked, why was the Employee terminated on July 16, 2019? "Employee #1, stated, he was terminated on July 16, 2019, as a result of the DC Department of Health Complaint Investigation Report [C-19-057, DC-4819, harm level deficiency cited], gross negligence,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	07/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON CTR FOR AGING SVCS	2601 18TH STREET NE WASHINGTON, DC 20018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 15	F 610		

carelessness, failure to follow the policy and procedure in the care of a resident. We could have done better."

Summary of Findings:

" The facility failed to provide an interpreter to communicate with the resident while providing health care services (ADL care) Per the MDS dated June 3, 2019.

" The facility failed to provide two (2) person physical assistant when performing adl care for Resident #4 on June 16, 2019, Per the MDS dated June 3, 2019.

" The facility staff failed to ask why Resident #164's family did not want male CNAs caring for the resident.
" The facility staff failed to have written documentation that staff were in-serviced on the family's wishes not to have male CNAs care for Resident #164.

" The facility CNA staff failed to follow their resident care assignments given by the Charge Nurse on June 16, 2019.
" Employee #4 (CNA) failed to stop caring for Resident #164 who became combative during ADL care on June 16, 2019.
" Employee #4 failed to call for assistance when Resident #164 became combative on June 16, 2019.

" The facility's investigation lacked evidence such as, the supervisor's written account of what occurred and how Employee #4 was supervised/managed after the incident, and a written statement from Employee #4 at the time

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	07/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON CTR FOR AGING SVCS	2601 18TH STREET NE WASHINGTON, DC 20018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 16 of the incident stating what occurred during care of the resident. There was no formal written summary/conclusion of the facility's investigation. " The facility administrative staff failed to thoroughly investigate and recognize the incident on June 16, 2019 as a likelihood of abuse or neglect. The administrative staff, however, identified the incident on June 16, 2019 as a "care issue". The facility's administration received the survey findings from the [DC Department of Health] complaint report, and as a result of the findings Employee #4 was terminated on July 16, 2019 for gross negligence, carelessness, and failure to follow the policy and procedure in the care of a resident. Employee #4 worked 33 hours providing care to other residents from June 27, 2019 to July 16, 2019, prior to being terminated. During the face-to-face interview on July 23, 2019 approximately at 2:15 PM, Employees' #1 and #2 acknowledged the findings.	F 610		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview for one (1) of 56 sampled residents, facility staff failed to accurately code the Comprehensive Minimum Data Set (MDS) for one (1) resident with a diagnosis of Glaucoma.	F 641	1. The Comprehensive Minimum Data Set (MDS) for resident#175 was corrected to reflect the diagnosis of Glaucoma and resubmitted on August 16, 2019. 2. A review of residents with Glaucoma was conducted, no other resident was found to be affected by this practice.	9-30-19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	07/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON CTR FOR AGING SVCS	2601 18TH STREET NE WASHINGTON, DC 20018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 17 Findings included ... Resident #175 was admitted on 10/26/2011 with diagnoses to include End Stage Renal Disease, Presence of Cardiac Pacemaker, Glaucoma, and Essential Hypertension. Review of the Comprehensive Minimum Data Set (MDS) dated 6/8/19 showed Resident #175 is cognitively intact as evidenced by a Brief Interview for Mental Status score of "15." Review of the physician's order report dated 7/2/19 showed "Brimonidine drops 0.2% 1 drop in both eyes three times daily for Glaucoma; Latanoprost 0.005% one drop in both eyes at bedtime for Glaucoma." Further review of the MDS showed Section I Active Diagnoses: Vision Cataracts, Glaucoma or Macular Degeneration was left blank which indicate resident does not have an active diagnosis of "Glaucoma." Facility staff failed to accurately code the MDS to include resident's active diagnosis of Glaucoma. During a face-to-face interview on 7/29/19 at 11:30 AM Employee #12 acknowledged the finding and stated "yes, the resident has Glaucoma I will make the change now".	F 641	3. The MDS and RN Management Staff were re-educated regarding importance of accuracy when coding MDS. 4. The MDS leadership reviews and audits MDS for accuracy each month. This information is presented to the QAPI committee at a minimum quarterly.	9-30-19
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability.	F 645		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	07/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON CTR FOR AGING SVCS	2601 18TH STREET NE WASHINGTON, DC 20018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 645	Continued From page 18 §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under	F 645	**1.** Resident #7 was reassessed. Unable to retrospectively correct the practice, but was able to apply for a Level II screening. **2.** A review of resident in facility was conducted. No other residents who required a Level 2 screening was found. **3.** The Admission team was re-educated regarding the importance of ensuring a Level II screening is conducted when the resident's condition warrants it. **4.** The Admission staff will monitor all new admissions monthly to determine that Level I and Level II screening is done. This information will be presented to the QAPI committee quarterly.	9-30-19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	07/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON CTR FOR AGING SVCS	2601 18TH STREET NE WASHINGTON, DC 20018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 645	Continued From page 19 paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 56 sampled residents, it was determined that facility staff failed to ensure that the resident on admission was referred to the appropriate state-designated authority for a Level II Pre-Admission Screen/Resident Review for Mental Illness and or Mental Retardation evaluation and determination. Resident #7. Findings included ... A review of the Pre-Admission Screening/Resident Review for Mental Illness and	F 645		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	07/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON CTR FOR AGING SVCS	2601 18TH STREET NE WASHINGTON, DC 20018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 645	Continued From page 20 or Mental Retardation Level I [PASRR] screen, signed as completed by the facility staff on October 31, 2014, revealed that Resident #7 was identified as positive for major mental disorder Schizophrenia, and a Level II screen is required. There is no evidence that the facility staff completed the Level II Pre-Admission Screening/Resident Review as indicated from the level I screening. Facility staff failed to ensure that the Level 2 Pre-Admission Screen/Resident Review for Mental Illness and or Mental Retardation for Resident #7 who had a diagnosis of Schizophrenia was completed and sent to the appropriate state-designated authority for evaluation and determination. A face-to-face interview was conducted with Employee #11 [SW] on 7/25/2019 at 9:00 AM. After a review of the findings she acknowledged that the level II screening was not done.	F 645		
F 655 SS=E	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information	F 655	1. Resident #235 was reassessed. Facility unable to modify baseline care plan; however, the care plan has been updated to include resident-centered goals and approaches for Lymphedema on the right arm.	9-30-19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	07/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON CTR FOR AGING SVCS	2601 18TH STREET NE WASHINGTON, DC 20018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 655	Continued From page 21 necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 56 sampled residents, facility staff failed to ensure that a baseline care plan included goals and approaches needed to provide effective and person-centered care for one (1) resident who has Lymphedema to the right arm. Resident # 235	F 655	**2.** A review of baseline care plans was completed as it pertained to residents with diagnosis of Thrombosis, Lymphedema and Breast CA was done. Additionally, the base line care plan for residents was conducted for all new admissions (for last 90 days). No other resident was found to be affected by this practice. **3.** The Interdisciplinary team was re-educated regarding the Base line care plan ensuring that it follows person-centered care. **4.** Monitoring the Base line care plans is conducted by the Unit Management team. This information is presented to the DON and/or ADON. This information is then presented to the QAPI committee.	9-30-19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	07/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON CTR FOR AGING SVCS	2601 18TH STREET NE WASHINGTON, DC 20018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 655	Continued From page 22 Findings included... Facility staff failed to ensure that Resident #235 who has a diagnosis of Lymphedema, had a baseline care plan to include goals and approaches needed to provide effective and person-centered care. Resident #235 was admitted to the facility on 6/20/19, with diagnoses to include History of Venous Thrombosis and Embolism, Lymphedema, and Malignant Neoplasm of Breast. The physician's order dated 6/20/19 stipulated, "...4) Ace band apply to r [right] arm, may open daily to exam skin condition. 5) Elevate r [right] arm with pillow to reduce edema." Review of the facility's "48-hour baseline care plan" showed the care plan was initiated on 6/20/19; however, there are no goals or approaches to address the care or the resident's right arm. During a face-to-face interview conducted on 7/25/19 at 3:28 pm, with Employee #16, she acknowledged the findings.	F 655		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	07/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON CTR FOR AGING SVCS	2601 18TH STREET NE WASHINGTON, DC 20018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 23 resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for	F 656	1. Resident #545 is no longer a resident of the facility. Facility unable to retrospectively correct deficient practice. 2. A review of residents who are on a negative pressure system was conducted. No other resident was impacted by this practice. 3. The Interdisciplinary Team was re-educated regarding the Care plan, including ensuring that residents who may be on a negative pressure system was done. The education included the accuracy of care plan to meet the needs of the residents. 4. Monitoring the care plan for accuracy is conducted by the Unit Management team. This information is presented to the DON and/or ADON. This information is then presented to the QAPI committee quarterly.	9-30-19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	07/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON CTR FOR AGING SVCS	2601 18TH STREET NE WASHINGTON, DC 20018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 24 one (1) of 56 sampled residents, facility staff failed to develop a care plan with goals and approaches to properly care for one (1) resident who has a negative pressure dressing/device on her right knee. Resident # 545. Findings included... Facility staff failed to ensure that Resident #545 had a care plan to address the use of a negative pressure dressing and device. Resident #545 was admitted to the facility on July 12, 2019, with diagnoses, which included Presence of right artificial knee joint, obesity, and bipolar disorder. The physician's order dated July 17, 2019, showed, "Keep negative pressure dressing and device in place till follow up with surgeon. Monitor site for drainage and signs of infection [every] shift." On July 18, 2019 at approximately 9:40 AM, Resident #545 was observed sitting in a wheelchair in her room with the negative pressure dressing/device placed over her right knee. Review of Resident #545's care plan lacked evidence of problem/focus area with goals and approaches to address the care of treatment of the negative pressure device placed on the residents right knee. The findings were acknowledged during a	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	07/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON CTR FOR AGING SVCS	2601 18TH STREET NE WASHINGTON, DC 20018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 25 face-to-face interview with Employee #16 on July 22, 2019 at approximately 3:40 PM.	F 656		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interview and record review for three (3) of 56 sampled residents, facility staff failed to revise care plan for one (1) resident diagnosed with penile erosion and laceration, for one (1)	F 657	**1.1** Resident #58 was reassessed immediately, by both the clinical team and the Medical Director. The penile injury resolved and resident was followed up by urology. Resident verbalizes that he has no pain or discomfort in the area. The existing care plan for resident #58 has been reviewed is person centered and meets the needs of the residents. **1.2** A review of all residents with Foley catheters was conducted, no other resident was found to be affected by this practice. **1.3** The licensed staff have been re-educated regarding Foley Catheter Care. A competency has been developed to ensure licensed staffs are knowledgeable as it pertains to Foley Catheter Care.	9-30-19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	07/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON CTR FOR AGING SVCS	2601 18TH STREET NE WASHINGTON, DC 20018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 26 resident with a percutaneous endoscopic gastrostomy (PEG) tube and for one (1) resident who sustained a fall with injury. . Residents' #58, #155 and #182 Findings included .... 1. Facility staff failed to update/revise the care plan with resident-centered goals and approaches for care of Resident #58 with an indwelling Foley catheter who developed an penile injury. Resident #58 was admitted to facility on 1/27/15, with diagnosis to include - Neurogenic bladder, Anemia, Heart Failure, Hypertension, Diabetes Mellitus, Hyperkalemia, Hyperlipidemia, Alzheimer's disease, Non Alzheimer's dementia, Depression, Cataracts. A review of the Quarterly MDS (Minimum Data Set) dated 4/16/19 showed, Section C (Cognitive) - BIMS score 05 indicating resident has severe cognitive impairment. Section G Functional Status the resident was coded as needing total assistance with one to two person support and care under toileting. Section H Bladder/Bowel - Appliances was coded to indicate resident has indwelling urinary draining device. A review of NP (Nurse Practitioner) progress note dated 5/31/2019 revealed, " ...10:36 PM Pt with UR, observed during day, unable to pee, Foley	F 657	**1.4** The Nurse Managers monitor the care plans monthly. The audit tool is utilized to ensure that Person-centered care planning is in place. This includes monitoring the residents who have Foley catheter's care plan. This information is submitted to DON/ADON and is submitted to the QAPI committee quarterly. **2.1** Resident #155 was reassessed immediately. The care plan has been revised and updated to include her PEG tube. **2.2** A review of residents with a PEG tube was conducted. No other residents were found to be affected by this practice. **2.3** The licensed staffs have been re-educated regarding ensuring care plan in place for residents with PEG tube.	9-30-19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	07/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON CTR FOR AGING SVCS	2601 18TH STREET NE WASHINGTON, DC 20018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 27 reinserted able to drain urine. Penis lacerated from previous Foley catheter with ulcer at glans Pt states pain burning at penis. Purulent drainage from penis ... Foley inserted attached to right leg to avoid further laceration at left side Avoid diaper when patient has Foley (to lacerate penis)." There was no evidence facility staff revised care plan to include care of penile laceration and erosion. The findings were acknowledged during a face-to-face interview with Employee #3 (Unit Manager) on July 29, 2019 at 11:00 AM. 2. Facility staff failed to update/revise the care plan with resident-centered goals and approaches for care of Resident #155 percutaneous endoscopic gastrostomy (PEG) tube. Resident #155 was admitted to the facility on 4/17/19 with diagnoses which include Type II Diabetes Mellitus without Complications, Hypertension, End Stage Renal Disease, and Gastro-esophageal Reflux without Esophagitis. Review of the Quarterly Minimum Data Set (MDS) dated 6/1/19 showed resident Brief Interview for Mental Status (BIMS) is coded as "6" to indicate moderately impaired cognition. Further review of the MDS showed Section K [Swallowing/Nutritional Status] Nutrition Approach	F 657	**2.4** The Nurse Managers monitor the care plans monthly. The audit tool is utilized to ensure that care plans are person centered and meet the needs of the residents, including residents who have PEG tubes. This information is submitted to DON/ADON and is submitted to the QAPI committee quarterly. **3.1** Resident #182 is no longer in the facility. Facility unable to retrospectively correct this deficiency. **3.2** A review of residents with recent falls was conducted. The care plans were in compliance. **3.3** The licensed staff have been re-educated regarding updating and revising care plans following a fall.	9-30-19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	07/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON CTR FOR AGING SVCS	2601 18TH STREET NE WASHINGTON, DC 20018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 28 resident is coded as having a "feeding tube." On 7/25/19 at 3:00 PM review of the care plan failed to show goals and approaches for care of Resident #155 percutaneous endoscopic gastrostomy (PEG) tube. During an interview on 7/25/19 at 3:00 PM, Employee# 13 acknowledged the findings. 3.Facility staff failed to update/revise the care plan with resident-centered goals and approaches for care of Resident #182 who sustained a fall with injury. Resident #182 was admitted to the facility on May 15, 2019, with diagnoses that include Chronic Kidney Failure, Benign Prostatic Hyperplasia, Hypertension, Diabetes Mellitus, Hyperlipidemia, Anemia, Parkinsons Disease, and Congestive Heart Failure. A review of Resident #182's admission Minimum Data Set [MDS] dated 5/22/19, showed Section C [Cognitive Patterns] a Brief Interview for Mental Status [BIMS] with a score of "11" which indicated the resident had moderate cognitive impairment. Section G [Functional Status] resident is coded as "3" extensive assistance (resident involved in activity staff provide weight-bearing support) for bed mobility, transfer, locomotion on the unit and locomotion off the unit. A review of the Resident's progress note dated 7/7/19 showed the following: 7/9/19 1:51 PM Nurse Practitioner Progress note;	F 657	**3.4** The Nurse Managers monitor the care plans monthly. The audit tool is utilized to ensure that Person-centered care planning is in place, including a care plan for residents with falls. This information is submitted to DON/ADON and is submitted to the QAPI committee quarterly.	9-30-19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	07/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON CTR FOR AGING SVCS	2601 18TH STREET NE WASHINGTON, DC 20018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 29 "Pt c/o pain today at left leg ... x-ray ordered ... pain with ROM at left leg at knee part, had pain earlier at left hip, slight swelling left leg and lower thigh, x-ray left leg." 7/10/19 9:52 AM Nurse's late entry for 7/9/19 "Resident is status post fall day 3/3. Seen by the NP ...due to complaint of pain on the left hip that radiates to the lower extremity. As result, x-ray of the left hip, left femur and left knee was ordered. X-ray was done at 3 pm, preliminary x-ray result showed resident has fracture of the left femur NP was notified An order to transfer resident to the emergency room ... ." A review of the care plan initiated on 5/17/19 showed "resident at risk for falling r/t [related] cognitive impairment, unsteady gait and diagnosis of Parkinson disease. On 5/25/19 ... resident was observe on the floor with no injury." Further review of the fall care plan on July 25, 2019 failed to show any evidence that the facility reviewed and revised the care plan after the resident sustaineda fall with injury on July 7, 2019 During a face-to-face interview with Employee #13 on 7/26/19, at 1:44 PM, he acknowledged the findings	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced	F 658	**1.1** Resident #14's blood pressure was rechecked using an appropriate blood pressure cuff immediately. The staff identified during the survey was in serviced immediately.	9-30-19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	07/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON CTR FOR AGING SVCS	2601 18TH STREET NE WASHINGTON, DC 20018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 30 by: Based on Medpass observation and interview for one (1) of 56 sampled residents, the facility staff failed to provide care in accordance with professional nursing standards as evidenced by the staff was observed using the blood pressure machine incorrectly to measure one (1) resident's blood pressure. Resident #14. Findings included... According to the American Heart Association: "Accurate measurement of blood pressure is essential to classify individuals, to ascertain blood pressure-related risk, and to guide management. ... Selection of the correct cuff size, and proper patient positioning if accurate blood pressures are to be obtained ... In view of the consequences of inaccurate measurement, regulatory agencies should establish standards to ensure the use of validated devices, routine calibration of equipment, and the training and retraining of manual observers." Retrieved from: www.ahajournals.org/doi/full/10.1161/01.HYP.0000150859.47929.8e Resident #14 was admitted to the facility on December 27, 2017, with diagnoses, which include Chronic Kidney Disease, Neoplasm of Prostate, Cardiomegaly, Hypertension, Hyperlipidemia, and Coronary Atherosclerosis. . A review of the Quarterly Minimum Data Set [MDS] dated April 3, 2019, Section C0500 [BIMS	F 658	1.2 A review of all other licensed staff was conducted. All were identified to be proficient in measuring the blood pressure. 1.3 All units were checked to ensure appropriate workable blood pressure cuffs were in place. The licensed staff were re-educated and evaluated via competency testing as it pertains to blood pressure monitoring. 1.4 The nurse managers monitor their staff taking blood pressures monthly. This documentation is compiled and provided to the DON/ADON. This information is presented to the QAPI committee monthly.	9-30-19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	07/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON CTR FOR AGING SVCS	2601 18TH STREET NE WASHINGTON, DC 20018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 31 (Brief Interview for Mental Status) Summary Scores] of "12" Moderately impaired which indicates, "Resident unable to make decisions". During Med pass observation on July 23, 2019, at 8:55 AM, Employee #10 was observed using the blood pressure machine incorrectly to measure Resident # 14's blood pressure and to walk away out of the room, leaving the resident's medication at the bedside prior to administering the resident his medication. The employee used an automatic digital blood pressure machine provided by the facility for measuring residents blood pressure. Observation showed the blood pressure machine had a problem measuring Resident #14's blood pressure. Employee#17 removed and reapplied the digital upper arm blood pressure cuff to the resident's forearm to measure the resident's blood pressure. At the time of the observation, Employee #17 was asked what is the process used for applying a blood pressure cuff to measure the blood pressure. Employee #17 was able to verbalize the process used to measure the resident blood pressure and concluded that the machine was having a problem. At the time of the observation, Employee #, 17 did not recheck the resident's blood pressure for accuracy. A face-to-face interview was conducted on July 23, 2019, at approximately 10:15 AM, with Employee #18 and Employee #17. Both employees acknowledged the findings.	F 658		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	07/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON CTR FOR AGING SVCS	2601 18TH STREET NE WASHINGTON, DC 20018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 32 Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 56 sampled residents facility's staff failed to ensure the resident received treatment and care in accordance with professional standards of practice as evidenced by failure to ensure that Resident #548 was seen by the orthopedic physician in a timely manner. Findings included... Resident #548 was admitted to the facility on 7/10/19, with diagnoses to include Pain in Ankle and Joints of Unspecified Foot, Unstable Angina, Diabetes without Complications and Hypertension. During a face-to-face interview with Resident #548 on 7/17/19 he stated, "I have not had a follow up appointment related to my fractured toe(s). When I spoke with the facility, they stated the hospital did not give them the appointment date. I have not seen the orthopedic surgeon since I have been here and I do not have an appointment." Review of the discharge summary from the	F 684	1. Resident #548 was reassessed. An Orthopedic appointment was immediately re-scheduled. Resident #684 met his goals and was discharged home. 2. Review of residents who have consultations with follow-up appointments and/or newly admitted and with follow-up appointments. No resident was affected by this practice. 3. The nursing management and Unit Secretaries were re-educated regarding scheduling of follow-up appointment. A monitoring tool will be used to monitor the scheduled follow-up appointments. 4. Monitoring follow-up appointment has been added to the quality improvement tool. This will be done monthly and submitted to the DON and/or representative. This information will be submitted quarterly to the QAPI committee.	9-30-19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	07/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON CTR FOR AGING SVCS	2601 18TH STREET NE WASHINGTON, DC 20018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 33 hospital dated 7/10/19, showed, " ...[Resident #548] should remain NWB (Non weight bearing) LLE (left lower extremity) and elevate LLE when not ambulating ...Follow up with [Doctor Name] in 7-10 days after discharge. Splint should remain in place and will get repeat x-rays in ortho clinic in 2 weeks." The physician's order dated 7/13/19 stipulated, " ...Schedule appointment to follow up with orthopedic ..." The facility staff failed to schedule Resident #548 for a follow up orthopedic appointment in a timely manner. During a face-to-face interview with Employee #16 on 7/22/19, at 2:12 PM, she (nurse manager) stated the appointment has not been made. He did not come with an appointment date. Employee #16 then reviewed the discharge summary and stated, "We will make the appointment today." The facility staff failed to ensure that Resident #548 was seen by the orthopedic physician within 7 -10 days after he was discharged from the hospital.	F 684		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident 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	F 689	**1.1** The staffs were immediately in-serviced on Solarium Coverage. Resident #182 is no longer in facility therefore unable to retrospectively make any changes in his care needs.	9-30-19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	07/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON CTR FOR AGING SVCS	2601 18TH STREET NE WASHINGTON, DC 20018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 34 accidents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 56 sampled residents, facility staff failed to ensure one (1) resident who was identified as a fall risk received adequate supervision. The resident was left unattended in the solarium where he subsequently fell from his wheel chair and sustained a left Femur fracture. Resident #182 Findings included... A review of the Resident's Clinical record showed that on July 7, 2019, at 11: 00 AM Resident #182 was left unattended in the solarium where he subsequently fell from his wheel chair and sustained a left Femur fracture. Resident #182 was admitted to the facility on May 15, 2019, with diagnoses that includes Chronic Kidney Failure, Benign Prostatic Hyperplasia, Hypertension, Diabetes Mellitus, Hyperlipidemia, Anemia, Parkinsons Disease, and Congestive Heart Failure. A review of Resident #182's admission Minimum Data Set [MDS] dated 5/22/19, showed Section C [Cognitive Patterns] a Brief Interview for Mental Status [BIMS] with a score of "11" which indicates the resident had moderate cognitive impairment. Section G [Functional Status] resident is coded as "3" extensive assistance with one (1) person physical assist for bed mobility, transfer, locomotion on the unit and locomotion off the unit. Section G 0400 Functional Limitation in Range of motion code "0" indicates No impairment. Section J I700 Fall History on Admission/entry was coded	F 689	**1.2** A review of all Solariums was conducted; no other Solariums were impacted by this practice. **1.3** The nursing staff were re-educated regarding Solarium coverage including roles and responsibility when assigned to the Solarium. **1.4** Monitoring the Solarium is a part of the QI monitoring program. The nursing management team conducts evaluation of Solarium at least once a week. This information is presented to the QAPI committee.	9-30-19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	07/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON CTR FOR AGING SVCS	2601 18TH STREET NE WASHINGTON, DC 20018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 35 as"1" to indicate that the resident had a fall 2 - 6 months prior to his admission to the facility. A review of the care plan initiated on 5/17/19 showed "resident at risk for falling r/t [related] cognitive impairment, unsteady gait and diagnosis of Parkinson disease. On 5/25/19 ... resident was observe on the floor with no injury." There was no mention that Resident #182 had a fall on 7/7/19. A review of the Resident's progress note showed the following: 7/7/19/ 1:41 PM "Writer [RN Supervisor] was called to unit 3 green and noted resident in a sitting position in front of his wheel chair in the solarium. Upon assessment resident denied pain or discomfort, no injury noted, denied hitting his head able to move his upper arm and lower extremities without difficulty to his baseline. ... Resident was asked how he got to the floor he said that he did not know" 7/9/19 1:51 PM NP's [Nurse Practitioner's] Progress note showed "Pt c/o pain today at left leg ... x-ray ordered ... pain with ROM at left leg at knee part, had pain earlier at left hip, slight swelling left leg and lower thigh, x-ray left leg." 7/10/19 9:52 AM [RN] late entry for 7/9/19 "Resident is status post fall day 3/3. Seen by the NP ...due to complaint of pain on the left hip that radiates to the lower extremity. As result, x-ray of the left hip, left femur and left knee was ordered. X-ray was done at 3 pm, preliminary x-ray result showed resident has fracture of the left femur NP was notified An order to transfer resident to the	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	07/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON CTR FOR AGING SVCS	2601 18TH STREET NE WASHINGTON, DC 20018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 36 emergency room ... ." A review of the result of the stat x-ray of left femur, left knee, left hip and pelvis on 7/9/19 ordered by NP showed "Impression: Acute Fracture of the Proximal Left Femur." A face to face interview was conducted on 7/26/19 at 1:55 PM with Employee #19 [CNA] who stated, "I was in the solarium watching and monitoring residents when my coworker in the room next to the solarium asked me for help to put a resident in chair. I left the solarium to the room right outside the solarium to help with another resident. While in the room I heard someone say resident on the floor in solarium and ran back in there he was sitting on the floor in front of wheel chair. On Tuesday I was giving AM care when I went to move him he says ouch, ouch. I asked what was wrong he pointed to left side of hip. I called charge nurse and she came to see him." Another face to face interview was conducted on 7/26/19 at 1:59 PM with Employee #20 [CNA] who stated, "I was in [resident,s name] room getting her ready to get out of bed, [CNA name] in solarium covering residents in solarium. I had went to her to ask her to help me put [resident's name] in chair. She did and while in room another resident called out patient on floor. We both ran out to solarium he was sitting up on the floor beside his wheel chair. He did not complain staff came and assessed him." The evidence showed that facility staff failed to ensure one (1) resident who sustained a fall with an injury received adequate supervision to prevent an accident as evidenced by the staff	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	07/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON CTR FOR AGING SVCS	2601 18TH STREET NE WASHINGTON, DC 20018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 37 assigned to watch and monitor the residents in the solarium left him unattended. During a face-to-face interview with Employee #13 [unit manager] on 7/26/19, at 1:44 PM, he acknowledged the findings and stated, "The staff assigned to the solarium left to help a coworker although we educate them not to leave residents in the solarium alone."	F 689		
F 690 SS=G	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.	F 690	**1.** Resident #58 was reassessed by the clinical team and the Medical Director. It was determined that the area identified was not lacerated and appeared old. Resident was sent out for urology appointment for further follow-up. Resident verbalized no discomfort. **2.** A review of residents with Foley Catheters was conducted; no other residents were noted to be impacted by this practice. **3.** The licensed nursing leadership team was re-educated and Competency of staff was conducted as it pertains to Foley Catheter.	9-30-19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	07/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON CTR FOR AGING SVCS	2601 18TH STREET NE WASHINGTON, DC 20018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 38 §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on policy review, medical record review, and staff interviews for one (1) of 56 sampled residents, the facility staff failed to provide appropriate and sufficient catheter care and assessments and reassessments to prevent Harm for Resident #58 who was admitted with an indwelling Foley catheter which resulted in penile erosion and laceration. Findings included... "Wound, Ostomy and Continence Nurses Society. (2016). Care and management of patients with urinary catheters: A clinical resource guide. MT. Laurel: NJ. Author" "Securement Devices: ...Indwelling catheters should be secured to avoid traction on the catheter, which causes irritation and trauma to the urethra(e.g., urethritis, necrosis, erosion, stricture) ...monitor the urethra daily for irritation, erosion, or urine leakage and assess the skin integrity under the securement device." Resident #58 was readmitted to facility on 12/21/18, with diagnosis to include - Neurogenic bladder, Anemia, Heart Failure, Hypertension, Diabetes Mellitus, Hyperkalemia, Hyperlipidemia,	F 690	**4.** An audit tool was conducted monitoring residents with Foley Catheters ensuring that catheter care is done and documentation in place. This information is provided to the QAPI committee quarterly.	9-30-19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	07/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON CTR FOR AGING SVCS	2601 18TH STREET NE WASHINGTON, DC 20018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 39 Alzheimer's disease, Non Alzheimer's dementia, Depression, Cataracts. A review of the Comprehensive MDS (Minimum Data Set) dated 4/16/19 showed, Section C (Cognitive) - BIMS score 05 indicating resident has severe cognitive impairment. Section G Functional Status the resident was coded as needing total assistance with one to two person support and care under toileting. Section H Bladder/Bowel - Appliances was coded to indicate resident has indwelling urinary draining device. A review of the care plan for Foley Catheter due to Urinary Retention showed it was initiated on 1/23/2019. Goal: resident will have catheter care managed appropriately ...not exhibiting signs of urinary tract infection or urethral trauma. Approach: ...report signs of UTI ...manipulate tubing as little as possible during care ...provide catheter care ...use catheter strap ...use leg bag as needed ..." A review of Medical Record Revealed: A physician's order dated 12/7/2018, "Insert Foley for UR [urinary retention]." "Urology consult for UR" 12/10/2018." "Urology Consult-1/3/2019, Diagnosis; Urinary Retention with chronic indwelling Foley catheter and urethral erosion." A review of NP (Nurse Practitioner) progress note dated 5/31/2019, revealed, "...10:36 PM Pt with UR, observed during day, unable to pee, Foley	F 690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	07/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON CTR FOR AGING SVCS	2601 18TH STREET NE WASHINGTON, DC 20018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 40	F 690		

reinserted able to drain urine. Penis lacerated from previous Foley catheter with ulcer at glans Pt states pain burning at penis. Purulent drainage from penis ... Foley inserted attached to right leg to avoid further laceration at left side avoid diaper when patient has Foley (to lacerate penis)."

5/31/2019 - Interim Order, "Please avoid diaper when pt. has a Foley (cause Laceration of penis) Foley inserted routine Foley care q shift."

A review of NP Progress note dated 6/4/2019, "...Pt with Foley catheter with ulcer of glans purulent drainage from penis ..."

6/5/2019- Interim Order, "D/C order to avoid diaper when pt. has a Foley Use diaper to make it loose to prevent laceration."

"Urology Consult for possible Suprapubic catheter (6/20/2019) ...Progress note Urinary retention UTI [Urinary ...Penile erosion ...plan for SP [Suprapubic] tube placement under local ..."

"Urology consultation for urinary retention at [Hospital Name] at 1:30 PM with [Physician name] (07/03/19). Change Foley catheter q 6 weeks obtain medical records or other history to determine if there are reasonable alternative to indwelling Foley catheter ..."

7/5/2019- Urology Consult findings: S/P tube inserted under u/s (ultrasound) guidance New diagnosis: Urinary Retention managed with SP tube ...urethral erosion.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	07/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON CTR FOR AGING SVCS	2601 18TH STREET NE WASHINGTON, DC 20018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 41 7/9/ 2019- Interim Order" urology F/U [follow up] for Suprapubic Cath ..." Upon review of the nursing progress notes dated April 1, 2019 through July 30, 2019 showed no evidence the facility staff assessed the resident's genitourinary status for complications (irritation and trauma to the penis or urethra) regarding indwelling Foley catheter prior to or after the penile laceration and erosion occurred and was documented by Nurse Practitioner resulting in the surgical insertion of the suprapubic catheter directly in to the Residents bladder for further care. Through record review, it was noted the resident was diagnosed with penial erosion on 1/3/19. There was no evidence that facility staff conducted an initial and ongoing genitourinary assessment (size, discoloration of skin, odor, swelling, pain, drainage) and treatment plan to promote healing. On 5/31/19, the resident was noted with a laceration to his penis from previous Foley catheter with ulcer at glans, with pain burning and purulent drainage from penis. On 7/5/19, the resident had a suprapubic catheter inserted due to urinary retention and urethral erosion. The findings were acknowledged on July 29, 2019, at 10:00 AM during a face-to-face interview with Employee # 3 who stated she did not know what erosion was and would look it up on the internet."	F 690		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5)	F 693		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	07/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON CTR FOR AGING SVCS	2601 18TH STREET NE WASHINGTON, DC 20018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 693	Continued From page 42 §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview for one (1) of 56 sampled residents facility staff failed to provide evidence of providing care for one (1) resident's percutaneous endoscopic gastrostomy (PEG) site. Resident #155. Findings included ... Resident #155 was admitted to the facility on 4/17/19 with diagnoses which include Type II Diabetes Mellitus without Complications, Hypertension, End Stage Renal Disease, and Gastro-esophageal Reflux without Esophagitis.	F 693	1. Resident #155 was reassessed. A review of orders from Medical Staff was noted. Documentation and Care plan updated to meet the needs of the resident as it pertained to the PEG tube. 2. A review of residents with PEG tube was conducted. No other residents were found to be impacted by this practice. 3. The licensed staff were re-educated regarding monitoring physician's orders and the care needs of the residents including residents with PEG tube. A competency was put in place to ensure that staffs understand the needs of residents with PEG tube. 4. Monitoring of residents with PEG tubes is done by the Nursing Managements at a minimum once a month with a tool designed to monitor residents with a PEG tube. This information will be presented to the DON and then submitted to the QAPI committee quarterly.	9-30-19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	07/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON CTR FOR AGING SVCS	2601 18TH STREET NE WASHINGTON, DC 20018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 693	Continued From page 43	F 693		

Review of the Quarterly Minimum Data Set (MDS) dated 6/1/19 showed resident Brief Interview for Mental Status (BIMS) is coded as "6" to indicate moderately impaired cognition. Further review of the MDS showed Section K [Swallowing/Nutritional Status] Nutrition Approach resident is coded as having a "feeding tube." Percutaneous Endoscopic Gastrostomy (PEG) is a medical procedure in whch a tube is passed into a patient's stomach to provide a means of feeding when oral intake is not adequate.

Review of the nurses note on 6/28/19 showed "resident went to the emergency room via non-emergency ambulance for evaluation."

Review of [Hospital name] transfer summary dated 7/3/19 showed "the patient was found to have skin excoriation and some pus discharge around the PEG tube site on admission." Further review of the transfer summary showed discharge plan "please continue the PEG care at the nursing home, clean the area around the PEG tube."

Observation on 7/26/19 at 11:30 AM of Resident #155 PEG site showed PEG tube insertion site without a dressing in place or evidence the site was cleaned.

During an interview on 7/26/19, at 11:30 AM Employee #13 was asked if nurses were providing PEG site care? Employee #13, I did not see this on the transfer summary, I will let the doctor know right away."

Review of the medical record showed no

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	07/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON CTR FOR AGING SVCS	2601 18TH STREET NE WASHINGTON, DC 20018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 693	Continued From page 44 documented evidence facility staff are cleaning around the PEG site. Facility staff failed to provide evidence of providing skin care to PEG site to maintain infection control practices. During a face-to-face interview on 7/26/19 at 11:30 AM, Employee #13 acknowleged the finding.	F 693		
F 726 SS=E	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides.	F 726	**1.1** Resident #58 was reassessed by the clinical team and the Medical Director. It was determined that the area identified was not lacerated and appeared old. Resident was sent out for urology appointment for further follow-up. Resident verbalized no discomfort. The staffs assigned to provide care to Resident #58 were immediately re-educated. **1.2** A review of residents with Foley Catheters was conducted; no other residents were noted to be impacted by this practice. **1.3** The licensed nursing leadership team was re-educated and Competency of staff was conducted as it pertains to Foley Catheter.	9-30-19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	07/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON CTR FOR AGING SVCS	2601 18TH STREET NE WASHINGTON, DC 20018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 726	Continued From page 45 The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews for two (2) of 56 sampled residents, the facility staff failed to provide competent nursing staff to care for one (1) resident with an indwelling Foley catheter who developed an penile injury; and failed to ensure nursing staff has specific competencies and skills to assess and care for one (1) resident who is dialysis-dependent and has a arteriovenous (AV) fistula graft site. Residents' #58 and #175. Findings included... 1. Facility staff failed to provide competent nursing staff to care for Resident #58 with an indwelling Foley catheter who developed an penile injury. "Wound, Ostomy and Continence Nurses Society. (2016). Care and management of patients with urinary catheters: A clinical resource guide. MT. Laurel: NJ. Author" "Securement Devices: ...Indwelling catheters should be secured to avoid traction on the catheter, which causes irritation and trauma to the urethra(e.g., urethritis, necrosis, erosion, stricture) ...monitor the urethra daily for irritation, erosion, or urine leakage and assess the skin integrity under the securement device."	F 726	**1.4** An audit tool was conducted monitoring residents with Foley Catheters ensuring that catheter care is done and documentation in place. This information is provided to the QAPI committee quarterly. **2.1** Resident #175 was reassessed. A review of resident's care needs was determined and care plan in place to ensure that resident's needs are met. The staffs assigned to provide care to Resident #175 were immediately re-educated. **2.2** A review of dialysis dependent residents with arteriovenous (AV) fistula graft was conducted; no other residents were impacted by this practice. **2.3** The licensed nursing leadership team was re-educated and Competency of staff was conducted as it pertains to residents on dialysis with AV fistula grafts.	9-30-19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	07/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON CTR FOR AGING SVCS	2601 18TH STREET NE WASHINGTON, DC 20018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 726	Continued From page 46 Resident #58 was readmitted to facility on 12/21/18, with diagnosis to include - Neurogenic bladder, Anemia, Heart Failure, Hypertension, Diabetes Mellitus, Hyperkalemia, Hyperlipidemia, Alzheimer's disease, Non Alzheimer's dementia, Depression, Cataracts. A review of the Comprehensive MDS (Minimum Data Set) dated 4/16/19 showed, Section C (Cognitive) - BIMS score 05 indicating resident has severe cognitive impairment. Section G Functional Status the resident was coded as needing total assistance with one to two person support and care under toileting. Section H Bladder/Bowel - Appliances was coded to indicate resident has indwelling urinary draining device. A review of the care plan for Foley Catheter due to Urinary Retention showed it was initiated on 1/23/2019. Goal: resident will have catheter care managed appropriately ...not exhibiting signs of urinary tract infection or urethral trauma. Approach: ...report signs of UTI ...manipulate tubing as little as possible during care ...provide catheter care ...use catheter strap ...use leg bag as needed ..." A review of Medical Record Revealed: A physician's order dated 12/7/2018, "Insert Foley for UR [urinary retention]." "Urology consult for UR" 12/10/2018." "Urology Consult-1/3/2019, Diagnosis; Urinary Retention with chronic indwelling Foley catheter and urethral erosion."	F 726	**1.4** An audit tool was conducted monitoring residents with Dialysis and AV graft is done ensuring appropriate documentation in place. This information is provided to the QAPI committee quarterly.	9-30-19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	07/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON CTR FOR AGING SVCS	2601 18TH STREET NE WASHINGTON, DC 20018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 726	Continued From page 47	F 726		

A review of NP (Nurse Practitioner) progress note dated 5/31/2019, revealed, "...10:36 PM Pt with UR, observed during day, unable to pee, Foley reinserted able to drain urine. Penis lacerated from previous Foley catheter with ulcer at glans Pt states pain burning at penis. Purulent drainage from penis ... Foley inserted attached to right leg to avoid further laceration at left side avoid diaper when patient has Foley (to lacerate penis)."

5/31/2019 - Interim Order, "Please avoid diaper when pt. has a Foley (cause Laceration of penis) Foley inserted routine Foley care q shift."

A review of NP Progress note dated 6/4/2019, "...Pt with Foley catheter with ulcer of glans purulent drainage from penis ..."

6/5/2019- Interim Order, "D/C order to avoid diaper when pt. has a Foley Use diaper to make it loose to prevent laceration."

"Urology Consult for possible Suprapubic catheter (6/20/2019) ...Progress note Urinary retention UTI [Urinary ...Penile erosion ...plan for SP [Suprapubic] tube placement under local ..."

"Urology consultation for urinary retention at [Hospital Name] at 1:30 PM with [Physician name] (07/03/19). Change Foley catheter q 6 weeks obtain medical records or other history to determine if there are reasonable alternative to indwelling Foley catheter ..."

7/5/2019- Urology Consult findings: S/P tube

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	07/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON CTR FOR AGING SVCS	2601 18TH STREET NE WASHINGTON, DC 20018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 726	Continued From page 48 inserted under u/s (ultrasound) guidance New diagnosis: Urinary Retention managed with SP tube ...urethral erosion. 7/9/ 2019- Interim Order" urology F/U [follow up] for Suprapubic Cath ..." Upon review of the nursing progress notes dated April 1, 2019 through July 30, 2019 showed no evidence the facility staff assessed the resident's genital-urinal status for complications (irritation and trauma to the penis or urethra) regarding indwelling Foley catheter prior to or after the penile laceration and erosion occurred and was documented by Nurse Practitioner resulting in the surgical insertion of the suprapubic catheter directly in to the Residents bladder for further care. Through record review, it was noted the resident was diagnosed with penial erosion on 1/3/19. There was no evidence that facility staff conducted an initial and ongoing genitourinary assessment (size, discoloration of skin, odor, swelling, pain, drainage) and treatment plan to promote healing. On 5/31/19, the resident was noted with a laceration to his penis from previous Foley catheter with ulcer at glans, with pain burning and purulent drainage from penis. On 7/5/19, the resident had a suprapubic catheter inserted due to urinary retention and urethral erosion. The findings were acknowledged on July 29, 2019, at 10:00 AM during a face-to-face interview with Employee # 3 who stated she did not know what erosion was and would look it up on the	F 726		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	07/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON CTR FOR AGING SVCS	2601 18TH STREET NE WASHINGTON, DC 20018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 726	Continued From page 49 internet." 2. Facility staff failed to ensure nursing staff has specific competencies and skills to assess and care for a dialysis-dependent arteriovenous (AV) fistula graft site. Resident #175. Record review of the facility's undated policy titled, "Care of Resident Receiving Dialysis" showed "the nurse will check the thrill/bruit at the access site every shift." Caring for a Patient's Vascular Access for Hemodialysis: Assess for patency at least every eight hours. Palpate the vascular access to feel for a thrill or vibration that indicates arterial and venous blood flow and patency. Auscultate the vascular access with a stethoscope to detect a bruit or "swishing" sound that indicates patency. Retrieved from: Nursing Management (2011). Resident #175 was admitted to the facility on 10/26/11, with diagnoses which include Hypertension, End Stage Renal Disease dependence on Dialysis, Type II Diabetes Mellitus and Chronic Kidney Disease. Review of the Comprehensive Minimum Data Set (MDS) dated 6/8/19, showed resident Brief Interview for Mental Status (BIMS) is coded as "15" to indicate cognitively intact. Further review of the MDS showed Section O [Special Treatments, Procedures and Programs] resident is coded as receiving dialysis.	F 726		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	07/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON CTR FOR AGING SVCS	2601 18TH STREET NE WASHINGTON, DC 20018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 726	Continued From page 50 Review of physician's order dated 7/2/19, showed "Resident has dialysis on Tuesdays, Thursdays and Saturdays for End Stage Renal Disease." Review of resident's care plan showed, "Dialysis Dependent: monitor dialysis access site arteriovenous fistula (AV) to left arm for bruit, thrill and bleeding." Review of the nursing assessment notes of the AV fistula site showed the following entries: 5/5/19: "Thrill/Trust present." 5/14/19: "No infection, thrill/trust present." 6/4/19: "Thrill/Trust present at this time." 6/11/19: "No infection noted, thrill/trust present." 7/16/19: "Thrill/Trust was present." 7/17/19: "Thrill/Trust present." On 7/25/19, at 1:00 PM an interview with Employee #15 in the presence of Employee #14. Employee #15 was asked how do you assess the resident's AV graft site. Employee #15 stated, "I look for infection and bleeding." Employee #15 was asked what is a trust? Employee responded, "That is when the blood is going back and forth." Employee #15 was asked do you use a stethoscope when assessing the AV fistula site. Employee #15 responded, "No." There is no evidence the nurse assessing the AV fistula has the skill or competency to provide care in accordance with professional standards of	F 726		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	07/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON CTR FOR AGING SVCS	2601 18TH STREET NE WASHINGTON, DC 20018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 726	Continued From page 51 practice; review of the medical showed there was no harm to the resident. At the time of the interview on 7/25/19, at 1:00 PM Employee#14 and Employee #15 acknowledged the finding.	F 726		
F 740 SS=E	Behavioral Health Services CFR(s): 483.40 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 56 sampled residents facility staff failed to provide the necessary behavioral health care services and antidepressant medication for Resident #63 to attain the highest practicable physical, psychosocial and mental well-being in accordance with the comprehensive assessment and plan of care. Findings included .... Resident #63 was admitted to the facility on 4/17/19, with diagnoses which include: Dyspnea, Hypokalemia, Major Depressive Disorder, Essential (Primary) Hypertension and Hyperlipidemia.	F 740	**1.** Resident # 63 was seen by the psychiatrist on 7/24/2019. Prozac (antidepressant) was ordered. Plan of care updated to reflect the new medication for major depressive disorder **2.** A review of residents with diagnosis of depression was conducted. No other residents were found to be impacted by this practice. **3.** The Interdisciplinary Team was re-educated regarding provision of necessary behavioral health care and services as necessary for residents to attain the highest practicable physical, psychological and mental well being	9-30-19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	07/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON CTR FOR AGING SVCS	2601 18TH STREET NE WASHINGTON, DC 20018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 740	Continued From page 52 Review of the Comprehensive Minimum Data Set (MDS) dated 4/24/19, showed Resident #63's Brief Interview for Mental Status (BIMS) is coded as "15" to indicate she is cognitively intact. Further review of the MDS showed Section D [Mood] resident is coded as "1" to indicate the presence of the following symptoms: "feeling down, depressed or hopeless, trouble concentrating on things, poor appetite, trouble falling or staying asleep ..."Section I [Active Diagnoses] showed Psychiatric/Mood Disorder, Depression is selected. Section N [Medications] Antidepressants is not selected to indicate resident did not receive antidepressant medication. Review of the Social Service note dated 7/19/19, showed "resident stopped this social worker stating that she took Prozac in the past but has not, since being admitted ..." During a resident interview on 7/24/19, at 4:00 PM, Resident #63 stated, "I told the nurse that I was on an antidepressant and I have not been getting my medicine and I have nightmares." Resident denied wanting to harm herself or others. Review of the physician's orders for April-June 2019, failed to show the resident was prescribed an antidepressant. During an interview on 7/24/19, at 4:30 PM with the Employee #13 stated, "She is care planned for depression but no she is not on medication or seeing the psychiatrist, I will get on this right away".	F 740	4. As a component of the Quality Assurance/Improvement Program the monitoring of residents needing behavioral services has been added to the quality improvement tool. This information is presented to the DON and/or ADON. This information is then presented to the QAPI committee quarterly	9-30-19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	07/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON CTR FOR AGING SVCS	2601 18TH STREET NE WASHINGTON, DC 20018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 740	Continued From page 53 Observations during survey period (7/17/19 through 7/30/19) showed resident participating in activities daily and talking with other residents. Facility staff failed to provide the necessary behavioral health care and services (to include medications) to a resident with a Major Depressive Disorder. Review of the medical record showed there was no harm to the resident. During a face-to-face interview on 7/24/19, at 4:30 PM, Employee #13 acknowledged the finding.	F 740		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.	F 755	**1.** The Narcotic shift count for Units 1 Orange and 1 Green were immediately reconciled. No residents on units 1 Orange and 1 Green were impacted by this practice. **2.** All other Unit Narcotic Books were checked. No other units and no other residents were impacted by this practice. **3.** All licensed staff were re-educated regarding the Standard of Practice to account for the receipt, usage, disposition and reconciliation of controlled substances.	9-30-19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	07/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON CTR FOR AGING SVCS	2601 18TH STREET NE WASHINGTON, DC 20018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 54 §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews for two (2) of nine (9) nursing units, the facility staff failed to ensure that the system use for acceptable standard of practice to account for the receipt, usage, disposition, and reconciliation of controlled medications was followed. Findings included... A review of the Shift count Narcotic records on Unit 1 Green was completed on July 19, 2019, at approximately 9:00 AM. The review showed that on June 5, 2019, the Shift count Narcotic was missing a nurse signature (indicating it was not done) in the space allotted the nurse going off duty to reconcile the Narcotics for the 7:30 AM to 3:30 PM shift. A review of the Shift count Narcotic records on Unit 1 Orange was completed on July 19, 2019, at approximately 9:10 AM. On July 12, 2019, the Narcotic count sheet, showed the spaces allotted for nurse signature going off duty to reconcile the Narcotics for the 11:00 PM to 7:30 AM shift was left blank indicating "Not Done".	F 755	4. The Nurse Managers will conduct audits of their Narcotic Records monthly. This information will be presented to the DON and/or ADON monthly and presented to the QAPI committee quarterly.	9-30-19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	07/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON CTR FOR AGING SVCS	2601 18TH STREET NE WASHINGTON, DC 20018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 55 A review of the Shift Verification of Accuracy of Controlled Drug Record to the Actual Narcotic Count [Reconciliation Controlled Drug Count Verification Form] directed, "Shift count sheet for Narcotics balance must be verified by the nurse coming on duty and nurse going off duty at each change of shift" The evidence showed that the system's use for acceptable standard of practice to account for the receipt, usage, disposition, and reconciliation of controlled medications was not followed. A face-to-face interview was conducted with Employee #5 on July 26, 2019, at approximately 11:10 AM. After a review of the documentation, she acknowledged the findings.	F 755		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.	F 812	1. The Sprinklers located above the tilt skillet, the grease fryer and the stove were cleaned immediately. The contractor was called and corrected the tent skillet at the defector. A safety barrier was placed around the main kitchen fountain. A new form was updated for the water temperature log, unable to retrospectively correct the dish machine temperature log.	9-30-19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	07/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON CTR FOR AGING SVCS	2601 18TH STREET NE WASHINGTON, DC 20018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 56 §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the facility failed to prepare foods under sanitary conditions as evidenced by four (4) of four (4) soiled fire sprinklers heads, one (1) of four (4) damaged sprinkler head, a water fountain with a missing cover and erroneous dish machine final rinse temperature documentation. Findings included... During a walkthrough of the facility's dietary services on July 17, 2019, at approximately 8:10 AM: 1. Four (4) of four (4) fire sprinklers located above the tilt skillet, the grill, the grease fryer and the stove were soiled with a sticky, oily sludge. 2. One (1) of four (4) fire sprinkler heads located above the tilt skillet was bent at the deflector. 3. The water fountain located in the main kitchen lacked an enclosure to protect its internal parts and provide a safety barrier. 4. Dish Machine Temperature logs from January 2019 through June 2019 were inaccurately recorded. Final Rinse temperatures were consistently documented at less than 180 degrees Fahrenheit (F) on 19	F 812	**2.** A review of the kitchen including the sprinklers, appliances, and other items was conducted no other area was identified to be impacted by this practice. **3.** The Engineering/Maintenance/Dietary staff were re-educated regarding the sanitation of the kitchen and ensuring its preventive maintenance program is in place. **4.** As a component of the Quality Assurance/Improvement Program the checking of Sprinklers, Appliances and pots and pans will be added to Engineering and Dietary Quality tool. It will be conducted monthly and it will be presented to the QAPI committee quarterly.	9-30-19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	07/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON CTR FOR AGING SVCS	2601 18TH STREET NE WASHINGTON, DC 20018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 57 occasions in January 2019, 76 times in February 2019, 81 times in March 2019, 80 times in April 2019, and 79 times in May 2019, and twice in June 2019. During a face-to-face interview with Employee #8 on July 26, 2019, at approximately 11:00 AM and Employee #9 on July 26, 2019, at approximately 12:15 PM, they both acknowledged there were no mechanical breakdowns with the dish machine when the above final rinse temperatures were recorded at less than 180 degrees Fahrenheit (F). Dish Machine temperatures are recorded two (2) to three (3) times daily according to the Dish Machine Temperature logs. Employee #8 acknowledged the above findings during a face-to-face interview on July 26, 2019, at approximately 11:00 AM.	F 812		
F 835 SS=F	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on staff interview, Administration failed to	F 835	**F 835 Administrations** **1.1** The Administrator and the clinical team were re-educated as it pertains to completing an investigation, particularly in cases of abuse. Resident #164 is no longer in the facility.	9-30-19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	07/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON CTR FOR AGING SVCS	2601 18TH STREET NE WASHINGTON, DC 20018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 835	Continued From page 58 ensure that action plans were developed and implemented to ensure that facility staff thoroughly investigated the incident which caused Resident #1 to sustained an orbital fracture and multiple bruises during am care as a potential for abuse, neglect. Administration, failed to ensure facility staff implemented measures to prevent further potential abuse, neglect from occurring to other residents within the facility; and as a result of their investigation appropriate corrective action was not taken in accordance with the facility's Abuse policy. Also, Administration failed to ensure that the facility staff provided adequate supervision to prevent an accident for Resident #182 who had a fall with an injury and to provide appropriate and sufficient catheter care and assessments and reassessments to prevent Harm for Resident #58 who was admitted with an indwelling Foley catheter which resulted in penile erosion and laceration. The census on the first day of survey was 243. Findings included ... 1.In the area of 42 CFR§ 483.12 (c)(2)-(4), F610, Investigate/Prevent/Correct/Alleged Violation. Administration failed to thoroughly investigate the incident which caused Resident #1 to sustained an orbital fracture and multiple bruises during am care as a potential for abuse, neglect. In addition, the facility failed implement measures to prevent further potential abuse, neglect from occurring to other residents within the facility; and as a result of their investigation appropriate corrective action was not taken in accordance with the facility's Abuse policy.	F 835	**1.2** A review of incidents was conducted. Areas of concern were addressed using a new form developed to ensure a detailed and thorough investigation is done. **1.3** The Administrator and the Clinical Team were re-educated on investigation. A new form was developed for completing an investigation. An Abuse team utilizes the form to ensure a more detailed investigation of incidents of abuse is conducted. **1.4** A review of unusual incidents is conducted and incorporated into the quality improvement risk management plan. The Administrator monitors this area monthly and submits to the Governing Body. The information is summarized and presented to the QAPI team quarterly.	9-30-19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	07/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON CTR FOR AGING SVCS	2601 18TH STREET NE WASHINGTON, DC 20018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 835	Continued From page 59 On July 23, 2019, at 11:09 AM an Immediate Jeopardy (IJ)-"L" was identified at 42 CFR§ 483.12 (c)(2)-(4), F610, Investigate/Prevent/Correct/Alleged Violation. During the face-to-face interview on July 23, 2019 approximately at 2:15 PM, Employees' #1 and #2 acknowledged the findings. Cross reference 42 CFR§ 483.12 (c)(2)-(4), F610, Investigate/Prevent/Correct/Alleged Violation. 2. In the area of 42 CFR 483.25(d)(1)(2), F689 Free of Accident Hazards/Supervision/Devices, the Administration failed to ensure that the facility staff provided adequate supervision to prevent an accident for Resident #182 who had a fall with an injury. During a face-to-face interview with Employee #13 on 7/26/19, at 1:44 PM, he acknowledged the findings and stated, "The staff assigned to the solarium left to help a coworker although we educate them not to leave residents in the solarium alone." Cross Reference 42 CFR 483.25(d)(1)(2), F689 Free of Accident Hazards/Supervision/Devices 3. In the area of 42 CFR 483.25(e)(1)-(3), F690 Bowel/bladder/Incontinence, Catheter, UTI, the Governing Body failed to ensure facility staff provided appropriate and sufficient catheter care and assessments and reassessments to prevent Harm for Resident #58 who was admitted with an	F 835	**2.1** The Administrator met with the DON and leadership staff particularly as it pertains to the purpose of staff member assigned to Solarium stays in the Solarium to monitor residents. Unable to retrospectively correct practice as it pertains to resident #182. **2.2** A review of all Solariums was conducted, staff members were present in the Solarium, No other residents were impacted by this practice. **2.3** The nursing staff were re-educated regarding the purpose of staff members remaining at post when assigned to Solarium. A meeting was conducted with the Administrator by the Governing Body. A review of the purpose for ensuring that established policies stay in place.	9-30-19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	07/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON CTR FOR AGING SVCS	2601 18TH STREET NE WASHINGTON, DC 20018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 835	Continued From page 60 In-dwelling Foley catheter which resulted in penile erosion and laceration. The findings were acknowledged on July 29, 2019, at 10:00 AM during a face-to-face interview with Employee #3 (Unit manager) who stated she did not know what erosion was and would look it up on the internet." Cross reference 42 CFR 483.25(e)(1)-(3), F690 Bowel/bladder/Incontinence, Catheter, UTI	F 835	**F835 Administration** **2.4** Monitoring the Solarium is a part of the Quality Program. Additionally, the Administrator conducts rounds on a daily basis and/or ensures the Administrator on duty conducts daily rounds including monitoring the Solarium. This information is presented at the QA/QI committee quarterly. **3.1** The Administrator met with the Medical Director who conducted an assessment of the resident's genital area. It was determined that the area was not lacerated and appeared as an old injury. Resident was sent out for urology appointment for further follow-up. Resident #58 verbalized no discomfort. The Administrator and nursing leadership team were re-educated regarding assessment of Reproductive area. **3.2** A review of residents with Foley Catheters was conducted; no other residents were noted to be impacted by this practice.	9-30-19
F 837 SS=F	Governing Body CFR(s): 483.70(d)(1)(2) §483.70(d) Governing body. §483.70(d)(1) The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and §483.70(d)(2) The governing body appoints the administrator who is- (i) Licensed by the State, where licensing is required; (ii) Responsible for management of the facility; and (iii) Reports to and is accountable to the governing body. This REQUIREMENT is not met as evidenced by: Based on staff interview, Governing Body failed to ensure that action plans were developed and implemented to ensure that facility staff thoroughly investigated the incident which caused Resident #1 to sustained an orbital fracture and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	07/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON CTR FOR AGING SVCS	2601 18TH STREET NE WASHINGTON, DC 20018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 837	Continued From page 61 multiple bruises during am care as a potential for abuse, neglect. The Governing Body failed to ensure facility staff implemented measures to prevent further potential abuse, neglect from occurring to other residents within the facility; and as a result of their investigation appropriate corrective action was not taken in accordance with the facility's Abuse policy. Also, the Governing Body failed to ensure that the facility staff provided adequate supervision to prevent an accident for Resident #182 who had a fall with an injury and to provide appropriate and sufficient catheter care and assessments and reassessments to prevent Harm for Resident #58 who was admitted with an indwelling Foley catheter which resulted in penile erosion and laceration. The census on the first day of survey was 243. Based on record review and staff interview for two (2) of 56 sampled residents facility staff failed to ensure one (1) resident who had a fall with an injury received adequate supervision to prevent an accident. Resident #182 Findings included ... 1.In the area of 42 CFR§ 483.12 (c)(2)-(4), F610, Investigate/Prevent/Correct/Alleged Violation. The Governing Body failed to thoroughly investigate the incident which caused Resident #1 to sustained an orbital fracture and multiple bruises during am care as a potential for abuse,	F 837	**3.3** A meeting was held by the Governing Body with the Administrator. A review of appropriate assessment was conducted and additional training of nursing leadership was conducted. **3.4** The Administrator will provide monthly reports to the governing body, outlining any residents who have Foley Catheters and care of residents with Foley Catheter. This will be submitted to the Governing Body monthly and will be presented to the QAPI team quarterly. **F 837 Governing Body** **1.1** The Governing Body met with the Administrator regarding the investigation process and abuse. A review of resident Incident and Accident process was completed and the process for conducting investigation was conducted. Resident #164 is no longer in the facility, unable to retrospectively correct. **1.2** A review of all incidents and accidents was conducted. No other resident was impacted by this practice.	9-30-19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	07/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON CTR FOR AGING SVCS	2601 18TH STREET NE WASHINGTON, DC 20018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 837	Continued From page 62 neglect. In addition, the facility failed implement measures to prevent further potential abuse, neglect from occurring to other residents within the facility; and as a result of their investigation appropriate corrective action was not taken in accordance with the facility's Abuse policy. On July 23, 2019, at 11:09 AM an Immediate Jeopardy (IJ)-"L" was identified at 42 CFR§ 483.12 (c)(2)-(4), F610, Investigate/Prevent/Correct/Alleged Violation. During the face-to-face interview on July 23, 2019 approximately at 2:15 PM, Employees' #1 and #2 acknowledged the findings. Cross reference 42 CFR§ 483.12 (c)(2)-(4), F610, Investigate/Prevent/Correct/Alleged Violation. 2. In the area of 42 CFR 483.25(d)(1)(2), F689 Free of Accident Hazards/Supervision/Devices, the Governing Body failed to ensure that the facility staff provided adequate supervision to prevent an accident for Resident #182 who had a fall with an injury. During a face-to-face interview with Employee #13 on 7/26/19, at 1:44 PM, he acknowledged the findings and stated, "The staff assigned to the solarium left to help a coworker although we educate them not to leave residents in the solarium alone." Cross reference 42 CFR 483.25(d)(1)(2), F689 Free of Accident Hazards/Supervision/Devices	F 837	**1.3** The Governing body conducted weekly meetings with the Administrator and different members of the leadership team. A review of the investigation process was conducted and a new investigation tool was developed. The Governing Body also requested documentation demonstrating that facility staff was educated regarding abuse and the investigation, which was provided. **1.4** The Administrator will provide monthly reports to the governing body, outlining any areas of Risk Management including: Abuse, Falls, Foley Catheters, Changes in a Wound. This will be submitted to the Governing Body monthly and will be presented to the QAPI team quarterly. **2.1** The Governing Body met with the Administrator regarding the policy and procedures and practice for ensuring a resident's safety. Nursing staff involved received immediate education regarding the role of a staff member assigned to the solarium. Facility unable to retrospectively correct the process with resident #182. **2.2** A review of the falls in the facility was conducted. No other resident was noted to have sustained a fall in the Solarium.	9-30-19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	07/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON CTR FOR AGING SVCS	2601 18TH STREET NE WASHINGTON, DC 20018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 837	Continued From page 63 3. In the area of 42 CFR 483.25(e)(1)-(3), F690 Bowel/bladder/Incontinence, Catheter, UTI, the Governing Body failed to ensure facility staff provided appropriate and sufficient catheter care and assessments and reassessments to prevent Harm for Resident #58 who was admitted with an indwelling Foley catheter which resulted in penile erosion and laceration. The findings were acknowledged on July 29, 2019, at 10:00 AM during a face-to-face interview with Employee #3 (Unit manager) who stated she did not know what erosion was and would look it up on the internet." Cross reference 42 CFR 483.25(e)(1)-(3), F690 Bowel/bladder/Incontinence, Catheter, UTI	F 837	**F 837 Continued** **2.3** The Governing body conducted weekly meetings with the Administrator and different members of the leadership team. A review of the policy and procedure as it pertains to monitoring of residents in the Solarium was conducted. The Governing Body also requested documentation demonstrating that facility staff was educated regarding falls and purpose of staff monitoring in the Solarium **2.4** The Administrator will provide monthly reports to the governing body, outlining any areas of Risk Management including: Abuse, Falls, Foley Catheters, Changes in a Wound. This will be submitted to the Governing Body monthly and will be presented to the QAPI team quarterly. **3.1** The Governing Body met with the Administrator regarding the policy, procedures and practice for ensuring a resident's safety. Medical Director and Urology assessed resident #58. The Medical Director indicated the area no longer noted to be "erosion/laceration". The area has resolved.	9-30-19
F 865 SS=F	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(2)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	07/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON CTR FOR AGING SVCS	2601 18TH STREET NE WASHINGTON, DC 20018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 865	Continued From page 64 §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility staff failed to develop and implement an effective comprehensive quality assurance and performance improvement (QAPI) program inclusive of all systems by failing to implement systems to correct identified problems to ensure that action plans were developed and implemented to ensure that facility staff thoroughly investigated the incident which caused Resident #1 to sustained an orbital fracture and multiple bruises during am care as a potential for abuse, neglect. There was failure to ensure that the facility staff provided adequate supervision to prevent an accident for Resident #182 who had a fall with an injury and to provide appropriate and failure to ensure a process was in place to provide sufficient catheter care and assessments and reassessments to prevent Harm for Resident #58 who was admitted with an indwelling Foley catheter, which resulted in penile erosion and laceration. The facility census was 243 on the first day of the survey. Findings included... During the interview on July 30, 2019 at approximately 10:40 AM, a review of the facility ' s quality assurance and performance improvement (QAPI) program was conducted with the facility's administration.		**3.2** A review of all residents in the facility with Foley Catheter was conducted. No other resident was impacted by this practice. **3.3** The Governing body conducted weekly meetings with the Administrator and different members of the leadership team. A review of the practice as it pertains to the Foley Catheter was conducted. The Governing Body also requested documentation demonstrating education of facility staff, which was conducted. **3.4** The Administrator will provide monthly reports to the governing body, outlining any areas of Risk Management including: Abuse, Falls, Foley Catheters, Changes in a Wound. This will be submitted to the Governing Body monthly and will be presented to the QAPI team quarterly.	9-30-19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	07/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON CTR FOR AGING SVCS	2601 18TH STREET NE WASHINGTON, DC 20018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 865	Continued From page 65 The review of the program showed the facility failed to identify concerns, and develop and implement actions plans to correct identified areas of deficient practice in: " 42 CFR§ 483.12 (c)(2)-(4), F610, Investigate/Prevent/Correct/Alleged Violation. Administration failed to thoroughly investigate the incident which caused Resident #1 to sustained an orbital fracture and multiple bruises during am care as a potential for abuse, neglect. In addition, the facility failed implement measures to prevent further potential abuse, neglect from occurring to other residents within the facility; and as a result of their investigation appropriate corrective action was not taken in accordance with the facility's Abuse policy. Employee #5 stated, we review all allegations of resident. " 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 assistive devices to prevent accidents. Employee #5 stated, resident falls were reviewed. I do a root cause analysis on all falls. The falls committee meets every 3 months, but we are now moving to monthly. We found that most falls occurred at night between 1:55 am to 5:30 AM. The nursing team does a huddle every shift to tell staff who are at risk of falls and the supervisor makes frequent rounds. We have no monitoring tool in place. We have someone in the solarium at all times when the resident are there. The Director of Nursing did a marathon inservice on	F 865	1. A review of resident #164, #182, and #58 was conducted. Unable to retrospectively correct the areas identified for residents #164 and #182 who are no longer in the facility. Resident #58 was reassessed by the clinical team and the Medical Director. It was determined that the area identified was not lacerated and appeared old. Resident was sent out for urology appointment for further follow-up. Resident verbalized no discomfort. The staffs assigned to provide care to Resident #58 were immediately re-educated. 2. A review of residents who have complaints and/or concerns that could potentially be abuse, as well as falls and residents with Foley Catheters was conducted. Areas of concern were addressed, via assessment and care planning to meet the resident's needs. 3. The facility staff was re-educated on Quality and the importance of a QA/PI program. The importance of monitoring all new residents, changes in orders and residents with concern was provided, with the expectation that the nursing management team monitor these areas and submit the audit tool to the DON and QAPI Director monthly. Counselling of staff maybe indicated for failure to comply with QAPI programs	9-30-19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	07/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON CTR FOR AGING SVCS	2601 18TH STREET NE WASHINGTON, DC 20018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 865	Continued From page 66 falls in early July [2019]. Since then the number of falls reduced in July 2019. " 42 CFR 483.25(e)(1)-(3), F690 Bowel/bladder/Incontinence, Catheter, UTI, the Governing Body failed to ensure facility staff provided appropriate and sufficient catheter care and assessments and reassessments to prevent Harm for Resident #58 who was admitted with an indwelling Foley catheter which resulted in penile erosion and laceration. Employee #5 stated, we review all wounds, wounds associated from Foley catheter use was not a part of quality assurance program. Staff not reporting information on the 24-hour report- unit mangers not reporting information over to stand up. On July 30, 2019, at 10:40 AM, Employee #5 stated the facility made good faith efforts to get things done based on what was reported and acknowledged the findings.		4. A review of the QAPI program was conducted. Changes in the program were updated to include monitoring, interviewing and checking at a minimum 10% of the residents for areas of concern including but not limited to abuse, falls, Foley. This will be done by the QA, Education, Infection Control and Social Work team. A report will be sent to the DON, ADON and QA Director monthly and presented to the QA/PI committee quarterly.	9-30-19
F 908 SS=E	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, facility staff failed to maintain essential equipment in safe condition as evidenced by four (4) of four (4) fire sprinkler heads from the Ansul fire suppression system in the main kitchen that were soiled with grease and one (1) of four (4) fire	F 908	**1.** The Sprinklers located above the tilt skillet, the grease fryer and the stove were cleaned immediately. The contractor was called and corrected the tent skillet at the defector. A safety barrier was placed around the main kitchen fountain. A new form was updated for the water temperature log, unable to retrospectively correct the dish machine temperature log.	9-30-19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	07/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON CTR FOR AGING SVCS	2601 18TH STREET NE WASHINGTON, DC 20018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 908	Continued From page 67 sprinklers with a bent deflector and a water fountain with a missing cover. Findings included... During a walkthrough of the facility's dietary services on July 17, 2019, at approximately 8:10 AM: 1. Four (4) of four (4) fire sprinklers located above the tilt skillet, the grill, the grease fryer and the stove were soiled with a sticky, oily sludge. 2. One (1) of four (4) fire sprinkler heads located above the tilt skillet was bent at the deflector. 3. The water fountain located in the main kitchen lacked an enclosure to protect its internal parts and provide a safety barrier. Employee #8 acknowledged the findings during a face-to-face interview on July 26, 2019, at approximately 11:00 AM.	F 908	**2.** A review of the kitchen including the sprinklers, appliances, and other items was conducted no other area was identified to be impacted by this practice. **3.** The Engineering/Maintenance/Dietary staff were re-educated regarding the sanitation of the kitchen and ensuring its preventive maintenance program is in place. **4.** As a component of the Quality Assurance/Improvement Program the checking of Sprinklers, Appliances and pots and pans will be added to Engineering and Dietary Quality tool. It will be conducted monthly and it will be presented to the QAPI committee quarterly.	9-30-19
F 919 SS=D	Resident Call System CFR(s): 483.90(g)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area. §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by:	F 919	**1.** The Call Bell System in rooms 155A and 309A was corrected immediately. **2.** A review of the call bells and its operation was conducted. No other call bell rooms were affected.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	07/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON CTR FOR AGING SVCS	2601 18TH STREET NE WASHINGTON, DC 20018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 919	Continued From page 68 Based on observations and staff interview, facility staff failed to maintain the call bell system in good working condition as evidenced by a call bell in two (2) of 65 resident's rooms that failed to alarm when tested. Findings included... During an environmental walkthrough of the facility on July 18, 2019, between 10:00 AM and 3:30 PM, the call bell in resident rooms #155A and #309A did not alarm when activated, two (2) of 65 resident's rooms. This breakdown could prevent or delay care to residents in an emergency. Employee #9 acknowledged the above findings during a face-to-face interview on July 18, 2019 at approximately 3:00 PM.	F 919	**3.** The Engineering/Maintenance staff were re-educated regarding the call bell systems and checking of functionality. **4.** The Call Bell System is audited as a part of the Engineering/Maintenance program monthly. This information is presented to the QAPI committee quarterly.	9-30-19