Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0007	A. BUILDING: _____ B. WING _____	06/22/2021

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		(X5) COMPLETE DATE
L 000	Initial Comments An Annual Survey was conducted at Washington Center for Aging Services from June 13, 2021 to June 22, 2021. Survey activities consisted of a review of 56 sampled residents. The following deficiencies are based on observation, record review, resident, and staff interviews. After analysis of the findings, it was determined that the facility is not in compliance with the requirements of Title 22B Chapter 32 DCMR . The resident census during the survey was 175. The following is a directory of abbreviations and/or acronyms that may be utilized in the report: 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 CPR - Cardiopulmonary resuscitation CMS - Centers for Medicare and Medicaid Services CNA- Certified Nurse Aide CRF - Community Residential Facility DVT - Deep Vein Thrombosis D.C. - District of Columbia DCMR- District of Columbia Municipal Regulations D/C Discontinue DI - deciliter DMH - Department of Mental Health EHR - Electronic Healrh Record EKG - 12 lead Electrocardiogram	L 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 required by Federal and State Law.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0007	A. BUILDING: _____ B. WING _____	06/22/2021

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) COMPLETE DATE
L 000	Continued From page 1	L 000		

EMS - Emergency Medical Services (911)
ESRD - End Stage Renal Disease
G-tube Gastrostomy.tube
HR- Hour
HSC - Health Service Center
HVAC - Heating ventilation/Air conditioning
ID - Intellectual disability
IDT - interdisciplinary team
L - Liter
Lbs - Pounds (unit of mass)
MAR - Medication Administration Record
MD- Medical Doctor
MDS - Minimum Data Set
Mg - milligrams (metric system unit of mass)
mL - milliliters (metric system measure of volume)
mg/dl - milligrams per deciliter
mm/Hg - millimeters of mercury
MN midnight
Neuro - Neurological
NP - Nurse Practitioner
O2- Oxygen
PASRR - Preadmission screen and Resident Review
Peg tube - Percutaneous Endoscopic Gastrostomy
PPE - Personal Protective Equipment
PO- by mouth
POS - physician's order sheet
Prn - As needed
Pt - Patient
Q- Every
QIS - Quality Indicator Survey
RN - Registered Nurse
ROM Range of Motion
Rp, R/P - Responsible party
SCC Special Care Center
Sol- Solution
TAR - Treatment Administration Record

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0007	A. BUILDING: _____ B. WING _____	06/22/2021

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) COMPLETE DATE
L 022	Continued From page 2	L 022		
L 022	3206.1 Nursing Facilities There shall be written policies to govern nursing care and related medical and other services provided. This Statute is not met as evidenced by: Based on record review and staff interview, for two (2) of 56 sampled residents, facility staff failed to promptly notify the ordering physician of laboratory results that fall outside of a clinical reference range in accordance with facility policies and procedures for notification. Residents' #7 and #99. The findings include: Review of the facility's policy entitled, "Documentation Requirements", item #12 "Laboratory, X-rays, and other tests", revealed, "Results of laboratory and x-ray studies are documented in the record. It is documented by a licensed nurse that the attending physician was notified of the abnormal results." Review of the facility's policy entitled, "Lab Results", revealed, " ... Once the physician has been notified, a notation must be made on the lab slip regarding date, time, signature of reporting person and a brief description of orders, if any; followed by documentation in the clinical record ..." 1. Resident #7 was admitted to the facility on 12/01/2018, with multiple diagnoses, including Hypothyroidism, Anxiety and Mild Cognitive Impairement. A review of the resident's medical record revealed the following:	L 022	**3206.1 Nursing Facilities** 1. **Resident #7's lab was re-evaluated two additional times, after which the medication was adjusted, and lab was done to ensure it met resident's needs. Resident #99 was re-evaluated, and physician was notified. The nursing staff documented this notification.** 2. **A review abnormal lab for CBC and TSH was conducted. No other resident was found to be affected by this practice.** 3. **The nursing management team was re-educated on the importance of monitoring lab results and notification of results timely. Additionally, they were re-educated on the importance of documenting that the physician or physician extenders were notified.** 4. **Daily lab monitoring log was established to monitor all labs to ensure compliance. Labs will be reported daily via 24 Hr. report as well as documented in resident medical record.** 5. **The nurse managers will audit the medical records for lab results, notification of physician as indicated as well as documented the findings. This will be reported to the DON/ADON and QAPI Committee quarterly.**	**JULY 31, 2021**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0007	A. BUILDING: _____ B. WING _____	06/22/2021

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) COMPLETE DATE
L 022	Continued From page 3 02/06/21 [Physician's Order], " ...TSH (thyroid-stimulating hormone) [lab] ...hypothyroidism ...every three (3) months." 04/11/21 [Physician's Order], "Synthroid (treats hypothyroidism) 25mcg (micrograms) PO (by mouth) daily for thyroid hormone deficiency." A review of a document from the facility's consultant pharmacist entitled, "Note to Attending Physician/Prescriber" documented, "Patient had a high TSH [lab] of 19.683 on 3/4/21. Current dose of Synthroid is Synthroid 25 mcg (micrograms) daily. Recommend consider increasing the dose and re-checking lab in 8 weeks." The nurse practitioner initialed the previously mentioned document on 04/12/2021 (indicating he reviewed and agreed with the pharmacist's recommendations). 04/13/21 [TSH Lab Results], "TSH level "17.719 (H [high]) ... Range: 0.350-4.940 ..." A review of the lab results dated 04/13/2021 and nursing progress notes from 04/13/2021 to 06/16/2021 lacked documented evidence the nursing staff informed the physician or nurse practitioner of Resident #7's elevated TSH level on 04/13/2021. During a face-to-face interview conducted on 06/16/2021 at approximately 12:30 PM, Employee #4 (Unit Manager) stated that she did not see any documentation in the resident's record that the charge nurse or the nursing staff informed the physician or nurse practitioner of Resident #7's 04/13/21 elevated TSH level.	L 022		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0007	A. BUILDING: _____ B. WING _____	06/22/2021

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) COMPLETE DATE
L 022	Continued From page 4 During a face-to-face interview conducted on 06/16/2021, at approximately 1:00 PM, Employee #23 (physician) stated, "I don't know how the labs were missed. It should not have happened." When asked if Resident #7's Synthroid will remain at 25 mcg daily, he stated that he would probably increase it to "50 mcg daily," but he needed to assess the resident. 2. Resident #99 was admitted to the facility on 05/06/2020, with diagnoses that included: Anemia, Hypertension, Renal Insufficiency, Viral Hepatitis C, Diabetes Mellitus, Depression and Chronic Obstructive Pulmonary Disease (COPD). Review of the physician's orders revealed the following: "6/7/21 CBC [complete blood count] on Mondays, " Review of the Resident #99's CBC results revealed the following: "06/07/21 ...Hemoglobin 7.7 (CL [critically low]) Reference Range 13.5- 17.5 g (grams)/dl (deciliter) ..." "06/10/21 ...Hemoglobin 7.4 (CL) Reference Range 13.5- 17.5 g/dl ..." "06/15/21 ...Hemoglobin 7.4 (CL) Reference Range 13.5- 17.5 g/dl ..." Review of the Resident #99's medical record from 06/07/2021, to 06/15/2021, to include progress notes, lacked documented evidence that the ordering physician was notified of the aforementioned laboratory results and made aware of the abnormal laboratory results.	L 022		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0007	A. BUILDING: _____ B. WING _____	06/22/2021

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) COMPLETE DATE
L 022	Continued From page 5 During a face-to-face interview conducted on 06/16/2021, at 2:53 PM, Employee #9 (Unit Manager) stated that their policy and practice is to notify the nurse practitioner of any abnormal results and he will give instructions on the next steps. She also stated, "I know the nurses called the nurse practitioner, they must have forgot to document it."	L 022		
L 051	3210.4 Nursing Facilities A charge nurse shall be responsible for the following: (a)Making daily resident visits to assess physical and emotional status and implementing any required nursing intervention; (b)Reviewing medication records for completeness, accuracy in the transcription of physician orders, and adherences to stop-order policies; (c)Reviewing residents' plans of care for appropriate goals and approaches, and revising them as needed; (d)Delegating responsibility to the nursing staff for direct resident nursing care of specific residents; (e)Supervising and evaluating each nursing employee on the unit; and (f)Keeping the Director of Nursing Services or his or her designee informed about the status of residents. This Statute is not met as evidenced by: Based on record review and staff interview, for	L 051	SEE NEXT PAGE	JULY 31, 2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0007	A. BUILDING: _____ B. WING _____	06/22/2021

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) COMPLETE DATE
L 051	Continued From page 6 two (2) of 56 sampled residents, the charge nurse failed to update a resident's care plan to address one (1) resident with iron deficiency-anemia to include person-centered measurable objectives and time frames and for one (1) resident with a perm-a-cath access site for dialysis treatment. Residents' #99 and #134. The findings include: 1.The charge nurse failed to update Resident #99's iron deficiency anemia care plan to include person-centered measurable objectives and time frames. Resident #99 was admitted to the facility on 05/06/2020, with diagnoses that included: Anemia, Hypertension, Renal Insufficiency, Viral Hepatitis C, Diabetes Mellitus, Depression and Chronic Obstructive Pulmonary Disease (COPD). Review of the physician's orders revealed the following: "06/02/21 Ferrous sulfate tablet, delayed release 325 mg (milligram) ... administer 1 tablet by mouth daily for anemia..." "6/7/21 CBC [complete blood count] on Mondays..." "06/09/2021 Head to toe skin observation for any abnormalities (bruises ... discoloration) twice a week on shower days Monday and Friday... Record abnormalities in the nurses note. " Review of the progress notes revealed the following:	L 051	**3210.4 Nursing Facilities** **1. a. Resident #99 was reassessed, and the care plan was reviewed. Anemia care plan was updated to include measurable objectives and time frames to meet the resident's goals such as monitoring for bleeding in urine and bleeding gums.** **b. Resident #134 was reassessed. Previous Care plan was updated with goals and approaches to address resident's use of perm-a-cath for dialysis.** **2. All residents with the diagnosis of anemia's care plan were identified, plan of care reviewed and none of them were affected by this deficient practice. All other Residents using perm-a-cath for dialysis were identified plan of care reviewed and were incompliance.** **3. All unit managers and supervisors were in-serviced on how to update plan of care for new diagnoses and how to use person centered goals with measurable objectives for the residents' plan of care to include new goals and approaches as indicated for the resident.** **4. An audit was developed to monitor the care plans to ensure that the care plans are updated to include person centered measurable goals and approaches. The nursing management team will conduct the audits submit to DON or ADON for further review and submitted to QAPI committee quarterly.**	**JULY 31, 2021**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0007	A. BUILDING: _____ B. WING _____	06/22/2021

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) COMPLETE DATE
L 051	Continued From page 7 04/21/2021 at 6:50 PM [physician's note] Resident is a 67 years old male re-admitted to the facility from VAMC [Veterans Administration Medical Center] to unit 2 orange at 6:40 PM after recent hospitalization on 4/12/21 due to low H &H [hemoglobin and hematocrit] ... PMHD [past medical history diagnosis] Chronic anemia ..." 04/24/2021 at 11:01 AM [Attending Physician Note] ... Problems: 1) Chronic Anemia ...He has had numerous admissions to the hospital for GI [gastrointestinal bleed] and anemia, required 7 units PRBCs [packed red blood cells] in March [2021] and his most recent admission he received 6 units of PRBCs ...Assessment ... The poor production of clotting factors is the most likely reason he continues to have bleeding, as well as the likelihood that he has esophageal varices ..." 05/11/2021 at 4:32 PM [Nursing Note] This resident went out to a VA [Veterans Administration] clinic and returned at about 12:30 pm and at about 1:00 Pm this writer got a call from [VAMC doctor] stating that the HBG [hemoglobin] result that was done during the morning visit is 6 and resident needed to return to the Hospital for blood transfusion. Resident left for the transfusion at about 1:35 pm ..." 06/01/2021 at 8:20 PM [Nursing Note] Resident is 67 years old male re-admitted to the facility from VAMC at 4: 00 pm to unit 2 orange room 260-P after hospitalization 5/11/21 for low H&H of 6. Resident received 7 u [units] PRBC ..." Review of the care plan on 06/16/2021, revealed: " ... Problem: Has discomfort related to iron deficiency anemia. Category Anemia Start Date	L 051		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0007	A. BUILDING: _____ B. WING _____	06/22/2021

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) COMPLETE DATE
L 051	Continued From page 8 05/08/2020 Last Reviewed/Revised 03/10/2021 at 10:25 AM The care plan lacked documented evidence that Resident #99's care plan included measurable objectives and time frames to meet the residents goals such as monitoring for bleeding (petechiae, blood in the urine, bleeding of the gums). During a face-to-face interview conducted on 06/16/2021, at 2:53 PM with Employee #9 (Unit Manager), she stated, "The nurse managers will update the care plan on admission and for any new diagnoses. He [Resident #99]does not have the goals and approaches in place to monitor for bleeding, but it is something that we do." 2.The charge nurse failed to update Resident #134's care plan with goals and approaches to address the resident's use of a perm-a-cath for dialysis. Resident #134 was admitted to the facility on 02/22/2019, with diagnoses that included End-Stage Renal Disease on Hemodialysis, Hypertension, Diabetes Mellitus 2,Gastroesophageal Reflux Disease, Anemia, Cerebral Infraction, Seizure and Dementia. A review of the Quarterly MDS (Minimum Data Set) dated 05/08/2021 revealed in Section C, (Cognitive Patterns) the resident had a Brief Interview for Mental Status (BIMS) score of "01", indicating severe cognitive impairment. Section I (Active Diagnosis) End-Stage Renal Disease was documented. Subsection I8000 (Addtional active diagnoses)" it documented, "Dependence on renal dialysis".	L 051		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0007	A. BUILDING: _____ B. WING _____	06/22/2021

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) COMPLETE DATE
L 051	Continued From page 9 A physician's telephone order dated 5/19/2021 at 9:25 AM revealed, "Transfer resident to [hospital name] for Access Evaluation (AVF [arteriovenous fistula] Ulcer)" A review of the progress notes showed the following: 5/19/2021 at 12:41 PM [Nursing Note] "Resident left to dialysis at 9:15 AM and back to unit at 9:30 AM with referral to ER (emergency room) for Access site ulcer. Resident transferred to [hospital name] ER at10:00 AM ..." 5/19/2021 at 6:50 PM [Nursing Note] "[Hospital Name] called to check on resident status resident is going to be admitted" 5/21//2021 at 11:52 PM [Nurse Practitioner Note] "Seen and examined for re-admission, she had a brief hospitalization 2/2 [secondary to] infected AVF now has left upper chest perm-a-cath, left forearm old dialysis access with closed incision sutures intact" A review of Resident #134's dialysis care plan with a start date of 01/27/2021 lacked documented evidence that facility updated the previously mentioned care plan with goals and approaches to address the resident's use of a perm-a-cath for dialysis starting on 05/21/2021. During a face-to-face interview conducted on 06/17/2021, at 10:43 AM with Employee #14 (Registered Nurse), he acknowledged the findings.	L 051		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0007	A. BUILDING: _____ B. WING _____	06/22/2021

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) COMPLETE DATE
L 056	Continued From page 10	L 056		
L 056	3211.5 Nursing Facilities Beginning January 1, 2012, each facility shall provide a minimum daily average of four and one tenth (4.1) hours of direct nursing care per resident per day, of which at least six tenths (0.6) hours shall be provided by an advanced practice registered nurse or registered nurse, which shall be in addition to any coverage required by subsection 3211.4. This Statute is not met as evidenced by: Based on record review and staff interview, during a review of staffing [direct care per resident day hours], it was determined that the facility failed to meet the four and one-tenths (4.1) hours of direct nursing care per resident per day on two (2) of five (5) days reviewed and the 0.6 [six-tenths] hour for Registered Nurses /Advanced Practice Registered Nurse hours on three (3) of five (5) days reviewed in accordance with Title 22 DCMR Section 3211 Nursing Personnel and Required Staffing Levels. The findings include: According to the District of Columbia Municipal Regulations for Nursing Facilities: 3211.5 Beginning January 1, 2012, each facility shall provide a minimum daily average of four and one tenth (4.1) hours of direct nursing care per resident per day, of which at least six-tenths (0.6) hour shall be provided by an advanced practice registered nurse or registered nurse, which shall be in addition to any coverage required by subsection 3211.4.	L 056	**3211.5 Nursing Facilities** 1. **A review of nurse staffing was conducted. No resident was impacted by this practice. Facility was unable to retrospectively correct the deficiency.** 2. **A review of nurse staffing was conducted. The average overall number PPD is 4.7.The average RN is 0.8.** 3. **Daily staffing Nursing continues to aggressively hire staff during the pandemic.** 4. **Nursing management will audit staffing every day. The report is presented in QA meeting quarterly.**	**JULY 31, 2021**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0007	A. BUILDING: _____ B. WING _____	06/22/2021

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) COMPLETE DATE
L 056	Continued From page 11 1. The facility failed to meet the minimum direct nursing care staffing rate of four and one-tenths (4.1) hours per resident per day, for two (2) of five (5) days reviewed as outlined below: January 1, 2021- 4.04 hours January 3, 2021- 4.02 hours 2. The facility failed to meet the minimum Registered Nurse/ Advanced Practice Registered Nurse rate of 0.6 [six-tenths] hour per resident per day on three (3) of the five (5) days reviewed as outlined below: January 1, 2021- 0.5 hours January 2, 2021- 0.47 hours January 3, 2021- 0.47 hours During the staffing review conducted on June 22, 2021, in the presence of Employee #22, which acknowledged the findings.	L 056	SEE NEXT PAGE	
L 087	3217.2 Nursing Facilities The Chairperson of the Infection Control Committee shall be knowledgeable about or have experience in infection control. This Statute is not met as evidenced by: Based on observation, record review and staff interview, on three (3) of three (3) observations, facility staff failed to maintain infection control and prevention practices in accordance with standards of practice to minimize the potential spread of infections. The findings included:	L 087		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0007	A. BUILDING: _____ B. WING _____	06/22/2021

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) COMPLETE DATE
L 087	Continued From page 12 1. Review of the facility's policy entitled, "Occupied Resident Isolation Room Cleaning- Contact, Strict Contact and Droplet Isolations" revealed, "Reline all trash liners." During a tour of room 260 on unit 2 Orange on 06/14/2021, at 2:30 PM, a red trash can was observed with no trash bag, with used discarded personal protective equipment inside. It should be noted that room 260 is on the COVID-19 observation unit where strict contact and droplet transmission-based precautions were in place. During a face-to-face interview conducted on 06/14/2021, at 2:35 PM, Employee #11 (Registered Nurse) stated, "I am not sure who put the items in the trash can. They shouldn't have put any trash inside without a trash bag. The unit manager was made aware and called housekeeping." 2. During a tour of unit 2 Orange on 06/17/2021, at 1:19 PM, it was noted that two (2) soap dispensers at two (2) separate hand washing stations were empty. During a face-to- face interview conducted on 06/17/2021, at approximately 1:30 PM, Employee #9 (Unit Manager) stated, "I am calling housekeeping right now to address it." 3. During a tour of unit 3 Orange on 06/13/2021, at approximately 7:45 AM, Employee #12 (Certified Nurse Aide) was observed not wearing a face shield while performing resident care. During a face-to-face interview conducted at the time of the observation, Employee #12 stated, "I don't wear it [face shield] because I wear glasses and it bothers my eyes." When asked if she has	L 087	**3217.2 Nursing Facilities** **1. The Trash in the trash can was immediately discarded in a trash can with a liner in it and a liner was placed in the trash car without the liner. The two empty soap dispensers were immediately filled. The employee #12 was re-educated regarding the use of the face shield.** **2. All observation rooms were checked, and all trash cans were noted to have red liners. All rooms on all units were checked to ensure soap dispensers were filled, no other dispenser was noted to be affected by this practice. A review of the unit was conducted, and no other staff member was noted to be without their face shield.** **3. A detailed Root Cause Analysis was done to ensure that corrective action would prevent reoccurrence of Infection Control practices. The nursing and housekeeping staff was in-serviced on liners for trash can as well as notification of housekeeping when soap dispensers are empty. All staff were re-in-serviced on the face shield requirements.** **4. An Infection Control audit is done monthly to address IC areas including lining of trash cans, soap dispensers and use of face shields and other PPE as maybe indicated. This information is reported to QAPI quarterly.**	**JULY 31, 2021**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0007	A. BUILDING: _____ B. WING _____	06/22/2021

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) COMPLETE DATE
L 087	Continued From page 13 brought this to the manager attention, she stated, "I did not report it to anyone." During a face-to-face interview conducted on 06/22/2021, at 1:05 PM, Employee #13 (Infection Control Preventionist) stated, "We train and educate all the staff on the importance of PPE (personal protective equipment). I will be calling that staff member and talking to her."	L 087	**3224.3 Nursing Facilities** **1. A review of residents #60, 162, and 177 was done. The Pharmacist updated the Medication Regimen Review (MRR) to ensure it was completed correctly.** **2. A review of all residents' MRR was conducted. Corrections were made as indicated.** **3. The Pharmacy was contacted and advised that MRR must be done timely and accurately. A follow-up memo was sent to the pharmacy.** **4. The unit secretaries will monitor record, completely and dated appropriately monthly. It will be reported to the Medical Records Director. The findings will be presented in the QAPI Committee meeting quarterly.**	**JULY 31, 2021**
L 128	3224.3 Nursing Facilities The supervising pharmacist shall do the following: (a)Review the drug regimen of each resident at least monthly and report any irregularities to the Medical Director, Administrator, and the Director of Nursing Services; (b)Submit a written report to the Administrator on the status of the pharmaceutical services and staff performances, at least quarterly; (c)Provide a minimum of two (2) in-service sessions per year to all nursing employees, including one (1) session that includes indications, contraindications and possible side effects of commonly used medications; (d)Establish a system of records of receipt and disposition of all controlled substances in sufficient detail to enable an accurate reconciliation; and (e)Determine that drug records are in order and that an account of all controlled substances is maintained and periodically reconciled. This Statute is not met as evidenced by:	L 128		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0007	A. BUILDING: _____ B. WING _____	06/22/2021

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) COMPLETE DATE
L 128	Continued From page 14 Based on record review and staff interview, for three (3) of 56 sampled residents, facility staff failed to conduct a Medication Regimen Review (MRR) at least monthly. Residents' #60, #162 and #177. The findings include: Review of the facility's policy entitled, "Consultant Pharmacist Services" revealed, "... Reviewing the medication regimen of each resident at least monthly, complying with Federal, State, and Local mandated standards of care in addition to other applicable standards, and documenting the review and findings in consulting software ..." 1. Resident #60 was admitted to the facility on 06/12/2018, with diagnoses that included: Peripheral Vascular Disease, Traumatic Brain Injury, Chronic Pain, Contracture, Gastrostomy Status and Mild Cognitive Impairment. Review of Resident #60's record revealed that there was no MRR done for the month of May 2021. During a telephone interview conducted on 06/16/2021, at 1:06 PM, Employee #10 (Pharmacist) stated, "I am not sure if I have a MRR for this resident for May. I do a review monthly for all residents in the building but sometimes it goes over a month between reviews." 2. Resident #162 was admitted to the facility on 05/05/2020, with diagnoses, which included Chronic Kidney Disease, Congestive Heart Failure, Hypertension, Hyperlipidemia, Seizures, Gastroesophageal Reflux Disease, Bipolar Disorder, and Major Depression.	L 128		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0007	A. BUILDING: _____ B. WING _____	06/22/2021

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) COMPLETE DATE
L 128	Continued From page 15 A review of the Medication Regimen Review progress notes dated from July 2020 to June 2021, lacked documented evidence that the pharmacist conducted a MRR for October 2020. During a face-to-face interview conducted with Employee #14 (Registered Nurse) on 06/16/2021, at approximately 1:00 PM, she reviewed the documents and acknowledged the findings. 3. Resident #177 was admitted to the facility on 07/15/2016, with diagnoses, which included Dementia, Hypertension, Diabetes Mellitus, Hypercholesterolemia, Peripheral Vascular Disease, and Chronic Obstructive Pulmonary Disease. A review of the Medication Regimen Review progress notes dated from May 2020 to June 2021, lacked documented evidence that the pharmacist conducted a MRR for September 2020 and March 2021. During a face-to-face interview conducted with Employee #14 (Registered Nurse) on 06/16/2021, at approximately 1:00 PM, she reviewed the documents and acknowledged the findings.	L 128		
L 201	3231.12 Nursing Facilities Each medical record shall include the following information: (a)The resident's name, age, sex, date of birth, race, martial status home address, telephone number, and religion; (b)Full name, addresses and telephone numbers	L 201	**3231.12 Nursing Facilities** **1) Facility cannot retroactively correct inappropriate documentation.** **2) Behavior monitoring on all Resident on Antipsychotic medications was reviewed to reflect appropriate documentation.** **3) Unit managers to review behavioral orders and nursing documentation weekly** **4) Monitoring tool initiated to ensure compliance**	**JULY 31, 2021**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0007	A. BUILDING: _____ B. WING _____	06/22/2021

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) COMPLETE DATE
L 201	Continued From page 16 of the personal physician, dentist and interested family member or sponsor; (c)Medicaid, Medicare and health insurance numbers; (d)Social security and other entitlement numbers; (e)Date of admission, results of pre-admission screening, admitting diagnoses, and final diagnoses; (f)Date of discharge, and condition on discharge; (g)Hospital discharge summaries or a transfer form from the attending physician; (h)Medical history, allergies, physical examination, diagnosis, prognosis and rehabilitation; (i)Vaccine history, if applicable, and other pertinent information about immune status in relation to vaccine preventable disease; (j)Current status of resident's condition; (k)Physician progress notes which shall be written at the time of observation to describe significant changes in the resident's condition, when medication or treatment orders are changed or renewed or when the resident's condition remains stable to indicate a status quo condition; (l)The resident's medical experience upon discharge, which shall be summarized by the attending physician and shall include final diagnoses, course of treatment in the facility,	L 201	**F641 Accuracy of Assessment** **1. (#1)** **2. Resident # 60 was reassessed. Facility cannot retrospectively correct inappropriate documentation.** **3. Behavior monitoring on all Resident on Antipsychotic medications and documentations was reviewed. No other resident was affected by this practice.** **4. Unit managers were reeducated and will review behavioral orders and nursing documentation weekly.** **5. Unit managers will audit documentation on the MAR as it pertains to antipsychotic medications. The report will be submitted to the DON/ADON and reported to the QAPI report quarterly.**	**JULY 31, 2021**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0007	A. BUILDING: _____ B. WING _____	06/22/2021

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) COMPLETE DATE
L 201	Continued From page 17 essential information of illness, medications on discharge and location to which the resident was discharged; (m)Nurse's notes which shall be kept in accordance with the resident's medical assessment and the policies of the nursing service; (n)A record of the resident's assessment and ongoing reports of physical therapy, occupational therapy, speech therapy, podiatry, dental, therapeutic recreation, dietary, and social services; (o)The plan of care; (p)Consent forms and advance directives; and (q)A current inventory of the resident's personal clothing, belongings and valuables. This Statute is not met as evidenced by: Based on observation, record review and staff interview for five (5) of 56 sampled residents, facility staff failed to accurately code the Minimum Data Set for one (1) resident who had episodes of anxiety; one (1) resident having impairment on one side; one (1) resident for dialysis; one (1) resident for shortness of breath, and for one (1) resident for discharge assessment. Residents' #60, #100, #134, #179 and #181. The findings include: 1. Resident #60 was admitted to the facility on 06/12/2018, with diagnoses that included: Peripheral Vascular Disease, Traumatic Brain	L 201	**F641 Accuracy of Assessment (#2)** **1. The assessment of resident #100 with ARD 5/5/21 was modified to correctly code the functional limitation in range of motion.** **2. Audit was conducted on the last Quarterly MDS and Annual MDS assessments in the last 6 months of all residents with splint and identified contracture. All identified missed functional limitation in ROM coding was modified.** **3. In-service was held with all the MDS coordinators, and restorative nursing on proper identification and accurate coding of the functional limitation in range of motion.** **4. The MDS manager will audit the MDS assessments of all residents with splints and identified contracture for correct coding of functional limitation in range of motion. The findings will be reported to QAPI committee quarterly.**	**JULY 31, 2021**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0007	A. BUILDING: _____ B. WING _____	06/22/2021

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) COMPLETE DATE
L 201	Continued From page 18 Injury, Chronic Pain, Contracture, Gastrostomy Status and Mild Cognitive Impairment. Review of the Quarterly Minimum Data Set (MDS) dated 04/09/2021, revealed: Section C (Cognition) Brief Interview for Mental Status (BIMS) score of 12, indicating moderately impaired. Section E (Behavior) "Delusions (misconceptions or beliefs that are firmly held, contrary to reality)" is documented. Review of the physician's orders revealed the following: "7/21/2020 instructed staff to document,"Target behavioral symptoms (Refusing medications and wound treatment) every shift". "11/17/2020 Haloperidol (antipsychotic) 0.5mg (milligram) Administer 0.25mg via PEG [percutaneous endoscopic gastrostomy] tube daily for agitation Start Date once a day" Review of the June 2021 Medication Administration Record (MAR) revealed that facility staff documented that Resident #60 refused the Haloperidol on June 15th and 16th, 2021, during the day shift. However, in the "Target Behavior" section of the previously mentioned MAR, the facility staff documented, "00" for the number of episodes Resident #60 refused medications that occurred on June 15th and 16th, 2021, during the day shift. During a face-to-face interview conducted on 06/16/2021, at 12:28 PM, Employee #7 (Registered Nurse) acknowledged the finding that he incorrectly documented the assessment of the	L 201	**F641 Accuracy of Assessment (#3)** **1. The assessment of resident #134 with ARD 5/8/21 was modified to correctly code dialysis in section O0100(2)(K) of the resident's MDS assessment.** **2. MDS Team audited accurate coding of Dialysis on MDS assessment within the past 6 months to identify missed coding of section O0100 (2)(K). No missed coding found.** **3. In-service was conducted for all MDS coordinators on proper coding of dialysis in section O0100(2)(K) of MDS assessment:** **4. The MDS manager will audit assessments of all dialysis resident at least once every month for MDS dialysis coding compliance. The findings will be reported to the QAPI committee quarterly.**	JULY 31, 2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0007	A. BUILDING: _____ B. WING _____	06/22/2021

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) COMPLETE DATE
L 201	Continued From page 19 resident and stated, "I documented "00" to indicate that the resident didn't have any episodes of anxiety instead of him refusing the medication." 2. Resident # 100 was admitted to the facility on 7/25/2016, with diagnoses that included Hemiplegia, Unspecified Affecting Left Nondominant Side and Aphasia. According to the Minimum Data Set completed 5/5/2021 Under Section G (Functional Status) Resident # 100 required extensive assistance with the assistance of one person for bed mobility, dressing, and personal hygiene. Under Section G0400 (Functional Limitation in Range of Motion) the resident was not coded as having impairment on one side- upper extremity (shoulder, elbow, wrist hand). Section I (Active Diagnoses) was coded as the resident having Hemiplegia, unspecified Affecting Left Nondominant side. Review of the Resident #100's care plan for "Left Hand Palm Guard" last updated 5/4/2021 showed the following approach "Left hand palm guard-4 hours on and 4 hours off, off at night" The physician's orders last signed and dated 6/3/2021 directed, "splint clarification order: palm guard to be applied on left hand by gently opening fingers and placing palm guard in hand, secure with strap ..." Observations: On 6/15/2021 at 1:00 PM and 6/17/2021 at 12:00 PM Resident #100 was observed and the hand splint/palm guard was not applied to his left hand. During a face-to-face interview conducted on	L 201	**F641 Accuracy of Assessment (#4)** 1. **The assessment of resident #179 with ARD 4/22/21 with the coding error was modified to accurately code shortness of breath in section J100.** 2. **Audit was conducted on MDS assessments of residents in the last 6 months with continuous oxygen. All identified missed coding of shortness of breath were modified.** 3. **In-service was conducted for MDS coordinators on proper coding, and documentation of shortness of in section J100.** 4. **MDS manager will audit MDS assessments of all residents on continuous oxygen every 3 months for accurate coding of section J100. The findings will be reported in QAPI quarterly.**	**JULY 31, 2021**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0007	A. BUILDING: _____ B. WING _____	06/22/2021

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) COMPLETE DATE
L 201	Continued From page 20 06/22/2021 at approximately 12:00 PM with Employee #9 (MDS Manager) he observed the resident and acknowledged that the MDS should have been coded for the resident having impairment on one side- upper extremity. 3. Facility staff failed to code a Quarterly Minimum Data Set for Resident #134's use of Dialysis. Resident #134 was admitted to the facility on 02/22/2019, with diagnoses, which included End-stage renal Disease on Hemodialysis, Hypertension, Diabetes Mellitus 2, , Gastroesophageal Reflux Disease, Anemia, Cerebral Infraction, Seizure and Dementia. A review of the Quarterly Minimum Data Set dated 05/08/2021 showed under Section O (Special Treatments, Procedures and Programs) O100 #2 "while a resident" facility staff failed to code in section "Other J. Dialysis" The box next to "Dialysis" was not checked indicating, it was not coded. During a face-to-face interview conducted on 06/22/2021, at 1:43 PM, Employee #17, reviewed the aforementioned MDS and acknowledged the findings. 4. Resident #179 was admitted to the facility on 04/15/2021, with diagnoses that included: Fatigue, Shortness of Breath (SOB), Acute Respiratory Failure with Hypercapnia, Chronic Lung Disease and Hypertension. Review of the Admission MDS dated 04/22/2021 revealed:	L 201		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0007	A. BUILDING: _____ B. WING _____	06/22/2021

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) COMPLETE DATE
L 201	Continued From page 21 Section I (Active Diagnoses) - Acute Respiratory Failure with Hypercapnia, Hypertension, Obstructive Sleep Apnea. Section J (Health Conditions) subsection "J1100 Shortness of Breath (dyspnea)", facility staff documented, "none of the above". Review of the physician's orders revealed: "04/16/2021 O2 (oxygen) @ (at) 2l (liters)/min via NC (nasal canula) for sob (shortness of breath) Every Shift Night, Day, Evening Start Date" "04/16/2021 Montelukast (anti-inflammatory) tablet; 10 mg; amt (amount): 1 tab (tablet); oral Special Instructions: Montelukast 10 mg 1tab oral at night for COPD (chronic obstructive pulmonary disease) at bedtime" Review of the Care Plan revealed: "04/15/2021 Problem: Resident has shortness of breath R/T (related to) Respiratory Failure, Resident receives Oxygen at 2L/min via nasal cannula..." "04/15/2021 Problem: Resident has needs related to respiratory disease: Chronic Lung Disease with Hypercapnia/Respiratory Failure/COPD/SOB..." The admissions MDS lacked documented evidence that Resident #179 was coded as having Shortness of Breath. During a face-to-face interview conducted on 06/17/2021, at 1:34 PM, Employee #8 (MDS Coordinator) stated, "It was not documented properly in the MDS."	L 201		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0007	A. BUILDING: _____ B. WING _____	06/22/2021

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) COMPLETE DATE
L 201	Continued From page 22 5. Resident #181 was admitted to the facility on 04/03/2021, with diagnoses that included: Cancer, Anemia, Diabetes Mellitus and Non-Alzheimer's Dementia. Review of the progress notes revealed the following: 04/27/2021 at 11:38 AM [Nursing Discharge Note]: "Resident was discharged home today (4-27-21) and his RP [resident's representative] (wife) and his son picked up the resident ..." Review of the Discharge MDS dated 04/27/2021, in section A2100 (Discharge Status) revealed that facility staff coded Resident #181's discharge as "03" indicating the resident was discharged to an "Acute hospital". During a face-to-face interview conducted on 06/17/2021, at 4:22 PM, Employee #8 (MDS Coordinator) acknowledged the findings.	L 201		JULY 31, 2021
L 214	3234.1 Nursing Facilities Each facility shall be designed, constructed, located, equipped, and maintained to provide a functional, healthful, safe, comfortable, and supportive environment for each resident, employee and the visiting public. This Statute is not met as evidenced by: Based on observations and interview, the facility failed to provide an environment free from accident hazards as evidenced by surge protectors that were observed in use, on the floor of two (2) of 46 resident's rooms and an extension cord that was observed in one (1) of 46 resident's rooms.	L 214	**3234.1 Nursing Facilities** **Free of Accident Hazards/Supervision/Devices** **1. Identified surge protector on the floor in room #310 and #320 were removed on 6/15/2021. The Extension Cord in resident room #377 was removed on 6/15/2021. No negative outcome was noted to Facility Residents.** **2. Maintenance team conducted facility wide inspection of surge protectors, extension cords and other safety devices to identify and repair or replace as needed. No other surge protectors or extension cords were noted.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0007	A. BUILDING: _____ B. WING _____	06/22/2021

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) COMPLETE DATE
L 214	Continued From page 23 The findings include: 1. Surge protectors were observed in use, on the floor of resident's room #310 and #320, two (2) of 46 resident's rooms. 2. An extension cord was observed in use, in one (1) of 46 resident's rooms resident room. (#377). During a face-to-face interview on June 16, 2021, at approximately 10:00 AM, Employee #5 acknowledged the findings and stated they had already been corrected.	L 214	3. **Facility Maintenance manager provided education to maintenance staff on 6/16/20121 on the importance of frequent rounding to identify and remove surge protector and extension cords on the floor and/or in the resident's room. The Maintenance team will conduct weekly Inspection on surge protector, extension cords and other safety devices. Any identified surge protector or extension cords on the floor will be removed.** 4. **Weekly inspection of surge protectors and extension cords will be monitored. A report of the inspection will be forward to the QAPI committee and reported on quarterly.**	**JUNE 15, 2021**
L 306	3245.10 Nursing Facilities A call system that meets the following requirements shall be provided: (a)Be accessible to each resident, indicating signals from each bed location, toilet room, and bath or shower room and other rooms used by residents; (b)In new facilities or when major renovations are made to existing facilities, be of type in which the call bell can be terminated only in the resident's room; (c)Be of a quality which is, at the time of installation, consistent with current technology; and (d)Be in good working order at all times. This Statute is not met as evidenced by: Based on observation and interview, facility staff failed to maintain the call bell system in good	L 306	**L306** **3245.10 Nursing Facilities** 1. **Identified call bells that did not emit an audible or visual alarm in rooms #314, #353, #361, #364, #379 were corrected on 6/15/2021. No negative outcome was noted to Facility Residents.** 2. **Maintenance team conducted facility wide inspection of call bells on 6/15/2021 and other devices to identify and repair or replace as needed. No other call bell was identified.**	**JUUNE 15, 2021**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0007	A. BUILDING: _____ B. WING _____	06/22/2021

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)	2)
L 306	Continued From page 24 working condition as evidenced by call bells that failed to initiate an audible or visual alarm when tested in five (5) of 46 resident's rooms. The findings include: During an environmental walkthrough of the facility on June 15, 2021, at approximately 10:00 AM, call bell in five (5) of 46 resident's rooms did not emit an audible or visual alarm when tested. (#314, #353, #361, #364, #379). This breakdown could prevent or delay care to residents in an emergency. During a face-to-face interview on June 16, 2021, at approximately 10:00 AM, Employee #5 acknowledged the findings and stated they had already been corrected.	L 306	**3. Facility Maintenance manager provided education to the maintenance staff on 6/16/2021 on the importance of frequent rounding to identify and timely replacement or repair call bells and other devices as needed. The Maintenance team will conduct weekly inspection on call bells and other devices. Any device identified will be repaired or replaced.** **4. 4-Weekly inspection of Call Bells will be monitored. A report of the inspection will be forward to the QAPI committee and reported on quarterly.**	JUNE 16, 2021
L 410	3256.1 Nursing Facilities Each facility shall provide housekeeping and maintenance services necessary to maintain the exterior and the interior of the facility in a safe, sanitary, orderly, comfortable and attractive manner. This Statute is not met as evidenced by: Based on observations and interview, facility staff failed to provide housekeeping and maintenance services necessary to maintain a safe, clean, comfortable environment as evidenced by a loose privacy curtain bracket in one (1) of 46 resident's rooms, stained ceiling tiles in one (1) of 46 resident's rooms, and two (2) of five (5) ceiling vents that lacked a cover in the hallway of unit 2 Orange. The findings include:	L 410	L410 **3256.1 Nursing Facilities** **1) Identified surge protector on the floor in room #310 and #320 were removed on 6/15/2021. The Extension Cord in resident room #377 was removed on 6/15/2021. No negative outcome was noted to Facility Residents.** **2) Maintenance team conducted facility wide inspection of surge protectors, extension cords and other safety devices to identify and repair or replace as needed. No other surge protectors or extension cords were noted.**	JUNE 16, 2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0007	A. BUILDING: _____ B. WING _____	06/22/2021

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	(X5) COMPLETE DATE
L 410	Continued From page 25 During an environmental walkthrough of the facility on June 15, 2021, at approximately 10:00 AM: 1. The privacy curtain holder (bracket) in resident room #356 was loose, one (1) of 46 resident's rooms. 2. Ceiling tiles were stained in resident room #353, one (1) of 46 resident's rooms. 3. Two (2) of five (5) ceiling vent covers were missing in the hallway near resident's room #257 and #261 on unit 2 Orange. During a face-to-face interview on June 16, 2021, at approximately 10:00 AM, Employee #5 acknowledged the findings and stated they had already been corrected.	L 410	**3256.1 Nursing Facilities** 1. **Privacy Curtain Holder (Bracket) in room #356 was tightened. Stained ceiling tile in room #353 was removed and replaced. Vent covers near resident rooms #257 and #261 were installed.** 2. **Maintenance team conducted facility wide inspection of loose privacy curtain holder (bracket), stained ceiling tiles, ceiling vent covers and other devices to identify and repair or replace devices. No other privacy curtain holders (brackets), stained ceiling tiles or vent covers were noted.** 3. **Facility Maintenance manager provided education to maintenance staff on 6/16/2021 on the importance of frequent rounding to identify and timely replacement or repair of loose privacy curtain holder (bracket), stained ceiling tiles, ceiling vent covers, and other devices as needed.** 4. **The Maintenance team will conduct weekly inspection on loose privacy curtain holder (bracket), stained ceiling tiles, ceiling vent covers and other devices. Any device identified will be repaired or replaced.** 5. **Weekly inspection of privacy curtain holders, ceiling tiles and vent covers will be monitored. A report of the inspection will be forward to the QAPI committee and reported on quarterly.**	**JUNE 16, 2021**