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 ______	09/26/2018

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WASHINGTON CTR FOR AGING SVCS	2601 18TH STREET NE WASHINGTON, DC 20018

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L 000	Initial Comments An unannounced Licensure Survey was conducted at Washington Center for Aging Services from September 19, 2018 through September 26, 2018. Survey activities consisted of a review of 38 sampled residents. The following deficiencies are based on observation, record review, resident and staff interviews. 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 BID - Twice- a-day B/P - Blood Pressure cm - Centimeters CMS - Centers for Medicare and Medicaid Services CNA- Certified Nurse Aide CFU Colony Forming Unit CRF - Community Residential Facility D.C. - District of Columbia DCMR- District of Columbia Municipal Regulations D/C Discontinue Dl - deciliter DMH - Department of Mental Health EKG - 12 lead Electrocardiogram EMS - Emergency Medical Services (911) G-tube Gastrostomy tube HSC Health Service Center HVAC - Heating ventilation/Air conditioning ID - Intellectual disability IDT - Interdisciplinary team L - Liter	L 000	Stoddard Baptist Global Care (Washington Center for Aging Services) 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.	

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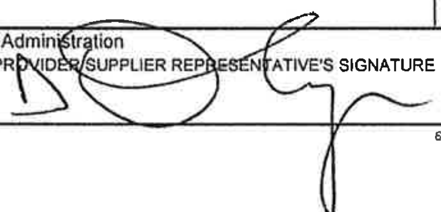
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE



TITLE LNHA

(X6) DATE 12/6/18

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L 000	Continued From page 1 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 ng- nanograms Neuro - Neurological NP - Nurse Practitioner PASRR - Preadmission screen and Resident Review Peg tube - Percutaneous Endoscopic Gastrostomy PO- by mouth POS - physician ' s order sheet Prn - As needed Pt - Patient PU- Partial Upper PL- Partial Lower Q- Every QIS - Quality Indicator Survey Rap, R/P - Responsible party SCSA Significant change status assessment Sol- Solution TAR - Treatment Administration Record Trach- Tracheostomy TV- Television TX- Treatment	L 000		
L 051	3210.4 Nursing Facilities A charge nurse shall be responsible for the following:	L 051	**Development/Implement Comprehensive Care Plan** **See Page 3**	12/4/18

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L 051	Continued From page 2 (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: 1. Based on medical record review, and staff interview, the charge nurse failed to develop and implement an individualized care plan to meet the needs of the resident in two (2) of nine (9) resident records reviewed (Residents #167 and 108). Findings included ... A. Resident #167 was admitted with a past medical history including Dementia. Review of the Minimum Data Set (MDS) dated 08/04/18 showed Brief Interview for Mental Status (BIMS) score of 1, indicating severe cognitive deficit. The surveyor conducted a tour of unit 2 Orange on 09/19/18 at approximately 10:00 AM. During	L 051	**Development/Implement Comprehensive Care Plan** The Care Plans for residents #167 and #108 were reviewed and updated to ensure they were person-centered and addressed activity pursuits and cognitive status. 2. A review of the activity care plans as well as a review of residents who were cognitively intact was conducted to ensure care plans met the resident needs. Care plans were addressed as indicated. 3. The Interdisciplinary team were re-educated regarding care plans ensuring they are person centered and meet the needs of the residents. 4. The Activity Director conducts monthly audits of the resident's preferences. The Social Services Director monitors the BIMS scores of the resident to ensure the care plan addresses their cognitive status. This information is presented at the QAPI Committee meeting quarterly.	12/4/18

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L 051	Continued From page 3 the observation Resident #167 was observed seated in a wheelchair in her room facing the hallway. The surveyor conducted another tour on 09/20/18 at approximately 11:00 AM. Resident #167 was again observed seated in a wheelchair in her room, facing the hallway. Later on the in the afternoon at approximately 2:00 PM, the Resident was seen sleeping in her bed. On 09/25/18 at approximately 11:30 AM, Resident #167 was again seen seated in her wheelchair, facing the hallway. Review of section F of the MDS dated 02/04/18, showed that listening to music and participating in her favorite activities, is very important. Doing things with groups of people and going outside to get fresh air while the weather is good, is somewhat important. Review of the Activities care plan for Resident #167, last reviewed on 05/08/18 shows that the resident prefers activities that identify with her prior lifestyle. The goal is that the Resident will express satisfaction with her daily routine and leisure activities. However, the activity preferences are not listed, and the approaches are not individualized to meet the needs of the resident. The surveyor conducted a face to face interview on 09/25/18 at 12:06 PM with Employee #11, Nurse Manager for 2 Orange, regarding the Activity plan for Resident #167. She stated that Resident #167 is non-compliant with leaving her room and from time to time the Activities staff will come by to visit her. The charge nurse failed to develop a care plan was individualized with goals and approaches to meet the needs of the resident.	L 051		

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L 051	Continued From page 4	L 051		

The surveyor conducted a face to face interview on 09/25/18 at 12:30 PM with Employee #11, and 25, and they acknowledged the findings.

B. Resident #108 was admitted with a past medical history of Dementia. Review of the Minimum Data Set (MDS), dated 07/10/18 showed a Brief Interview for Mental Status (BIMS) score of 14, indicating she is cognitively intact. She was admitted to 1 Blue, a locked unit designated Dementia unit.

Review of the care plan that addresses her Alzheimer's/Dementia, last edited 07/17/18 showed a goal that the "Resident will be reoriented to person, place and time and resident will be safe in their environment of the next 90 days."The approaches documented were: "1. Reorient resident to person, place and time as needed when confusion is noted. 2. Monitor residents whereabouts in the facility to ensure safe environment. 3. Remove resident from areas where there is over stimulation that agitated or confuses resident. 4. Document declines in cognitive status in the clinical record. 5. Administer medications as ordered by MD [Medical Doctor] 6. Psych [psychiatric] evaluations as needed."

The charge nurse failed to develop an individualized person-centered care plan with goals and approaches to meet the needs of the resident.

The surveyor conducted a face to face interview on 09/24/18 at 1:00 PM with Employee #26, Assistant Nurse Manager of 1 Blue. He acknowledged the findings.

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L 051	Continued From page 5 2. Based on observation, record review, resident and staff interview of one (1) of 38 sampled residents, the charge nurse failed to instruct resident proper administration of medication according to professional standards of practice and manufacturer's specification for one (1) of one resident receiving nasal spray. (Resident # 65) Finding included... The charge nurse failed to ensure the resident follow manufacturers specification for administering Fluticasone nasal spray (indicated for the management of the nasal symptoms of perennial nonallergic rhinitis in adult and pediatric patients aged 4 years and older) during medication administration observation for Resident #65. Resident #65 was admitted to the facility on August 3, 2013, with diagnosis that include Malignant Neoplasm of female breast, Type 2 Diabetes Mellitus, Essential Hypertension, Major Depressive Disorder, Chronic Rhinitis and Allergy. On September 20, 2018 at approximately 10:15 AM, the surveyor observed Employee #20 handed Resident #65 the Flonase nasal spray. Resident #65 self-administered Flonase one spray per nostril. Employee #20 instructed the resident to administer a second dose. The resident administered a second dose of Flonase, one spray per nostril. Employee #20, returned the Flonase to the medication cart.	L 051	**Quality of Care** Resident #65 was assessed immediately and was not found to be impacted. Additionally, it was determined that staff will administer her medications. 2. A review of residents using nasal spray was conducted, no resident was found to be impacted by this practice. 3. All licensed Nursing staffs were educated on proper administration of nasal spray according to professional standard of practice and manufacturer specification. The in-services were completed by 11/29/2018. 4. Medication administration, particularly nasal spray administration reviews are conducted by nursing leadership. This information is presented to the QAPI committee quarterly.	12/4/18

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L 051	Continued From page 6	L 051		

A review of the physician's order dated July 16, 2018 showed "Flonase nasal spray 50 microgram (mcg), 2 sprays to each nostril daily for rhinitis."

A face-to face interview conducted on September 20, 2018 at approximately 10:30 AM, Resident #65 stated she could take her own medication.

Manufacturer instructions stated the resident should first blow your nose; close one (1) nostril; tilt your head forward slightly; start to breathe in through your nose, and while breathing, press firmly and quickly down one (1) time on the applicator to release the spray; then breathe out through your mouth. If a second spray is required in that nostril, repeat the process.

The medication administration observation failed to support that the resident self-administered the nasal spray in accordance with manufacturer's recommendation to ensure adequate delivery of dose. Furthermore, the facility staff did not provide guidance while observing the resident's self-administration of medication.

https://www.rxlist.com/flonase-d6rug.htm#medguide l

A face-to-face interview conducted on September 20, 2018, at approximately 10:45 AM, Employees' # 20 and #15 acknowledged the findings.

3. Based on policy review, record review, and staff and resident interview of one (1) of 38 sampled residents, the nursing staff failed to evaluate and address catheter care for a resident with an indwelling catheter and recurrent urinary tract infections (Resident #197).

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L 051	Continued From page 7 Findings include ... The Washington Center for Aging Services policy entitled "Catheter Care - Suprapubic", undated, stipulates that the purpose of catheter care is to reduce infection and promote good hygiene. The procedure of catheter care included " ...cleanse the skin around the catheter and the entire visible length of the catheter with soap and water. Be sure all drainage is removed from skin and catheter ..." The policy describes that the type and amount of drainage should be noted, if present. Resident #197 was admitted to the facility with a diagnosis of Parkinson's Disease and a history of Prostate Cancer with a suprapubic catheter placement. Review of the medical record showed that Resident #197 had multiple unrinary tract infections (UTI's) beginning in 03/2017 when he was placed on isolation for an Extended Spectrum Beta-Lactamase (ESBL) infection in the urine. Additionally, he was treated for a UTI 03/2018, and in 08/2018, was again placed on isolation for ESBL in the urine. Review of the physician orders report for September, dated 07/29/18, directed that nursing staff perform catheter care. The surveyor conducted a face to face interview with Employee #25, Charge Nurse, 2 Orange, in the presence of Employee #11, Unit Manager 2 Orange, on 09/25/18 at 11:08 AM regarding catheter care. When asked what the procedure was for catheter care, she stated that the nurse observes the drainage bag and checks the urine for sediment, color, and blood. When the surveyor asked if	L 051	**Bowel/Bladder Incontinence** Resident #197 was assessed and catheter care was provided by the licensed nursing staff member immediately. 2. A review of residents with Foley Catheter care was conducted and no other resident was found to be affected by this practice. 3. The Licensed Nursing Staff were re-educated on Foley Cather Care, this included a review of the Policy and Procedure on Catheter Care and on Urinary Tract Infections. The training was completed by 11/29/2018. 4. Residents with Foley Catheter care and Catheter care is done by the leadership team. This is presented to the QAPI committee quarterly.	12/4/18

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L 051	Continued From page 8 cleaning the catheter was considered catheter care, she stated no, cleaning the catheter is considered an Activity of Daily Living (ADL) and is performed by the Certified Nursing Assistant (CNA). When asked how the resident's frequent UTI's were being addressed related to catheter care, she could offer no further insight. The surveyor conducted a face to face interview on 09/26/18 at 2:45 PM with Employee #27, Infection Control Nurse Practitioner, in the presence of Employee # 1, Administrator, and Employee 28, Infection Preventionist, regarding how the Infection Control department was addressing the recurrent Catheter Acquired Urinary Tract Infections (CAUTI's) for Resident #197. She stated that they provided education for staff regarding hand hygiene. When asked if training was provided to staff regarding catheter care, she stated no. The above employees acknowledged the findings.	L 051		
L 052	3211.1 Nursing Facilities Sufficient nursing time shall be given to each resident to ensure that the resident receives the following: (a)Treatment, medications, diet and nutritional supplements and fluids as prescribed, and rehabilitative nursing care as needed; (b)Proper care to minimize pressure ulcers and contractures and to promote the healing of ulcers: (c)Assistants in daily personal grooming so that the resident is comfortable, clean, and neat as evidenced by freedom from body odor, cleaned and trimmed nails, and clean, neat and	L 052	**Free of Accident Hazards** **See Page 11**	12/4/18

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L 052	Continued From page 9	L 052		

well-groomed hair;

(d) Protection from accident, injury, and infection;

(e)Encouragement, assistance, and training in self-care and group activities;

(f)Encouragement and assistance to:

(1)Get out of the bed and dress or be dressed in his or her own clothing; and shoes or slippers, which shall be clean and in good repair;

(2)Use the dining room if he or she is able; and

(3)Participate in meaningful social and recreational activities; with eating;

(g)Prompt, unhurried assistance if he or she requires or request help with eating;

(h)Prescribed adaptive self-help devices to assist him or her in eating independently;

(i)Assistance, if needed, with daily hygiene, including oral acre; and

j)Prompt response to an activated call bell or call for help.

This Statute is not met as evidenced by:

Based on record review and staff interview for one (1) of 38 sampled residents facility staff failed to provide sufficient nursing staff to provide care in accordance with physicians' order and professional standards of care as evidenced by a resident fall. Resident # 33.

Findings included ...

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L 052	Continued From page 10	L 052	**Free of Hazard Accidents**	12/4/18

Facility failed to provide sufficent nursing staff to maintain safety to prevent a resident fall by failing to raise the bed side rails when providing incontinent care.

Resident # 33 admitted to the facility on 6/12/10 with diagnoses which include Unspecified Dementia without Behavioral Disturbance, Chronic Kidney Disease, Dysphagia, and Hypertension.

Review on 9/24/18 at 10:00 AM of the Quarterly Minimum Data Set [MDS] dated 6/18/18 showed Section C [Cognitive Patterns] Brief Interview for Mental Status (BIMS) resident is scored as "0" which indicate resident is rarely/never understood. Section G [Functional Status] resident is coded as "4' totally dependent on staff for activities of daily living (dressing, toilet use, bathing, and personal hygiene).

Section H [Bladder and Bowel] Resident is coded as "3" which indicate, always incontinent of bladder and bowel.

Section J [Health Conditions] J1700 Fall History on Admission/Entry or Reentry is coded as "1" which indicate resident had a fall during the last month; J1900 Number of Falls since Admission/Entry or Reentry Prior Assessment is coded as "1" No injury (no evidence of any injury is noted on physical assessment by the nurse or primary care clinician).

Review of the nursing care plan showed "Resident at risk for falling; approaches "assess resident frequently to assure that resident is positioned correctly on the bed, keep call light in reach at all times, observe frequently and place in

Provider's Plan of Correction (L 052):

Resident #33 was reassessed, and is without injury and/or accidents, unable to retrospectively correct.

2. All residents who utilize side rails to enhance turning and re-positioning were checked. No other resident was found to be impacted by this practice.

3. The nursing staff was re-educated regarding the use of side rails and importance of elevating them while doing ADL care. The training was completed by 11/29/2018.

4. The nursing leadership team monitors ADL care including use of side rails when indicated. The information is provided to the QAPI committee quarterly.

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L 052	Continued From page 11	L 052		

supervised area when out of bed, provide incontinent care as needed."

Review of the physician order dated 5/2/18 showed "Both side rails up while in bed to enhance turning and repositioning every shift."

On 9/24/18 at 11:30 AM a review of the nurses note dated 5/3/18 showed "Resident has fallen while the Certified Nursing Assistant (CNA) and family member were changing the resident, CNA rolled the resident to her side, and she (resident) had fallen to the floor, there were no visible injuries, and the CNA stated the position of the side rails was down, the CNA was provided education that the side rails must be up when providing care."

On 9/24/18 at 1:00PM observed resident lying quietly in bed and the ½ side rails were raised, secured to the bed and functioning as intended.

During an interview with Employee#15, yes, I am aware of the resident's fall but there was no injury.

During an interview on 9/24/18 at 1:30 PM Employee#24 stated I received training on safety precautions to prevent falls, it takes two staff to provide incontinent care I should have asked staff for help and put the side rails up.

During an interview on 9/24/18 at 4:00 PM, Employee# 23 stated I was hereand Employee#2 4, CNA called for help I met the resident on the floor, there were no visible injuries, we got the reisdent on the bed and sent her (resident) to [hospital name].

During an interview with Employee#15, yes, I am

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L 052	Continued From page 12 aware of the resident's fall but there was no injury. A review of the medical record showed on resident was transferred to [Hospital name]. A further review of the medical record showed resident did not sustain an injury following the fall (5/3/18). Facility staff failed to maintain safety to prevent a resident fall by failing to raise the bed side rails when providing incontinent care. During a face-to-face interview on 9/24/18 at 5:00 PM Employee# acknowledged the finding.	L 052		
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 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;	L 201	**Bowel/Bladder Incontinence** **See Page 15**	12/4/18

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 ____	09/26/2018

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

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L 201	Continued From page 13 (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, 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;	L 201		

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L 201	Continued From page 14 (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 policy review, record review, and staff and resident interview of one (1) of 38 sampled residents, the nursing staff failed to evaluate and address catheter care for a resident with an indwelling catheter and recurrent urinary tract infections (Resident #197). Findings include ... The Washington Center for Aging Services policy **entitled** "Catheter Care - Suprapubic", undated, stipulates that the purpose of catheter care is to reduce infection and promote good hygiene. The procedure of catheter care included " ...cleanse the skin around the catheter and the entire visible length of the catheter with soap and water. Be sure all drainage is removed from skin and catheter ..." The policy describes that the type and amount of drainage should be noted, if present. Resident #197 was admitted to the facility with a diagnosis of Parkinson's Disease and a history of Prostate Cancer with a suprapubic catheter placement. Review of the medical record showed that Resident #197 had multiple unrinary tract infections (UTI's) beginning in 03/2017 when he was placed on isolation for an Extended	L 201	**Bowel /Bladder Incontinence** Resident #197 was assessed and catheter care was provided by the licensed nursing staff member immediately. 2. A review of residents with Foley Catheter care was conducted and no other resident was found to be affected by this practice. 3. The Licensed Nursing Staff were re-educated on Foley Cather Care, this included a review of the Policy and Procedure on Catheter Care and on Urinary Tract Infections. The training was completed by 11/29/2018. 4. Residents with Foley Catheter care and Catheter care is done by the leadership team. This is presented to the QAPI committee quarterly.	12/4/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD02-0007	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ______ B. WING ______	(X3) DATE SURVEY COMPLETED 09/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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L 201	Continued From page 15	L 201		

Spectrum Beta-Lactamase (ESBL) infection in the urine. Additionally, he was treated for a UTI 03/2018, and in 08/2018, was again placed on isolation for ESBL in the urine.

Review of the physician orders report for September, dated 07/29/18, directed that nursing staff perform catheter care. The surveyor conducted a face to face interview with Employee #25, Charge Nurse, 2 Orange, in the presence of Employee #11, Unit Manager 2 Orange, on 09/25/18 at 11:08 AM regarding catheter care. When asked what the procedure was for catheter care, she stated that the nurse observes the drainage bag and checks the urine for sediment, color, and blood. When the surveyor asked if cleaning the catheter was considered catheter care, she stated no, cleaning the catheter is considered an Activity of Daily Living (ADL) and is performed by the Certified Nursing Assistant (CNA). When asked how the resident's frequent UTI's were being addressed related to catheter care, she could offer no further insight.

The surveyor conducted a face to face interview on 09/26/18 at 2:45 PM with Employee #27, Infection Control Nurse Practitioner, in the presence of Employee # 1, Administrator, and Employee 28, Infection Preventionist, regarding how the Infection Control department was addressing the recurrent Catheter Acquired Urinary Tract Infections (CAUTI's) for Resident #197. She stated that they provided education for staff regarding hand hygiene. When asked if training was provided to staff regarding catheter care, she stated no. The above employees acknowledged the findings.

Health Regulation & Licensing Administration

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L 410	Continued From page 16	L 410		
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 staff interview the facility failed to provide housekeeping and maintenance services necessary to maintain a comfortable interior as evidenced by: one (1) of one (1) clogged sink; soiled floors were observed in one (1) of one (1) the electrical closet, one (1) of one (1) pantry and one (1) of one (1) clean linen room; soiled ceiling tiles in one (1) of one (1) panty and one (1) of nine (9) dayrooms; floor tile damaged near the ice machine in one (1) of one (1) pantry; antiskid strips were not secure in two (2) of two (2) resident bathrooms; urine odor in two (2) of two (2) resident bathrooms and a damaged wall in one (1) of 38 resident rooms. Findings included ... During observations on the first floor, second floor and third floors on September 26, 2018, between 4:00 PM and 7:30 PM, resident rooms and common areas were observed with the following: 3 green toilet training bathroom had a clogged sink in one (1) of one (1) observed Floors soiled with dust in the electrical closet C332D the storage room C333A, areas of the baseboard located in the dayroom where recessed in one (1) of one (1) observed 3 blue pantry floor was soled beside and behind	L 410	**Safe/Clean/Comfortable/Homelike Environment** The clogged sink (one), soiled floor in one electrical closet, one pantry, one linen room, soiled ceiling tiles in one pantry, one dayroom, floor tile damaged near one ice machine, antiskid strips, and odor identified in two bathrooms, and one damaged wall were repaired. There were no residents found to be affected by this practice. 2. All resident rooms and common areas were checked as it pertained to sinks, floors, ceiling tiles, floor tiles, antiskid strips, odors (particularly bathrooms) and walls. Any areas identified were corrected as indicated. 3. A preventative maintenance program is established to monitor, inspect and correct areas of concern including: sinks, floors, ceiling tiles, floor tiles, antiskid strips, odors and walls. The Maintenance and Housekeeping Staff were re-educated regarding these requirements. 4. Monitoring the environment as it pertains to safety; clean, comfortable, homelike is done by the Maintenance and Housekeeping leadership team. This information will be reported to the QAPI committee quarterly.	12/4/18

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	HFD02-0007	A. BUILDING: ______ B. WING ______	09/26/2018

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L 410	Continued From page 17 the ice machine with dust in one (1) nine (9) observed 3 orange clean linen room floor surface was soiled and had paper on the floor in one (1) on nine (9) observed 2 orange 287 dayroom ceiling tile stained in one (1) nine (9) observed 2 orange pantry ceiling tiles stained in one (1) nine (9) observed 3 blue pantry floor tile damaged near the ice machine in one (1) nine (9) observed Rooms 272 and 310 had a urine odor in the resident's bathroom in two (2) of 38 resident bathrooms 3 orange shower room C340 antiskid strips were not secure and the antiskid strips were not secure in toilet room A393C in two (2) of two (2) observed Damaged wall on 3green room #385 residents room in one (1) of 38 resident rooms. During a face-to-face interview on September 26, 2018, at the time of the observations, Employee #4 confirmed the findings.	L 410		

www.stoddardbaptistglobal.org

December 6, 2018

Veronica Longstreth, RN, MSN
Program Director
District of Columbia Department of Health
Health Care Regulation and Licensing Administration
899 North Capitol Street, NE, 2nd Floor
Washington, DC

Dear Ms. Longstreth:

Enclosed are our Plans of Correction for the Life Safety Code Survey conducted at Stoddard Baptist Global Care on September 26, 2018.

If any additional information is needed please feel free to contact me at (202) 541-6058.

Sincerely,

LNHA

Dennis Olaniyi, MSN, BC-RN, LNHA

2601 18th Street, N.E., Washington, DC 20018 202-541-6200 • www.wcasdc.org

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	09/26/2018

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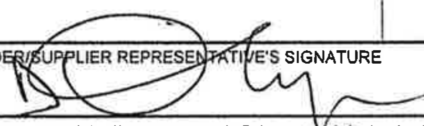
K 000	INITIAL COMMENTS These findings were observed in the presence of Maintenance Staff and Administrative Staff #1, 2, 3, and 4.	K 000	Stoddard Baptist Global Care (Washington Center for Aging Services) makes its best effort to operate in substantial compliance with both Federal and State Laws. Submission 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.	
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbs is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies.	K 363	**Corridor – Doors** **NFPA 101** 1. The double doors on Unit 3 Green near the shower room, the double doors on Unit 1 Green near Room 181, the bathroom door in Room 351 Green, the entrance door to the shower room #A392C on Unit 3 Green that failed to close and latch into frames were repaired immediately.	12/4/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE



TITLE: Lolita

(X6) DATE: 12/6/2018

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.

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	095014	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	09/26/2018

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K 363	Continued From page 1 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observations and interview during the Life Safety Code Inspection, it was determined that double fire doors and single doors failed to close and latch into frames when tested between 2:50 PM and 8.00 PM, on September 26, 2018 in four of 15 observations. These findings were observed and acknowledged in the presence of employees # 4 and 5. The findings included: 1.During the Life Safety Code Inspection; it was determined that double doors on Unit 3 Green near the Shower Room, failed to close and latch into frames when tested in one of three observations at, 3:10 PM on September 26, 2018. 2. Double doors on Unit 1 Green, near Room 181 failed to close and latch into frames when tested, in one of three observations, at 6:45 PM on September 26, 2018. 3. The bathroom door in Room 351 Green; failed to close and latch into frames when tested, in one of seven observations at 3:25 PM September 26, 2018. 4. The entrance door to the shower Room # A392C on Unit 3 Green failed to close and latch into the frame when tested, in one of two observations at 3:15 PM, on September 26, 2018.	K 363	2. All fire doors in the facility were checked to ensure that they close and latch into frames. No other doors were found with a problem of not latching and locking. 3. All doors were placed in a Preventive Maintenance System and the Engineering team were re-educated on Life Safety of fire doors with emphasis on latching and locking of fire doors. 4. A preventive maintenance program is now in place to monitor and inspect the operation of all fire doors in the facility once a month. 5. A quarterly report will be sent to the QAPI.	2/4/18

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