DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095021	A. BUILDING ____ B. WING ____	03/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH & REHABILITATION CENTER AT THOMAS CIRCLE	**1330 MASSACHUSETTS AVENUE NW** **WASHINGTON, DC 20005**

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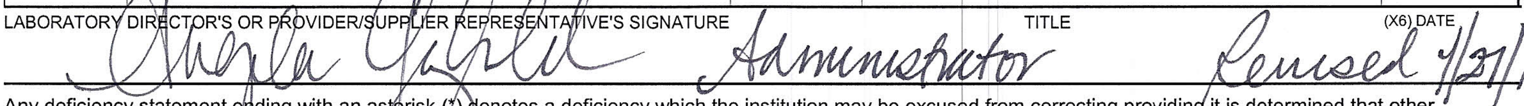
F 000	INITIAL COMMENTS An annual recertification survey was conducted on March 14 through 18, 2011. The following deficiencies were based on observations, resident and staff interview and record review. The sample size was 22 residents.	F 000	The Health and Rehabilitation Center at Thomas Circle files this Plan of Correction for the purposes of regulatory compliance. The facility is submitting this document to comply with applicable law and not as an admission or statement of agreement of deficient practices herein.	
F 226 SS=C	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined that the facility's abuse policy failed to ensure that procedures for "Prevention " for residents and family were written into the policy to provide residents and family with information on how and to whom they may report concerns, incidents, and grievances without the fear of retribution. The findings include: A review of the policy entitle: "Abuse of Residents" [no date indicated], stipulated, " III. Initial and On-going Training in the Facilities Policies- C. Training includes: ...2. How staff should report their knowledge related to about abuse allegations without fear of reprisal. " The policy lacked documented evidence that the facility included the written procedures for	F 226	**1. Corrective Action for Affected Residents:** No residents were affected by this practice. Upon discussion with surveyor, NHA updated policy entitled "Abuse of Residents" to address procedures for prevention for residents and family. The addition, which is section III.D. of the policy specifically addresses the mechanism utilized to provide residents and family with information on how and to whom they may report concerns, incidents, and grievances without fear of retaliation. **2. Identify Residents/ Corrective Action to be taken:** All residents had the potential to be affected by this practice. The policy was immediately updated with the following statement: "Residents/Family Members/POA/Resident Representatives are provided information Upon admission via exhibits D and E in the Admission packet. These exhibits give information regarding reporting concerns, incidents and grievances without fear of retribution. These parties are also advised of the procedure and contact information of who to contact if necessary. Signage is also posted in common areas accessible to all residents and guests with information regarding agencies to contact to report abuse and neglect."	**3/17/2011**

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE



Administrator — Revised 7/21/11

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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F 226	Continued From page 1 "Prevention" in the policy that would provide residents and family with information on how and to whom they may report concerns, incidents, and grievances without the fear of retribution. A face-to-face interview was conducted with Employee #1 on March 18, 2011 at 11:30 AM. The employee reviewed all aspects of the " Abuse of Residents " policy and acknowledged that written procedures for "Prevention" as it relates to information provided to residents and family on how and to whom they may report concerns, incidents, and grievances without the fear of retribution was not documented in the policy.		**3. Systemic Changes:** Policy updated during survey. No systemic changes necessary as practice was already in place per regulatory requirement. **4. Monitor Compliance:** The policy will be Reviewed per regulation by the DON, NHA And MD on an annual basis and updated as appropriate.	
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations that were made during a tour of the kitchen on March 14, 2011 at approximately 9:30 AM and March 18, 2011 at 1:19 PM, it was determined that the facility failed to prepare and serve food under sanitary conditions as evidenced by: Soiled floors and floor mats; one (1) of one (1) Soiled food processor; one (1) of one (1) soiled grill; one (1)	F 371	**1. Corrective Action for Affected Residents:** No residents were affected by this practice. The following actions were taken: **#1:** The soiled food processor was removed from service and cleaned immediately. **#2:** The grill was removed from service and cleaned immediately. **#3:** Oil in the deep fryer was removed and discarded immediately. Fryer was cleaned and fresh oil was replaced. A regular weekly schedule of fryer oil change has been instituted. A skimmer has been purchased to skim food particles from the surface of the oil. **#4:** All expired breads were pulled from the bread rack and discarded immediately. **#5:** All unlabeled packaged salads were removed from the salad refrigerator and discarded immediately. **#6:** Kitchen floors were swept of debris and then mopped immediately to remove spillage.	**5/1/2011**

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Continued From page 2

of one (1) cooking hood soiled over the grill; one (1) of one (1) deep fryer with very dark oil and food particles floating in oil [fryer was off]; 13 of 20 expired loaves of bread; nine (9) of (9) individual salad in the refrigerator with no preparation or expiration date; and one (1)facility staff person was observed in the main kitchen with uncovered hair/head on March 14 and 15, 2011.

The findings include:

1. One (1) of one (1) soiled food processor was observed on the counter top in food prep area.
2. One (1) of one (1) soiled grill was observed with built up grease around the edges and food residue while mushrooms were being cooked on the grill.
3. One (1) of one (1) deep fryer was observed with dark oil and food particles floating in oil [the fryer was off].
4. Expired bread:
   Four (4) of six (6) loaves of rye bread expired March 13, 2011
   One half loaf of rye bread expired on March 5, 2011
   One (1) of two (2) loaves of pumpernickel were observed in a torn bag and exposed to elements
   Six (6) of 10 loaves of white bread expired on March 13, 2011
   One (1) of one (1) bag of sandwich rolls expired on March 5, 2011
   One [1] of one [1] bag of dinner rolls expired on March 3, 2011
5. Nine (9) of nine (9) individual salads were stored in the salad refrigerator. There were no preparation and/or expiration dates observed.
6. Floor in the main kitchen was observed soiled

#7. Floor mats were removed from service, degreased, and washed immediately.

#8: The entire exhaust hood over the cooking ranges and ovens was immediately cleaned of accumulated dust and then degreased.

#9: All employees were immediately checked for wearing of hats or hairnets. Employee found without a hairnet immediately secured a hairnet upon their head.

2. Identify Residents/Corrective Action: All residents have the potential to be affected by findings #1, 2, 3, 4, 5, 6, 7, 8, and 9. As indicated in question 1, all findings were addressed immediately.

3. Systemic Changes: In-service was provided for proper procedures related to findings 1, 2, 3, 4, 5, 6, 7, 8, 9. A Cleaning Checklist has been created and will be Completed on a daily basis by the Executive Chef, or designee and will include daily checks of findings 1, 2, 3 and 6 to ensure continued cleanliness of floors, surfaces and equipment. In addition, #3 and 8 have been added to the weekly cleaning assignment task list. Findings #4 and 5 will be addressed via a daily Quality Inspection Checklist conducted by the Executive Chef, or designee to ensure that no expired food items remain in circulation and that all products are labeled and dated per regulation. In-service for kitchen staff on all findings.

4. Monitor Compliance: The Food & Beverage Director, or designee, will audit the Daily Cleaning and Quality Inspection Checklists daily x 7 days, weekly x 4 weeks, and at least monthly thereafter. Additionally, the Food & Beverage Director, or designee, will audit the Weekly Cleaning Checklist weekly x 12 weeks and at least monthly

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F 371	Continued From page 3 with spillage and debris. 7. The floor mats were visibly soiled and shoes were sticking to the mats when stepped on in two (2) of three (3) observations. 8. One (1) of one (1) cooking hood (over the grill) was observed soiled with accumulated grease and dust. 9. Employee #12 was observed with uncovered hair/head on March 14 and 15, 2011 while in the main kitchen. These observations were made in the presence of Employee #9. The findings were discussed with the employee and acknowledged by him/her at approximately 1:19 PM on March 18, 2011.		thereafter. Any issues noted during these audits will be cured immediately. Incidents of non-compliance will be reported at the quarterly Quality Assurance Committee Meetings.	
F 372 SS=D	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observations made during a tour of the kitchen at approximately 9:30 AM on March 14, 2011, it was determined that the facility failed to dispose of garbage and refuse properly as evidenced by paper and food particles stored in the same trash receptacle in four (4) of four (4) observed; and four (4) of four (4) trash receptacles were observed without lids. The findings include: 1. Garbage and refuse were not properly disposed of as evidenced by paper and food particles being stored in the same trash	F 372	**1. Corrective Action for Affected Residents:** No residents were affected by this practice. The following actions were taken: **#1**: Garbage and refuse containers with mixed paper and food were sealed, double bagged, and removed to well-secured trash containers to await pickup by commercial garbage removal. An immediate in-service was provided to instruct staff not to place food into trash cans but rather to dispose of them via the mechanical food disposals located in the kitchen. **#2**: All uncovered garbage cans were provided with covers immediately. **2. Identify Residents/Corrective Action:** All residents have the potential to be affected by this practice. As indicated in question 1, all findings were addressed immediately.	**5/1/2011**

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F 372	Continued From page 4 receptacle in four (4) of four (4) observed. 2. Four (4) of four (4) trash receptacles noted with refuse were observed without lids in the main kitchen. Additionally, the garbage disposals were in operating condition. The aforementioned observations were also made in the presence of Employee #9 at approximately 9:30 AM. He/she acknowledged the findings and stated, " We will be purchasing new trash cans soon. "		**3. Systemic Changes:** In-service was provided for proper procedures related to findings 1, 2. Findings #4 and 5 will be addressed via the a daily Quality Inspection Checklist conducted by the Executive Chef, or designee to ensure that food waste is not being disposed of via garbage containers and that lids are kept on garbage and refuse containers at all times. **4. Monitor Compliance:** The Food & Beverage Director, or designee, will audit the Quality Inspection Checklists daily x 7 days, weekly x 4 weeks, and at least monthly thereafter. Any issues noted during these audits will be cured immediately. Incidents of non-compliance will be reported at the quarterly Quality Assurance Committee Meetings.	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F431	**1. Corrective Action for Affected Residents:** No residents were affected by this practice. Upon discovery all expired/unlabeled biologicals were removed from the medication room and discarded as appropriate. **2. Identify Residents/Corrective Action:** All residents have the potential to be affected by this practice although no residents had current orders for the expired/unlabeled biologicals found. As indicated in question 1, all items were removed and discarded immediately upon discovery. **3. Systemic Changes:** In-service provided to all licensed nursing personnel regarding this finding with emphasis on proper storage, labeling, date opened and expiration date.	**5/1/2011**

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F 431	Continued From page 5 The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, it was determined that facility staff failed to ensure that expired medications and/or biologicals were not stored in the medication room. The findings include: 1. Facility staff failed to ensure that expired medications and/or biologicals were not stored in the medication room. Dorzolamide hcl ophthalmic sol 2% was observed open with no open date and not prescribed to a specific resident. The expiration date on the bottles were 04/12 and 6/2011. 2. Stored Heparin Lock Flush Solution syringes had the following expiration dates: May, 2010 - four (4) syringes; and August, 2010 - one (1) syringes; in five (5) of 63 observed Heparin Lock Flush Solution syringes. These observations were made at 3:20 PM in the		Additionally, an audit tool will be created and assigned by the Director of Nursing, or designee, to Charge Nurse who will review the medication room to ensure that no expired biologicals or unlabeled biologicals are in the medication room. The audit will be done daily x 7 days. Upon no incidents of non-compliance, the audit will be conducted on a weekly basis thereafter. All issues of non-compliance will be noted on the tool and cured immediately. **4. Monitor Compliance:** The Director of Nursing, or designee, will audit the tool weekly x 4 weeks and at least monthly thereafter. The Pharmacy shall also audit the medication Room on a monthly basis and all findings will be immediately reported to the Director of Nursing and/or Administrator. Any issues noted during these Audits will be cured immediately. Incidents of non-compliance will be reported at the quarterly Quality Assurance Committee Meetings.	

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F 431	Continued From page 8 presence of Employee # 2 at the time of the observations.			
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F441	**1. Corrective Action for Affected Residents:** No residents were adversely affected by this practice. Each resident listed on the matrix without complete information concerning organism and date resolved was evaluated. It was determined that each infection was found to be resolved at the conclusion of antibiotic therapy as evidenced by documentation of asymptom-atic status. The date of resolution was then documented on the infection matrix by the Director of Nursing, or designee. **2. Identify Residents/Corrective Action:** All residents have the potential to be affected by this practice. Action taken noted in question 1. **3. Systemic Changes:** Licensed personnel Will be in-serviced on the following protocols: In the event that the physician does not perform a culture but has reason to start a resident on antibiotic therapy, the lack of culture result will be documented on the Matrix by Director of Nursing or designee. In the event that a physician orders a culture But orders antibiotic therapy to commence Prior to the results, the organism will be updated on the Matrix Log for Infections by the Director of Nursing, or designee. In the event that a physician orders a culture prior to the start of antibiotic therapy, the Organism will be documented upon receipt on the Matrix Log for Infections by the Director of Nursing or designee.	**5/1/2011**

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F 441	Continued From page 8 Employee #2 on March 18, 2011 at approximately 10:30 AM. He/she acknowledged that the type of organism and the date the infection resolved was not consistently documented on the Matrix Log for Infection and that the facility did not use the outcome of the surveillance data to educate staff and detect clusters and trends.		All residents with active infection and/or on antibiotic therapy will be reviewed at the weekly risk meeting by the interdisciplinary team. The Matrix will be evaluated for accuracy, completeness and appropriate interventions. A root cause approach will be conducted by the IDT and evaluation for trends will be conducted and addressed immediately if present. **4. Monitor Corrective Action:** Surveillance data collected from the Infection matrix will be analyzed on a monthly basis by the Director of Nursing, or designee, and reported at the Quality Assurance meeting on a quarterly basis.	
F 456 SS=D	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on an observation made during the environmental tour of the facility on March 2, 2011, it was determined that the facility failed to maintain essential patient care equipment in safe operating condition as evidenced by an elevated water temperature in one (1) of one (1) sink observed in the Activity area of the facility. The findings include: The water temperature was as high as 120 degrees Fahrenheit in the Activity area of the nursing facility on March 2, 2011 at approximately 12:15 PM. A further investigation of the sink revealed that a mixing valve [used to control the water temperature] was not installed on this sink. The facility staff immediately placed a mixing	F 456	**1. Corrective Action for Affected Residents:** No residents were affected by this practice. The following action was taken to rectify the finding immediately: A mixing valve was immediately installed on to the activities sink. **2. Other Residents/Corrective Action:** All residents have the potential to be affected by this practice. All other sinks were audited and found to be in compliance. **3. Systemic Changes:** The activities sink will be added to the routine water temperature logging conducted at the facility by the maintenance team. The Maintenance Team will be informed and educated regarding the addition of this sink to the log and the importance of maintaining proper temperature for	5/1/2011

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F 456	Continued From page 9 valve on the sink to control the water temperature. A face-to-face interviews were conducted with alert and ambulatory (via a wheelchair or ambulation) Residents # 4, 5, 32 and 38 on March 2, 2011 at approximately 3:45 PM. They stated that they did not use the sink. This observation was made in the presence of Employees # 10 and 11 who acknowledged this finding at the time of the observation.		resident safety. Any temperatures noted to be outside of the acceptable range will be adjusted immediately via appropriate means. Any incidents of high/low temperature will be reported to the Director of Plant Operations. **4. Monitor Corrective Action:** The Plant Operations Director, or designee, will review the temperature logs following the staff review. He will spot check 100% of sinks in the first month and 25% per quarter thereafter to ensure temperatures are within appropriate range. Any variances will be recorded and reported at the quarterly Quality Assurance Committee meeting.	
F 469 SS=D	483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM The facility must maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observations made during the environmental tour of the facility on March 17 and 18, 2011, it was determined that the facility failed to maintain an effective pest control program as evidenced by crawling/flying insects seen on the nursing unit during the survey. The findings include: Crawling/flying insects were observed in the activities area on March 17, 2011 at approximately 12:15 PM and on March 18, 2011 at approximately 8:35 AM. The observation on March 17, 2011 was made in the presence of Employee # 7.	F 469	**1. Corrective Action for Affected Residents:** No residents were affected by this practice. The following action was taken: Pest Control contractor was contacted immediately upon report of sighting on 3/18/11. Within two hours the contractor was on sight and treated the area. **2. Other Residents/Corrective Action:** All residents have the potential to be affected by this practice. Environmental Service Director will conduct a full walk through with the Pest Control company to ensure all "hot spots" are on the routine list for treatment. Any areas with activity that are not on the routine treatment list will be added. **3. Systemic Changes:** The Housekeeping Supervisor, or designee, will conduct routine rounds, not less than weekly, of the activities space to ensure	5/1/2011

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no new pest activity is present. If activity is noted, a call will be placed to the Pest Control company and it will be noted in the Pest Control binder on the nursing unit.

Additionally, activities staff will be In-serviced on proper cleaning and maintenance of the activities space to assist in the prevention of pest activity in the area. Staff will be re-educated regarding the proper protocol and follow-up for a pest control sighting which includes logging in the binder and contacting the Environmental Services director who will in turn contact the Pest Control contractor for follow up.

4. Monitor Corrective Action: The Pest Control binders will be reviewed by the Environmental Services Director on a weekly basis to ensure sightings have been addressed by the Pest Control contractor. Any sightings noted but not addressed will be reported immediately. The number of sightings, locations and follow-up will be documented and presented at the quarterly Quality Assurance Meeting.