

Health Regulation & Licensing Administration

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD02-0001 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 11/27/2013 |
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| NAME OF PROVIDER OR SUPPLIER BRINTON WOODS HEALTH & REHAB CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 2131 O STREET NW WASHINGTON, DC 20037 |
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| L 000 | <p>Initial Comments</p> <p>The annual licensure survey was conducted on November 18, 2013 through November 27, 2013. The deficiencies are based on observation, record review, resident and staff interviews for 39 sampled residents.</p> <p>The following is a directory of abbreviations and/or acronyms that may be utilized in the report:</p> <p>Abbreviations AMS - Altered Mental Status g-tube Gastrostomy tube EKG - 12 lead Electrocardiogram NP - Nurse Practitioner BID - Twice- a-day EMS - emergency medical services (911) HVAC - Heating ventilation/Air conditioning Neuro - Neurological B/P - Blood Pressure CRF - Community Residential Facility CNA Certified Nurse Aide DMH - Department of Mental Health Peg tube - Percutaneous Endoscopic Gastrostomy NP - Nurse Practitioner L - Liter dl - deciliter CMS - Centers for Medicare and Medicaid Services 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)</p> | L 000 | <p>Brinton Woods Health and Rehabilitation Center at Dupont Circle is submitting this plan of correction in accordance with state and federal requirements. Submission of this plan of correction is not an admission to or an agreement with the alleged deficiencies cited within this statement of deficiencies.</p> | |
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TITLE

(X6) DATE



Administrator

1/27/14

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| L 000 | Continued From page 1 mg/dl - milligrams per deciliter mm/Hg - millimeters of mercury POS - physician 's order sheet Prn - As needed TAR - Treatment Administration Record PASRR - Preadmission screen and Resident Review ARD - assessment reference date IDT - interdisciplinary team ID - Intellectual disability QIS - Quality Indicator Survey D.C. - District of Columbia D/C- discontinue Rp, R/P- responsible party PO-By Mouth | L 000 | | |
| L 001 | 3200.1 Nursing Facilities Each nursing facility shall comply with the Act, these rules and the requirements of 42 CFR Part 483, Subpart B, Sections 483.1 to 483.75; Subpart D, Sections 483.150 to 483.158; and Subpart E, section 483.200 to 483.206, all of which shall constitute licensing standards for nursing facilities in the District of Columbia. This Statute is not met as evidenced by: Based on observations, clinical record reviews, resident and staff interviews, it was determined that the facility's Quality Assessment and Assurance (QAA) committee failed to develop, implement, and/or revise appropriate corrective actions for identified deficient practices as necessary. The findings include: | L 001 | | |

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| L 001 | <p>Continued From page 2</p> <p>During the survey, the following areas of concern were indentified:</p> <p>Facility staff failed to ensure that newly hired employees received Abuse training prior to working on the nursing units with residents; MDS ' were inaccurately coded under Section V, Care Area Assessment; facility staff failed to ensure the grooming of one (1) residents ' nails; failed to ensure that care plans were updated to address residents current status and failed to ensure that a resident's assistive devices were applied in accordance with the physician ' s orders.</p> <p>On November 27, 2013 at approximately 11:00 AM, the Director of Nursing was interviewed regarding their QAA Committee Meetings and identification of the concerns listed above.</p> <p>It was stated that they had not previously identified concerns related to the MDS-CAA summary. " We look at the coding of the MDS and we have not looked at the CAA area. The resident s nails are cleaned every day in the social room. We recommend that nails are done after Activities of Daily Living care because the nails are soft at this time. Splints, the old rehabilitation company ordered the splints and they were discontinued for that particular resident. We are working with the rehabilitation company regarding the splints but this fell through the cracks. We are constantly reviewing and updating the care plans. "</p> <p>Although the facility may have identified areas of concern in some of the aforementioned areas, there was no evidence that ongoing corrective action plans were implemented for the identified</p> | L 001 | | |
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| L 001 | Continued From page 3 areas. Additionally, there was no evidence that revisions were made to plans when the corrective action was not effective. | L 001 | | |
| L 051 | <p>3210.4 Nursing Facilities</p> <p>A charge nurse shall be responsible for the following:</p> <p>(a) Making daily resident visits to assess physical and emotional status and implementing any required nursing intervention;</p> <p>(b) Reviewing medication records for completeness, accuracy in the transcription of physician orders, and adherences to stop-order policies;</p> <p>(c) Reviewing residents' plans of care for appropriate goals and approaches, and revising them as needed;</p> <p>(d) Delegating responsibility to the nursing staff for direct resident nursing care of specific residents;</p> <p>(e) Supervising and evaluating each nursing employee on the unit; and</p> <p>(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:</p> <p>Based on observation, record review and staff and resident interviews for seven (7) of 39 sampled resident, it was determined that the charge nurse failed to: accurately assess the vascular access site for dialysis and administer medications in accordance with the physician's</p> | L 051 | | |

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| L 051 | <p>Continued From page 4</p> <p>order for one (1) resident; to update the care plan for the use of sunglasses for one (1) resident; to review and revise the care plan to include hospice services for one (1) resident; to update the care plan for one (1) resident's refusal to have his/her nails trimmed; and to update the care plan to address one (1) resident's significant weight loss.</p> <p>Additionally, the charge nurse failed to maintain clinical records that are accurately documented and maintained in accordance with accepted professional standards as evidenced by failure to: document in the active clinical record, attempts to notify the responsible party for one (1) resident who was admitted to the hospital; ensure that an order to provide Foley catheter care was transcribed onto the October and November 2013 physician's orders for one (1) resident and accurately document skin assessments for one (1) resident. Residents' #2, 84, 114, 123, 179, 230, and 242.</p> <p>The findings include:</p> <p>1. The charge nurse failed to accurately assess the [arteriovascular fistula] AVF (vascular access site) formally used for Hemodialysis treatment for Resident #2.</p> <p>A review of Admission Order Sheet and Physician Plan of Care records dated October 10, 2013 revealed that Resident #2 had Diagnoses that included: "ESRD [end stage renal disease] with initiation of dialysis], Glaucoma, Anemia of CKD [chronic kidney disease], and AV [arteriovascular] fistula</p> | L 051 | <p>1. Resident #2 vascular access site on right anterior chest wall permacath was properly assessed and noted to be in place. The AVF site was clotted and no longer in use.</p> <p>The resident was not harmed by this deficient practice.</p> <p>2. All other residents on Hemodialysis were reviewed on 11/29/13 and all were properly assessed. All charge nurses will assess permacath before and after dialysis.</p> | | |

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| L 051 | <p>Continued From page 5</p> <p>malfunction ."</p> <p>A review of Physician progress note dated October 16, 2013 revealed, " R [right] ant [anterior] cw [chest wall] permacath in place ...2) ESRD on Dialysis. 3) RUE (right upper extremity) and AVF clotted-Now has permacath ..."</p> <p>A review of nurses ' notes from October 10, 2013 to November 20, 2013 revealed that the nursing staff assessed Resident #2's clotted AVF as positive bruit and thrill [Bruit is the ' whooshing' noise that can be heard with a stethoscope if the fistula is functioning properly. Thrill is the vibration felt due to high blood flow and can also be felt in a fistula].</p> <p>The charge nurse failed to accurately assess the AVF (vascular access site) formally used for Hemodialysis treatment for Resident #2 from October 10, 2013 to November 20, 2013.</p> <p>A face-to-face interview was conducted with Employee #7 on November 22, 2013 at approximately 11:50AM. After reviewing the nurses ' notes in Resident #2 ' s record, Employee #7 acknowledged the findings.</p> <p>2. The charge nurse failed to update the care plan for the use of sunglasses for Resident #84.</p> <p>A review of the ophthalmology examination dated November 7, 2012 revealed, " Chief Complaint: Consult requested, pt</p> | L 051 | <p>3. All RCC's/nursing staff were in-serviced on 1/17/14 on proper assessment of dialysis access site for all residents receiving Hemodialysis.</p> <p>QA/designee will conduct bi-weekly audits to ensure compliance.</p> <p>4. Further findings on this matter will be discussed in the weekly, monthly and quarterly QA meetings.</p> <p>1. Resident #84 care plan was immediately updated on 11/29/13 to reflect the use of sunglasses.</p> <p>2. All other residents who require the use of sunglasses were reviewed, and none was found with this deficient practice.</p> | 1/21/14 |
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| L 051 | <p>Continued From page 6</p> <p>(patient) states mild Photophobia in bright sun OU (both eyes);</p> <p>Impression: 1. Blind painless eye OU. 2. Photophobia. Plan: ...Pt states sensitivity to light. Pt should have sunglasses for outdoors. "</p> <p>The October 2013 Physician ' s Orders signed and dated by the physician on October 10, 2013 directed, " Pt (patient) should have a pair of sunglasses for going out in sun due to Photophobia "</p> <p>On November 25, 2013 at approximately 11:15 AM Resident # 84 was observed being escorted out of the facility on a sunny day by a staff member and the resident was not wearing sunglasses.</p> <p>A review of the " Visual Impairment " care plan initiated November 2, 2011 and last revised on September 13, 2013 lacked evidence the care plan was updated to address the resident's need to wear sunglasses for outdoors due to the resident ' s sensitivity to light.</p> <p>A face-to-face interview was conducted with Employee #6 on November 25, 2013 at approximately 11:45 AM. Employee #6 searched Resident #84 ' s room for sunglasses and did not locate them. He/she then stated, [Resident #84] has the sunglasses in [his/her] bag.</p> <p>A face-to-face interview was conducted with Resident #84 on November 25, 2013 at approximately 4:00 PM. He/she stated, " I didn ' t wear any sunglasses to the doctors. I don ' t have any sunglasses. I need to wear them</p> | L 051 | <p>3. All nurse managers/RCC's were in-serviced on 1/17/14 on updating care plans for all residents who require the use of sunglasses while out in the sun.</p> <p>QA/designee will conduct bi-weekly audits to ensure compliance.</p> <p>4. Further findings on this matter will be discussed in the weekly, monthly and quarterly QA meetings</p> | 1/21/14 |

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| L 051 | <p>Continued From page 7</p> <p>because I am blind and the sun light hurts my eyes.</p> <p>"</p> <p>A face-to-face interview was conducted with Employee # 6 on November 25, 2013 at approximately 11:45 AM. He/she acknowledged that the care plan was not updated to include the resident wearing sunglasses when outdoors. The record was reviewed on November 25, 2013.</p> <p>3. The charge nurse failed to review and revise the care plan to include hospice services for Resident #179.</p> <p>A. According to a physician 's admission order dated October 14, 2013 " Resident is certified as Hospice. Admitted to [name of hospice]. "</p> <p>According to an interim physician 's order dated October 14, 2013 at 9:15 PM, " Please admit resident to [name of Hospice] [with diagnosis]: Dementia. "</p> <p>A review of the active clinical record revealed an IDT (Interdisciplinary Team Meeting) was conducted on October 17, 2013 and the registered nurse from Hospice services was in attendance.</p> <p>The comprehensive care plan dated October 15, 2013 included the problem " Death with Dignity resident is on hospice. Intervention included, " hospice care orders will be considered; however, there was no evidence that the care plan was revised when it was determined that the resident was admitted to hospice services.</p> | L 051 | <ol style="list-style-type: none"> 1. An integrative care plan was immediately put in place for resident #179 to reflect all IDT members and plan of care of resident on hospice. 2. Care plans for all other residents on hospice were reviewed on 11/29/13 and none was found with this deficient practice. 3. All RCC's/nurse managers were in-serviced on 1/17/14 on the implementation of an integrative care plan for hospice residents. QA/designee will conduct bi-weekly audits to ensure compliance. 4. Further findings on this matter will be discussed in the weekly, monthly and quarterly QA meetings | 1/21/14 |
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| L 051 | <p>Continued From page 8</p> <p>A review of the clinical record lacked evidence that the care plan was revised to include goals and interventions to specify the various aspects of hospice care.</p> <p>The charge nurse failed to review and revise the care plan to include hospice services.</p> <p>A face-to-face interview was conducted with Employees #6 and #12 on November 26, 2013 at approximately 10:30 AM. After reviewing the clinical record; both acknowledged that the care plan did not incorporate the hospice services.</p> <p>4. The charge nurse failed to update the care plan to include Resident #123's refusal to have his/her nails trimmed.</p> <p>During a face-to-face interview with Resident #123 on November 18, 2013 at approximately 4:10 PM, it was observed that his/her fingernails on his/her right hand were long and untrimmed.</p> <p>A face-to-face interview was conducted with Employee #32 (day shift staff) on November 21, 2013 at approximately 3:10 PM. He/she stated, " His/her nails are long, but [he/she] won ' t let me cut them, [he/she] refuses. "</p> <p>A face-to-face interview was conducted with Employee #6 on November 21, 2013 at approximately 4:30 PM. He/she stated, " I know that [his/her] nails are long, but [he/she] refuses to let us [facility staff] cut them. We have to call [his/her] [family member]. The [family member] will come to the facility and the resident will let us cut [his/her] nails.</p> | L 051 | <ol style="list-style-type: none"> 1. Resident #123 was immediately identified and nails care was provided. 2. All other residents had their nails assessed and none was noted with this deficient practice. 3. All nursing staff were in-serviced on 1/17/14 on nail care and grooming to meet the needs of residents. QA/designee will conduct bi-weekly audits to ensure compliance. 4. Further findings on this matter will be discussed in the weekly, monthly and quarterly QA meetings | 1/21/14 |
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| L 051 | <p>Continued From page 9</p> <p>A face-to-face interview was conducted with Employee #33 (evening shift staff) on November 22, 2013 at approximately 3:45 PM. He/she stated, "The resident ' s nails are long...[he/she] refuses, I don ' t cut them."</p> <p>A review of the " Self Care Deficit " care plan revealed that there were no interventions in place to address Resident #123 refusal to have his/her nails trimmed.</p> <p>A face-to-face interview was conducted with Employee # 6 on November 22, 2013 at approximately 4:00 PM. He/she acknowledged the findings. The record was reviewed on November 22, 2013.</p> <p>5. The charge nurse failed to update care plans to address Resident #230 ' s significant weight loss.</p> <p>A review of the " Weight Record " revealed the following:</p> <p>Initial weight July 15, 2013 - 218 pounds Weekly July 17, 2013- 221.4 pounds Weekly July 24, 2013- 200.2, reweight-199.6 pounds Weekly July 31, 2013- 193.8, reweight-193 pounds Monthly August 1, 2013- 191.8 pounds Weekly August 7, 2013 - 189.6 pounds Weekly August 14, 2013- 188.2 pounds Weekly August 21, 2013 - 194.8, reweight-195.2 pounds</p> <p>The Nutritional Progress Notes revealed:</p> | L 051 | <ol style="list-style-type: none"> 1. Resident #230 was discharged on 8/30/13. 2. All other residents with significant weight change were reviewed on 11/29/13 and none was found with this deficient practice. 3. Registered dietician/nurse managers were in-serviced on 1/17/14 to care plan all triggered significant changes. QA/designee will conduct bi-weekly audits to ensure compliance. 4. Further findings on this matter will be discussed in the weekly, monthly and quarterly QA meetings | 1/21/14 |

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| L 051 | <p>Continued From page 10</p> <p>" July 18, 2013 ...Addendum- admission wt 218 # (pounds), re-wt (weight) 221.4 #...mild wt. gain, will follow up with resident weight. "</p> <p>July 29, 2013 weekly weight x 4 ...7/24 200.2#, re-wt 7/25 199.6# weight change 18.4# decrease (8.4%) ... "</p> <p>" July 31, 2013, IBW (ideal body weight) 193.8# wt changes 5.8# decrease (2.9%) x 1 week moderate wt loss, resident admitted with edema on bilateral LE per NP note on 7/17. Weight changes possibly [secondary] to the edema ...PO meal intake 75 -100%.,,, will continue to monitor wt, labs, po intake and skin ... "</p> <p>" August 14, 2013 Resident review ...weekly wt x 4 ...8/1/13 191.8# [compared] to admission wt 7/15/13 218#, wt change 26.2# decrease (12.0%) x 2 weeks. Significant wt loss probably second to edema resolving. PO intake 76%-100%... "</p> <p>A review of the Progress Notes written by the Nurse Practitioner revealed:</p> <p>July 17, 2013 at 12:40 PM "...ext (extremity): +1 bil (bilateral) LE(lower extremity) edema. "</p> <p>July 22, 2013 at 2:45 PM " ...ext: +1 bil LE edema ... "</p> <p>July 30, 2013 at 9:00 PM " ...ext: (0) edema ... "</p> <p>August 12, 2013 at 14:15 " ...ext: (0) edema ... "</p> <p>August 15, 2013 at 16:00 " ...Evaluated for weight loss of 12% was 218# now 191.8 lbs (pounds)...on admission + [illegible] bilateral LE edema ... ext: (0) edema ... "</p> <p>The Physician ' s Order dated July 16, 2013 directed that the resident receive NCS (no</p> | L 051 | | |
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| L 051 | <p>Continued From page 11</p> <p>concentrated sweets), NAS (no added salt), Low fat/chol (cholesterol) diet, HS (hour of sleep) snack, encourage and document % consumed - 240 ml/fluid with meals for hydration.</p> <p>A review of the " Therapeutic Diet and Altered Nutrition " care plans initiated on July 16, 2013 lacked evidence that the resident ' s significant weight loss was included and addressed in the plan of care.</p> <p>A face-to-face interview was conducted with Employee #29 on November 22, 2013 at 11:20 AM. He/she acknowledged that the care plan was not updated to address the resident ' s significant weight loss. The record was reviewed on November 22, 2013.</p> <p>6. The charge nurse failed to document in the active clinical record attempts to notify the responsible party (RP) for Resident #2 when he/she was admitted to the hospital.</p> <p>A review of Resident #2 ' s clinical record revealed a physician ' s order dated October 4, 2013 at 5:30PM that directed, "Transfer resident to [name of hospital] under care of [doctor name] to be dialyzed [secondary to] clogged access site. "</p> <p>A nurses note dated October 5, 2013 at 7:00PM read, "Resident went to [Name of hospital] at 8:30AM for declog cath [catheter] of dialysis. Received a call at 4:30PM that resident [was] admitted in the ICU (intensive care unit). "</p> <p>A nurses ' note dated October 7, 2013 at 8:00 AM read, " Call placed to RP [Responsible</p> | L 051 | <ol style="list-style-type: none"> 1. Resident #2 responsible party was notified that resident was admitted in the hospital on 10/7/13 as soon as he was available, then documentation done in the active clinical records 2. All other residents records hospitalized were reviewed on 11/29/13 and none noted deficient practice. 3. All nurses were in-serviced on 1/17/14 on notifying responsible party during hospitalization and documenting attempts to notify responsible party in active clinical records. <p>QA/designee will conduct bi-weekly audits to ensure that each attempt or actual notification of responsible party during hospitalization is properly documented in the active clinical record.</p> <ol style="list-style-type: none"> 4. Further findings in this matter will be discussed in the weekly, monthly, and quarterly QA meetings. | 1/21/14 |
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| L 051 | <p>Continued From page 12</p> <p>Party Name] and got hold of [him/her] ... "</p> <p>A face-to-face interview was conducted on November 22, 2013 at approximately 11:50AM with Employee #7. He/she stated, " The staff told me that they tried to get in touch with resident's responsible party, but was not able to get [him/her] on the phone. After inquiring from staff ... I called and notified the RP [on October 7, 2013] and documented it in the resident's chart. "</p> <p>There was no evidence that the charge nurse documented the attempts to immediately notify Resident #2's responsible party (October 5, and 6, 2013) when it was determined he/she was hospitalized in the intensive care unit.</p> <p>A face-to-face interview was conducted with Employee #2 on November 22, 2013 at approximately 12:42PM. He/she acknowledged the findings. The record was reviewed on November 22, 2013.</p> <p>7. The charge nurse failed to ensure that an order to provide Foley [indwelling urinary] catheter care was transcribed onto the October and November 2013 Physician's Orders for Resident #114.</p> <p>A " History and Physical signed by the physician August 7, 2013 revealed Resident #114 ' s diagnoses included: " Active Problems: BPH (Benign Prostate Hypertrophy) ... "</p> <p>A physician ' s interim order dated September 26, 2013 directed, " Continue with Foley catheter due to Partial Obstruction; Continue to</p> | L 051 | <ol style="list-style-type: none"> 1. Resident #114 Foley catheter orders were identified and transcribed onto next month physicians orders. 2. All residents on Foley catheters orders were reviewed on 11/29/13 and none noted with this deficient practice. 3. All nurses were in-serviced on 1/17/14 to ensure that all monthly physician orders are transcribed/carried over onto next months physician order sheet. <p>QA/designee will conduct bi-weekly audits to ensure compliance.</p> <ol style="list-style-type: none"> 4. Further findings in this matter will be discussed in the weekly, monthly, and quarterly QA meetings. | 1/21/14 |

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| L 051 | <p>Continued From page 13</p> <p>monitor urine drainage every shift; Change Foley bag and tubing bi-weekly and as needed. "</p> <p>A review of the October and November 2013 Physician ' s Orders lacked evidence that the order to continue with Foley catheter care was transcribed onto the order sheets.</p> <p>A face-to-face interview was conducted with Employee #7 on November 26, 2013 at approximately 12:30 PM. He/she acknowledged the aforementioned findings.</p> <p>8. The charge nurse failed to accurately document Resident #242 ' s skin assessment.</p> <p>A review of Resident #242 ' s clinical record revealed that licensed staff documented skin assessments on three (3) dates prior to the resident ' s admission as follows:</p> <p>Resident #242's Minimum Data Set (MDS) dated August 8, 2013 revealed that the resident was coded as having no cognitive impairment under Section C [Cognitive Patterns] and was totally dependent for ADLs (activities of daily living) under Section G0110 J [Personal Hygiene]. Section I revealed the resident ' s diagnoses included Deep Vein Thrombosis (DVT), Hypertension, Cerebrovascular Accident (CVA), Quadriplegia, and Seizure Disorder</p> <p>A review of the Bath and Skin Report instructions stated: " C.N.A. is to perform skin check 2x (two times) weekly during resident ' s bath /shower; Record information above, place check- mark under any skin condition that applies (Normal,</p> | L 051 | <ol style="list-style-type: none"> 1. Resident #242 was identified, skin assessment done and accurate documentation .. 2. All other residents clinical record were reviewed on 11/29/13 and were noted to be accurate and reflective of the residents current skin condition. 3. All nurses were in-serviced on 1/17/14 on accurate assessment and documentation in the clinical record. <p>QA/designee will conduct bi-weekly audits to ensure compliance.</p> <ol style="list-style-type: none"> 4. Further findings in this matter will be discussed in the weekly, monthly, and quarterly QA meetings. | 1/21/14 |

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| L 051 | Continued From page 14 Redness/Rash, Peeling, Open Areas, Bruise). Check normal if no abnormal skin conditions are noted ...The Charge Nurse must sign skin report as indicated above and briefly describe action taken if abnormal skin condition exists. " Resident #242 ' s Bath and Skin Report included documentation on August 2, 2013, August 5, 2013 and August 7, 2013 " normal " [skin] signed by the licensed nurse. The " action taken " recorded by the certified nurses ' assistant (CNA) " received a shower. " The information recorded on the skin report was dated prior to the resident ' s admission to the facility on August 8, 2013. A face-to-face interview was conducted with Employee #6 on November 26, 2013 at 3:00 PM. He/ she] stated [Resident #242] does receive showers and when queried regarding the dates recorded on the skin sheets, wherein the resident was not in facility, Employee #6 provided no response. Employee # 8 acknowledged the documentation was inaccurate and that Resident # 242 was not in the facility at that time. The Medical Record was reviewed on November 26, 2013. | 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; | L 052 | | | |

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| L 052 | <p>Continued From page 15</p> <p>(b) Proper care to minimize pressure ulcers and contractures and to promote the healing of ulcers:</p> <p>(c) Assistants in daily personal grooming so that the resident is comfortable, clean, and neat as evidenced by freedom from body odor, cleaned and trimmed nails, and clean, neat and well-groomed hair;</p> <p>(d) Protection from accident, injury, and infection;</p> <p>(e) Encouragement, assistance, and training in self-care and group activities;</p> <p>(f) Encouragement and assistance to:</p> <p>(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;</p> <p>(2) Use the dining room if he or she is able; and</p> <p>(3) Participate in meaningful social and recreational activities; with eating;</p> <p>(g) Prompt, unhurried assistance if he or she requires or request help with eating;</p> <p>(h) Prescribed adaptive self-help devices to assist him or her in eating independently;</p> <p>(i) Assistance, if needed, with daily hygiene, including oral care; and</p> <p>j) Prompt response to an activated call bell or call for help.</p> | L 052 | | |

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| L 052 | <p>Continued From page 16</p> <p>This Statute is not met as evidenced by: Based on observation, record review and staff and resident interviews for five (5) of 39 sampled residents, it was determined that facility staff failed to ensure that sufficient nurse time was given to: apply splints and adaptive devices as prescribed for one (1) resident; apply sun glasses as prescribed for one (1) resident; clarify and administer an analgesic medication per physician ' s orders for one (1) resident and to ensure that one (1) resident's fingernails were cleaned and trimmed. Resident ' s #2, #38, #52, #84 and #242.</p> <p>The findings include:</p> <p>1A. The facility staff failed to ensure that sufficient nurse time was given to administer Renvela [Renvela is a medication used to control phosphorus levels in patients with chronic kidney disease on dialysis] medication in accordance with the Physician's Order for Resident #2.</p> <p>The Physician's Order dated September 10, 2013 directed, " Renvela tab 800mg, take 1 tab by mouth three times daily three times weekly on Tues [Tuesday], Thurs [Thursday], Sat [Saturday] (9AM, 5PM, 10PM). Renvela tab 800mg, take 1 tab by mouth three times daily four times weekly on Mon [Monday], Wed [Wednesday], Fri [Friday] and Sun [Sunday] (9AM, 1PM, 5PM) for ESRD.</p> <p>A review of Dialysis Laboratory (lab) Report revealed the following: September 5, 2013 Phosphorous (Phos) lab result 5.7 ... Goal: 3.5 - 5.5, " We will check this</p> | L 052 | <ol style="list-style-type: none"> 1. Renvela medication was given, facility counted the doses and found that nursing staff failed to sign-off on medication administration record. Monthly follow up lab result done on 12/13/13 indicates phosphorus level at 3.7, which is normal. 2. All other residents on Renvela were reviewed on 11/29/13 and no other deficient practice was noted. 3. All RCC's/charge nurses were in-serviced on 1/17/14 on consistent medication administration and signing on medication. QA/designee will conduct bi-weekly audits to ensure compliance. 4. Further findings on this matter will be discussed in the weekly, monthly and quarterly QA meetings. | 1/21/14 |

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| L 052 | <p>Continued From page 17</p> <p>again on 9/18. "</p> <p>September 20, 2013 Phos result abnormal 7.1 ... " Recent phos levels 5.7 - 7.1 " Please have pt. [patient] take one Renvela with each meal " signed by [dialysis doctor].</p> <p>October 25, 2013 Phos result abnormal 6.9 ... " [Resident name] Phosphorus was higher again. Any thoughts re: diet changes ... timing of meds? "</p> <p>November 13, 2013 Phos result High 6.8 [normal 3.5 - 5.5], " Any ideas? Is [he/she] taking Renvela at Dialysis with meals?? Increase to 2 pills.</p> <p>A review of Physician's Progress notes dated September 25, 2013 read, " On 9/5 PO4 [phosphate] = 5.7 Repeat on 9/20 PO4= 7.1 Hyper-phosphatemia 2o [secondary to] ESRD ... Pt (patient) is presently receiving Renvela 800mg tid with meals, except on Dialysis days when given when pt returns ...Follow PO4 ... "</p> <p>A review of Physician's Progress note dated November 13, 2013 read, " PO4 = 6.8 (3.5 - 5.5) on Renvela 800mg TID [three times daily] ... ESRD on Dialysis, Hyper-phosphatemia - on Renvela 800mg tid supposed to be with meals - not getting at dialysis with lunch. Notify Dialysis that elevated PO4 may be [second] to patient not getting Renvela at dialysis with meals. "</p> <p>A review of the Medication Administration</p> | L 052 | | |

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| L 052 | <p>Continued From page 18</p> <p>records revealed the following:</p> <p>October, 2013 the allotted space for acknowledgement of administration of Renvela was left blank on October 4 at 12:00 PM, October 11, 13, and 20 at 5:00PM.</p> <p>November, 2013 revealed that space allotted for acknowledgement of the resident's receipt of Renvela was left blank on November 16, 2013 at 10:00PM.</p> <p>There was no evidence that sufficient time was given to consistently administered Renvela to Resident #2 who was assessed with abnormal levels of phosphorus.</p> <p>A face-to-face interview was conducted with Employee #7 on November 22, 2013 at approximately 11:50AM. After reviewing the clinical record, he/she acknowledged the findings. The record was reviewed on November 22, 2013.</p> <p>1B. The facility staff failed to ensure that sufficient nurse time was given to administer Travatan Z Opth (ophthalmic) solution [eye drops] per the Physician 's Order for Resident #2.</p> <p>A review of the October 2013 Physician's Order sheet directed, " Travatan Z Opth Soln 1 drop in each eye at bedtime for Glaucoma".</p> <p>A review of the October 2013 Medication Administration Record revealed that Travatan Z</p> | L 052 | <ol style="list-style-type: none"> 1. Interview with employee #7 indicated Travatan Z eye drops were not administered per physicians order. Employee #7 was educated on administration and signing off on administered medication. 2. All other resident receiving Travatan Z eye drops were reviewed on 11/29/13 and none were noted with this deficient practice. 3. All RCC's/charge nurses were in-serviced on 1/17/13 on consistent administration of Travatan Z eye drops. RCC's/designee will conduct bi-weekly audits on MAR to ensure consistent administration of Travatan Z. 4. Further findings on this matter will be discussed in the weekly, monthly and quarterly QA meetings. | 1/21/14 |

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| L 052 | <p>Continued From page 18</p> <p>records revealed the following:</p> <p>October, 2013 the allotted space for acknowledgement of administration of Renvela was left blank on October 4 at 12:00 PM, October 11, 13, and 20 at 5:00PM.</p> <p>November, 2013 revealed that space allotted for acknowledgement of the resident's receipt of Renvela was left blank on November 16, 2013 at 10:00PM.</p> <p>There was no evidence that sufficient time was given to consistently administered Renvela to Resident #2 who was assessed with abnormal levels of phosphorus.</p> <p>A face-to-face interview was conducted with Employee #7 on November 22, 2013 at approximately 11:50AM. After reviewing the clinical record, he/she acknowledged the findings. The record was reviewed on November 22, 2013.</p> <p>1B. The facility staff failed to ensure that sufficient nurse time was given to administer Travatan Z Opth (ophthalmic) solution [eye drops] per the Physician 's Order for Resident #2.</p> <p>A review of the October 2013 Physician's Order sheet directed, " Travatan Z Opth Soln 1 drop in each eye at bedtime for Glaucoma".</p> <p>A review of the October 2013 Medication Administration Record revealed that Travatan Z</p> | L 052 | <ol style="list-style-type: none"> 1. Interview with employee #7 indicated Travatan Z eye drops were not administered per physicians order. Employee #7 was educated on administration and signing off on administered medication. 2. All other resident receiving Travatan Z eye drops were reviewed on 11/29/13 and none were noted with this deficient practice. 3. All RCC's/charge nurses were in-serviced on 1/17/13 on consistent administration of Travanton Z eye drops. RCC's/designee will conduct bi-weekly audits on MAR to ensure consistent administration of Travatan Z. 4. Further findings on this matter will be discussed in the weekly, monthly and quarterly QA meetings. | 1/21/14 |

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| L 052 | <p>Continued From page 19</p> <p>Opth Soln 1 drop in each eye at bedtime for Glaucoma was noted, however; the spaces allotted from October 10, 2013 to October 31, 2013 were left blank.</p> <p>There was no evidence that sufficient nurse time was given to administered Travatan Z to Resident #2 in accordance with the physician's order for the period of October 10 - 31, 2013.</p> <p>A face-to-face interview was conducted with Employee # 7 on November 22, 2013 at approximately 11:50AM. After reviewing the October 2013 Medication Administration Records for Resident #2, Employee#7 acknowledged the findings. The record was reviewed on November 22, 2013.</p> <p>2.Facility staff failed to ensure that sufficient nurse time was given to for Resident #38 to receive analgesic medication, Tramadol in accordance with physician ' s orders.</p> <p>The November 2013 Physician ' s Order signed and dated November 4, 2013 revealed, " Clarification: Use Tramadol 50 mg bid for pain greater than 6/10. Tramadol 50 mg take 1 tablet by mouth twice daily for back pain. "</p> <p>A review of the November 2013 MARs revealed that Tramadol 50 mg PO for pain greater than or equal to 6/10 was administered at 9:00 AM and 5:00 PM on November 1, 2, 3 and at 5:00 PM on the 4th.</p> <p>A review of the November 2013 pain assessment revealed that on the 11-7 shift, 7-3 shift and 3-11 shift ' N " [no] was documented in the</p> | L 052 | <ol style="list-style-type: none"> 1. Resident #38 did not suffer any harm from this deficient practice. 2. All other residents on Tramadol were reviewed on 11/29/13 and none was noted with this deficient practice. 3. All RCC's/charge nurses were in-serviced on 1/17/14 on Tramadol administration within directed parameters. <p>QA/designee will conduct bi-weekly audits on MAR/pain assessment to ensure that all pain medication in general and Tramadol in particular is administered with ordered parameters.</p> <ol style="list-style-type: none"> 4. Further findings on this matter will be discussed in the weekly, monthly and quarterly QA meetings. | 1/21/14 |

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| L 052 | <p>Continued From page 20</p> <p>designated area indicating that the resident did not have pain on assessment.</p> <p>There was no evidence that sufficient nurse time was given to ensure that Tramadol was administered within the directed parameters (for pain greater than or equal to 6/10).</p> <p>A face-to-face interview was conducted with Employee #2 on November 27, 2013 at approximately 1:05 PM. He/she acknowledged the findings. The record was reviewed on November 27, 2013.</p> <p>3. The facility staff failed to ensure that sufficient nurse time was given to Resident #84 who wore sunglasses when outdoors in the sun due to photophobia.</p> <p>A review of the ophthalmology examination dated November 7, 2012 revealed, " Chief Complaint: Consult requested, pt (patient) states mild Photophobia in bright sun OU (both eyes); Impression: 1.Blind painless eye OU. 2. Photophobia. Plan: ...Pt states sensitivity to light. Pt should have sunglasses for outdoors."</p> <p>The October 2013 Physician 's Orders signed and dated by the physician on October 10, 2013 directed, " Pt should have a pair of sunglasses for going out in sun due to Photophobia."</p> <p>On November 25, 2013 at approximately 11:15 AM Resident # 84 was observed being escorted out of the facility to an appointment on a sunny day by a staff member and the resident was not wearing sunglasses.</p> | L 052 | <ol style="list-style-type: none"> 1. Resident #84 sunglasses was located and placed by bedside for use in the sun due to photophobia as recommended on 11/7/12 by ophthalmology. 2. All other residents with sensitivity to light (photophobia) were reviewed on 11/29/13 and none were noted with this deficient practice. 3. All RCC's, charge nurses and CNA's were in-serviced on 1/17/14 on the use of sunglasses when outdoors for residents with photophobia if indicated by an ophthalmologist or physician. QA/designee will identify and conduct bi-weekly rounds on residents with photophobia to ensure that sunglasses are in use when outdoors if recommended. 4. Further findings on this matter will be discussed in the weekly, monthly and quarterly QA meetings. | 1/21/14 |

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| L 052 | <p>Continued From page 21</p> <p>A face-to-face interview was conducted with Employee #6 on November 25, 2013 at approximately 11:45 AM. He/she then stated, [Resident #84] has the sunglasses in [his/her] bag.</p> <p>A face-to-face interview was conducted with Resident #84 on November 25, 2013 at approximately 4:00 PM. He/she stated, " I didn ' t wear any sunglasses to the doctors. I don ' t have any sunglasses. I need to wear them because I am blind and the sun light hurts my eyes. "</p> <p>A follow-up interview was conducted with Employee #6 on November 25, 2013 at approximately 4:10 PM. Employee #6 acknowledged that Resident #84 went to an appointment and did not wear sunglasses as ordered by the physician.</p> <p>The facility staff failed to ensure that sufficient nurse time was given to Resident #84 to ensure that he/she wore a pair of sunglasses when he/she went outside on a sunny day for an appointment. The record was reviewed on November 25, 2013.</p> <p>4. The facility staff failed to ensure that sufficient nurse time was given to apply splints in accordance with physician ' s orders for Resident #242.</p> <p>The Physician's Order signed and dated November 03, 2012 directed, " Pt (patient) issued day time splint for R (right) and L (left) hand wrist support splint. Splint schedule on daytime at 9AM off 7PM.</p> | L 052 | <ol style="list-style-type: none"> 1. Resident #242 hand/wrist splints, neck collar and seat belt were located and applied per physicians order and schedule. 2. All other residents on hand/wrist splints, neck collars and seat belts were reviewed on 11/29/13 and none noted with this deficient practice. 3. All RCC's/charge nurses were in-serviced on 1/17/14 on the use of hand/wrist splints, neck collars and seat belts as directed by physician. <p>QA/designee will conduct bi-weekly rounds to ensure that hand/wrist splints, neck collars and seat belts are consistently applied on residents per physicians order.</p> | |
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| L 052 | <p>Continued From page 22</p> <p>On November 20, 2013 at approximately 1:00 PM, Resident #242 was observed sitting in a wheel chair without hand /wrist splints. On November 21, 2013 at approximately 3:30 PM, November 22, 2013 at approximately 11:00AM and November 23, 2013 at approximately 3:00 PM Resident # 242 was observed lying in bed without splints in place... Neck collar present on bedside table when queried resident stated he/she came to facility with the belt and neck collar.</p> <p>A review of the November 2012 Treatment Administration Record (TAR) revealed a physician's order was transcribed for upper extremity splints as follows: 9am on/ 7pm off signage for time and check in box for (on) or (off).</p> <p>The November 2013 treatment administration record [TAR] was signed denoting that the upper extremity splints were applied on the dates (listed above) that the resident was observed without them.</p> <p>A face-to-face interview was conducted with Employee #16 [Rehabilitative staff] on November 25, 2013 at approximately 12:15 PM. When queried [he/she] stated " Physical Therapy is treating Resident #242 for sitting balance-resident is NWB (non-weight bearing) ...and can ' t support [him/her-self] ...Resident ' s upper trunk is weak--...unaware of splints or neck brace...Has seen belt on resident... "</p> <p>A face-to-face interview was conducted with Employee #17 on November 25, 2013 at 12:30 PM. When queried Employee #17 stated</p> | L 052 | 4. Further findings on this matter will be discussed in the weekly, monthly and quarterly QA meetings. | 1/21/14 |

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| L 052 | <p>Continued From page 23</p> <p>resident receives services for upper body strengthening and s/he was not aware of [the resident] having bilateral hand splints a neck brace or wheel chair belt.</p> <p>A face-to-face interview was conducted with Employees #26 and # 27 at approximately 5:15PM on November 25, 2013. When queried Employee #26 stated that he/she is not very familiar with resident but has treated a couple of times ...today began with new assistive device, stated resident is capable of using but will also request to be fed by CNA. Resident's upper body strength is weak and that he/she has noted a neck collar in room on bedside table ... but has not seen bilateral hand splints or a wheel chair belt ...He/She does treat resident out of bed.</p> <p>Employee # 27 stated he/she was not aware of neck brace, bilateral hand splints or wheel chair belt, but stated now aware, a full assessment for their use would be done to determine need and effectiveness.</p> <p>A face-to-face interview was conducted with Employee #23 on November 26, 2013 at 1:15 PM. When queried [he/she] stated, "Restorative services were in place under the old Rehab Company; main function was assisting resident with his/her eating ...They did apply splints ...when old company left the restorative services for resident stopped ...has not been started again because resident is now skilled ... resident is now receiving active Physical Therapy Services. Stated resident came to facility with safety belt and it is placed on resident daily when out of bed ...Has also seen resident with neck collar on ...Has never been applied by [him/her]."</p> | L 052 | | |
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| L 052 | <p>Continued From page 24</p> <p>There was no evidence that prior history was considered to provide consistency in treatment as evidenced by failure to follow through with splint therapy management for Resident #242 in accordance with the physician's order.</p> <p>A face-to-face interview was conducted with Employee #3 on November 23, 2013 at 4:25 PM. He/she stated, " [Resident #242] does wear hand splints most of the time."</p> <p>There was no evidence that facility staff followed physician ' s orders to apply splints on November 20, 21, 22 and 25 and 26, 2013.</p> <p>A face-to-face interview was conducted with Employee #8 on November 26, 2013 at approximately 2:00: PM. He/she acknowledged the aforementioned findings. The record was reviewed on November 26, 2013.</p> <p>5. The facility staff failed to ensure that sufficient nurse time was given to to maintain good grooming and personal hygiene for Resident #52 who was observed with soiled and untrimmed fingernails.</p> <p>A review of Resident #52's Minimum Data Set (MDS) dated September 20, 2013 revealed that the resident was coded as cognitively impaired under Section C [Cognitive Patterns] and was totally dependent for ADLs (activities of daily living) under Section G0110 J [Personal Hygiene]. On November 20, 2013 at 9:15 PM Resident #52 was observed sitting in social room listening to music, with lengthy finger nails and a dark substance noted under the nail beds. On November 22, 2013 at approximately</p> | L 052 | <ol style="list-style-type: none"> 1. Resident #52 fingernails were identified, cleaned and trimmed. 2. All other residents fingernails were assessed on 11/29/13 and all were noted to be cleaned and trimmed. 3. All RCC's/charge nurses will be in-serviced by 1/17/14 on cleanliness and trimming fingernails to maintain good grooming and personal hygiene. <p>QA/designee will conduct bi-weekly rounds to ensure nails are clean and trimmed.</p> <ol style="list-style-type: none"> 4. Further findings on this matter will be discussed in the weekly, monthly and quarterly QA meetings. | 1/21/14 |

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| L 052 | <p>Continued From page 25</p> <p>3:00PM, Resident #52 was again observed with lengthy finger nails and a dark substance noted under the nail beds. Employees #6 and 18 were asked to observe Resident # 52's finger nails. At the time of the observation Employees #6 and 18 were queried about what is included in a resident ' s daily grooming routine. Both employees stated that nail care is included in daily grooming. Employee's #6 and 18 acknowledged findings at the time of the observation.</p> <p>Facility staff failed to ensured that Resident #52 ' s fingernails were clean and trimmed.</p> | L 052 | | |
| L 056 | <p>3211.5 Nursing Facilities</p> <p>Nursing personnel, licensed practical nurses, nurse aides, orderlies, and ward clerks shall be assigned duties consistent with their education and experience and based on the characteristics of the patient load.</p> <p>This Statute is not met as evidenced by:</p> <p>Based on record review and staff interview during a review of staffing [direct care per resident day hours], it was determined that facility staff failed to meet 0.6 [six tenths] hours for Registered Nurses/APRN [Advanced Practice Registered Nurse] hours on seven (7) of the seven (7) days reviewed; and two (2) of the seven days reviewed failed to meet minimum daily average of four and one tenth (4.1) hours of direct nursing care per resident per day in accordance with Title 22 DCMR Section 3211, Nursing Personnel and Required Staffing Levels.</p> <p>The findings include:</p> | L 056 | | |

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| L 056 | <p>Continued From page 26</p> <p>A review of Nurse Staffing was conducted on November 27, 2013 at approximately 3:00 PM.</p> <p>According the District of Columbia Municipal Regulations for Nursing Facilities: 3211.5 Beginning January 1, 2012, each facility shall provide a minimum daily average of four and one tenth (4.1) hours of direct nursing care per resident per day, of which at least six tenths (0.6) hours shall be provided by an advanced practice registered nurse or registered nurse, which shall be in addition to any coverage required by subsection 3211.5.</p> <p>Of the seven (7) days reviewed, seven (7) of the days failed to meet the 0.6 [six tenths] hours of direct nursing care per resident day for Registered Nurse/APRN [Advanced Practice Registered Nurse] as follows:</p> <p>On Friday November 15, 2013, it was determined that the facility provided RN coverage at a rate of 0.42 hours.</p> <p>On Saturday November 16, 2013, it was determined that the facility provided RN coverage at a rate of 0.37 hours.</p> <p>On Sunday November 17, 2013, it was determined that the facility provided RN coverage at a rate of 0.37 hours.</p> <p>On Monday November 18, 2013, it was determined that the facility provided RN coverage at a rate of 0.52 hours.</p> <p>On Tuesday November 19, 2013, it was determined that the facility provided RN coverage at a rate of 0.52 hours.</p> | L 056 | <ol style="list-style-type: none"> Review of staffing records was done for the two days . Facility is actively recruiting RN's to meet the 0.6 and 4.1 staffing mandate by DC regulations. Daily review of staffing records, status post survey indicate a consist pattern of 0.6 RN's and 4.1 direct care staff. Staffing coordinator and supervisors will be in-serviced on 1/17/14 on staffing mandate to maintain 0.6 RN's and 4.1 direct care staff. DON/designee will conduct daily audits to ensure staffing is within mandated regulations. Further findings on this matter will be discussed in weekly, monthly and quarterly QA meetings. | 1/21/14 |

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| L 056 | <p>Continued From page 27</p> <p>On Wednesday November 20, 2013, it was determined that the facility provided RN coverage at a rate of 0.53 hours.</p> <p>On Thursday November 21, 2013, it was determined that the facility provided RN coverage at a rate of 0.52 hours.</p> <p>Of the seven (7) days reviewed, two (2) of the days failed to meet minimum daily average of four and one tenth (4.1) hours of direct nursing care per resident per day as follows:</p> <p>November 16, 2013: 4.09 November 17, 2013: 3.9</p> <p>The review was made in the presence of the Employee #2 who acknowledged the findings</p> | L 056 | | |
| L 091 | <p>3217.6 Nursing Facilities</p> <p>The Infection Control Committee shall ensure that infection control policies and procedures are implemented and shall ensure that environmental services, including housekeeping, pest control, laundry, and linen supply are in accordance with the requirements of this chapter. This Statute is not met as evidenced by:</p> <p>Based on record review and staff interview, it was determined that the Infection Control Committee failed to ensure that infection control policies and procedures were implemented as evidenced by failure to ensure that Resident # 179 with a diagnosis of a Urinary Tract Infection was included on the Infection Control log for one (1) of 39 sampled residents.</p> | L 091 | | |

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| L 056 | Continued From page 27 On Wednesday November 20, 2013, it was determined that the facility provided RN coverage at a rate of 0.53 hours. On Thursday November 21, 2013, it was determined that the facility provided RN coverage at a rate of 0.52 hours. Of the seven (7) days reviewed, two (2) of the days failed to meet minimum daily average of four and one tenth (4.1) hours of direct nursing care per resident per day as follows: November 16, 2013: 4.09 November 17, 2013: 3.9 The review was made in the presence of the Employee #2 who acknowledged the findings | L 056 | | | |
| L 091 | 3217.6 Nursing Facilities The Infection Control Committee shall ensure that infection control policies and procedures are implemented and shall ensure that environmental services, including housekeeping, pest control, laundry, and linen supply are in accordance with the requirements of this chapter. This Statute is not met as evidenced by: Based on record review and staff interview, it was determined that the Infection Control Committee failed to ensure that infection control policies and procedures were implemented as evidenced by failure to ensure that Resident # 179 with a diagnosis of a Urinary Tract Infection was included on the Infection Control log for one (1) of 39 sampled residents. | L 091 | | | |

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| L 091 | <p>Continued From page 28</p> <p>The findings include:</p> <p>The Infection Control Committee failed to ensure that Resident #179 with a diagnosis of a Urinary Tract Infection was included on the facility's September 2013 Infection Control surveillance log.</p> <p>The Interim Order dated September 22, 2013 at 8:00 AM for Resident #179 directed, " Bactrim DS (Double Strength) - 1 (one) [tablet] po (by mouth) every 12 hours for UTI (Urinary Tract Infection). "</p> <p>A review of the September 2013 MAR revealed that Resident #179 received the Bactrim DS as ordered.</p> <p>During the interview with the facility's Infection Control Practitioner (Employee #2) on November 27, 2013 at approximately 3:30 PM a review of the facility ' s Infection Control logs were conducted.</p> <p>A review of the " Infection Control " log for September 2013 was revealed that Resident #179 was not listed on the log or included in the surveillance to capture information such as, the "Date of the onset "; " Nosocomial (In house)"; "Culture "; "Identified organism "; "List control techniques to include isolation" and "Final progress/date resolved. "</p> <p>There was no evidence that Resident #179 was included in the facility ' s infection control surveillance for September 2013.</p> | L 091 | <ol style="list-style-type: none"> 1. Resident # 179 was identified with diagnosis of urinary tract infection and was immediately included in the facility infection control surveillance log. 2. Facilities infection control surveillance log was reviewed by infection control practitioner on 11/29/13 and was determined to be accurate including all infections. 3. All nurses were in-serviced on 1/17/14 on providing accurate and complete information each month to infection control practitioner for accurate updates of infection control surveillance log. QA/designee will conduct audits to ensure Accurate and complete information for the Infection control surveillance log. 4. Further findings in this matter will be discussed in the weekly, monthly, and quarterly QA meetings. | 1/21/14 |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD02-0001 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 11/27/2013 |
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| NAME OF PROVIDER OR SUPPLIER BRINTON WOODS HEALTH & REHAB CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 2131 O STREET NW WASHINGTON, DC 20037 |
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| L 091 | Continued From page 29 A face-to-face interview was conducted with Employee #2 on June 13, 2012 at approximately 2:00 PM. He/she acknowledged that the resident was no listed on the Infection Control surveillance log. | L 091 | | |
| L 233 | <p>3236.2 Nursing Facilities</p> <p>There shall be no cross-connection between the potable safe water supply and each water supply that is non-potable, or any source of pollution through which a safe supply might become contaminated.</p> <p>This Statute is not met as evidenced by:</p> <p>Based on observation, and staff interview, it was determined that the Infection Control Committee failed to ensure that infection control policies and procedures were implemented as evidenced by failure to ensure that two (2) of three (3) sinks in the main kitchen had air gaps to prevent the backup of contaminated water.</p> <p>The findings include:</p> <p>Facility staff failed to ensure that two (2) of three (3) sinks in the main kitchen had air gaps to prevent the backup of contaminated water.</p> <p>During a tour of the kitchen area on November 18, 2013 at approximately 9:40 AM, an observation of the sink in the dessert area and the hand wash/coffee area revealed that the drain pipes were below ground level.</p> <p>Employee #11 acknowledged the findings at the time of the observation.</p> | L 233 | <ol style="list-style-type: none"> 1. The two air gaps in the kitchen were immediately identified and repaired by maintenance on 11/18/13. 2. The general inspection was conducted in facility for air gaps and none were found. 3. Maintenance staff were in-serviced on 1/17/13 on repairing air gaps. <p>Air gaps will be checked daily during AM rounds and identified issues will be immediately addressed.</p> <ol style="list-style-type: none"> 4. Further findings on this matter will be discussed in the weekly, monthly and quarterly QA meetings | 1/21/14 |

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| L 234 L 234 | Continued From page 30 3236.3 Nursing Facilities Each sink, bathroom, bathtub, and shower shall have a continuous supply of hot and cold running water. This Statute is not met as evidenced by: Based on observations, record reviews, staff and resident interviews, it was determined that facility staff failed to ensure that the resident environment remained as free of accident hazards as is possible as evidenced by failure to ensure that cold water faucets were operational in two (2) of two (2) bathtubs in one (1) resident room. The findings include: Facility staff failed to ensure that cold water was available for use in two (2) of two (2) tubs observed in resident room number 315. The hot water faucets for each of the bathtubs were functional. On November 22, 2013 at approximately 3:30 PM a tour of the bathroom located in resident room 315 was observed. It was noted that in two (2) of two (2) tub facets, the cold water did not release from the facet when the cold water was turned to the 'on' position. There was no evidence that cold water was available for use in two (2) bathtubs located in room 315, therefore prohibiting the ability of residents and/or staff to mix cold water with hot water for comfort. The observations were made in the presence of | L 234 L 234 | 1. Access to cold water was immediately identified and tubs in room 315 were taken out of service Permanently on 11/22/13. 2. All other tubs in room 115abcd, 215abcd, 315abcd, 415abcd, 515abcd, 107P, 207P 307P, 407P, and 507P were also permanently taken out of service on 11/22/13 3. Director of Maintenance/designee will conduct daily checks during AM rounds to ensure no water access to the identified areas in the facility. 4. Further findings on this matter will be discussed in the weekly, monthly and quarterly QA meetings. | 1/21/14 | |

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| L 234 | Continued From page 31 Employee's # 8 and 9 who also acknowledged the findings. | L 234 | | | |
| L 235 | 3236.4 Nursing Facilities The temperature of hot water of each fixture that is used by each resident shall be automatically controlled and shall not exceed one-hundred and ten degrees Fahrenheit (110 F) nor be less than ninety-five degrees Fahrenheit (95 F). This Statute is not met as evidenced by: Based on observations, staff interview, and a review of records for 10 of 17 resident rooms observed, it was determined that facility staff failed to ensure that hot water temperatures did not exceed 110 degrees Fahrenheit. The findings include: 1. Facility staff failed to ensure that water temperatures obtained from sinks located in resident rooms did not exceed 100 degree Fahrenheit. Water temperature readings were obtained from the sink in resident rooms located on the fourth floor. The water temperature readings were made in the presence of Employee #13 on November 19, 2013 at approximately 3:10 PM. Employee #13 used the facility 's thermometer to assess the temperatures. The water temperatures readings were as follows: Room #406 sink 116 F (degrees Fahrenheit) Room #408 sink 114 F Room #412 sink 111F Room #413 sink 113 F | L 235 | 1. Hot water temperatures in rooms 406, 408, 412, 413, 414, 416, 417, 418, 419 and 420 were immediately identified and restored back to compliance to the range of 95-110 degrees on 11/19/13. 2. Water temperatures throughout the facility were checked by the director of maintenance on 11/19/13 and non were noted with deficient practice. 3. Maintenance staff were in-service on 1/17/14 on water temperature maintaining regulation at 95-110 degrees. Director of Maintenance/designee during AM rounds will check water temperature daily during AM rounds, and logged in the facility's water temperature log book. 4. Further findings on this matter will be discussed in the weekly, monthly and quarterly QA meetings | 1/21/14 | |

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| L 235 | <p>Continued From page 32</p> <p>Room #414 sink 114 F Room #416 sink 112 F Room #417 sink 112 F Room #418 sink 113 F Room #419 sink 114 F Room #420 sink 113 F</p> <p>After the above observations, Employee #13 acknowledged the findings and made adjustments to the temperatures.</p> | L 235 | | |