**FOIA Data Base** - The Law Office of Jeffrey Downey

## Serving clients in Washington D.C., Virginia and Maryland

If you have been injured in a nursing home or assisted living facility, call the law office of Jeffrey J. Downey for a free consultation.

Phone: 703-564-7318; email: [jdowney@jeffdowney.com](mailto:jdowney@jeffdowney.com)

**Forest Hills of DC**

**(Formerly The Methodist Home of DC) 4901 Connecticut Avenue, NW Washington DC 20008**

**Facility Characteristics:**

## Nursing facility with 50 beds that is embedded within the NFPHC

* Directed by Susan Axleroad; Managing Employees Diana Lowe and Mary Savoy
* [**www.foresthillsdc.org**](http://www.foresthillsdc.org/)

## Non-Profit Corporation

As of 2019, Forest Hills of DC is listed on Medicare’s Nursing Home Compare as a four-star facility

**Researching Nursing Homes**

## A note by attorney Jeffrey J. Downey:

Thank you for visiting my website. Anyone who is considering the admission of a loved one into a nursing home should undertake a review of surveys or other data that will provide a snapshot of some of the issues or problems that the facility is experiencing. Keep in mind that this information can be limited and may not reflect the actual condition of the facility when your loved one is admitted. You should consider personal visits of any facility you are evaluating.

The District of Columbia Department of Health inspects nursing homes including Forest Hills of DC. Periodically they do inspections as complain surveys which should be public record. You can write to Phillip Husband at Department of Health, 899 North Capitol Street, NE,6th Floor, Washington DC 20002 or email directly to [Phillip.Husband@dc.gov](mailto:Phillip.Husband@dc.gov). There is no initial fee for submitting a FOIA request. However, a public body may charge fees for searching, reviewing, and reproducing records as provided in 1 DCMR § 408. You may include in your request letter a specific statement limiting the amount of fees you are willing to pay. You may request a waiver or reduction of fees in your request letter. You must include a statement describing how the requested records will be used to benefit the general public. Pursuant to DC Official Code § 2-532(b), if the public body determines that a waiver or fee reduction is in the public interest, i.e., furnishing the records primarily benefits the general public, a waiver or reduction may be granted.

Having already researched Forest Hill of DC and obtained FOIA responses, I am posting their statements of deficiencies here, in a searchable format. Keep in mind that these surveys may have been altered during the conversion process and you should update your search results.

I am interested in any additional information you may have on this facility. Please call me with any questions about this or any other facility you may be interested in researching or prosecuting civilly for patient neglect or abuse.

Disclaimer: Information is builtusing data sourcespublished by Centersfor Medicare& Medicaid Services (CMS) under Freedom of Information Act (FOIA). The information disclosed on the NPI Registry are FOIA-disclosable and are required to be disclosed under the FOIA and the eFOIA amendments to the FOIA. There is noway to 'optout' or 'suppress' the NPPES record data for health care providers with active NPls. Some documents may not be accurately copied or some results may have changed upon appeal, which may not be noted here.

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER  / CLIA IDENNTIFICATION NUMBER  **095038** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING 2. WING | | (X3) DATE SURVEY COMPLETED  **08/14/2018** |
| NAME OF PROVIDER OF SUPPLIER  **FOREST HILLS OF DC** | | | STREET ADDRESS, CITY, STATE, ZIP  **4901 CONNECTICUT AVENUE, NW WASHINGTON, DC 20008** | |
| For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. | | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | | |
| F 0610  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Few  F 0656  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Few  F 0657  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Few | (continued... from page 1)  found Resident #37 lying on the floor on her right side with both arms wrapped underneath her face, facing the wall. The incident was reported to the State Survey Agency at 1:31 AM on (MONTH) 10, (YEAR).  The facility was unable to provide documentation to demonstrate that the facility investigated an incident of unwitnessed fall with head injury and subsequent death.  During a face to face interview with Employee #2, Director of Nursing, on (MONTH) 13, (YEAR), at approximately 10:00 AM, when asked about the reporting of the incident to the State Agency, the employee stated that the facility followed their  normal process for reporting falls to the State Agency. When asked to provide evidence the incident was submitted to the State Agency and the investigation, Employee #2 stated that the only had the facility incident. At approximately 1:30 PM,  Employee #2 provided an email confirmation of the incident report submitted to the State Agency. However, Employee #2 was unable to provide the surveyors with documented evidence of the facility's incident investigation.  During a face to face interview conducted on (MONTH) 14, (YEAR), at 8:34 AM, Employee #1, Administrator, stated that she was informed of the incident. However, an incident was not conducted because it was assumed the resident had a [MEDICAL CONDITION]. In addition, the employee stated that there were no flags that suggested concerns. Further inquiry about the  showed that Employee #1 was aware the police and medical examiner was involved, but thought it was just a manner of protocol for the Emergency Medical Services (EMS) staff to notify them. Resident #37 was listed as deceased on the census that is used as a communication tool in Stand-up Meeting. Employee #1 could not provide any further insight into the reason why the facility did not conduct an investigation and acknowledged the findings.  **Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.**  \*\*NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY\*\*  Based on record review and staff interview for one (1) of 16 sampled residents, the facility failed to develop a comprehensive person-centered care plan to include goals and preferences address falls, activities of daily living, [MEDICAL CONDITION] drug use, and left wrist fracture (Resident #37).  Findings include .  Resident #37 was admitted on (MONTH) 15, (YEAR) with [DIAGNOSES REDACTED].  Review of medical record on (MONTH) 13, (YEAR) at 11:00 AM showed a Minimum Data Set, dated dated dated (MONTH) 22, (YEAR).  Resident #37 was documented as being cognitively intact with a Brief Interview for Mental Status (BIMS) Summary Score of 15 in Section C0500. Resident able to make self-understood and able to understand others. Section G Functional Status for Activities of Daily Living (ADLs) assistance showed Resident #37 required extensive assistance to self-perform bed  mobility, transfers, dressing, toilet use, and personal hygiene; and the assistance of one (1) for ADL support for bed mobility, dressing, personal hygiene. Resident #37 required two (2) ADL support for transfers and toilet use. For bathing, the resident was totally dependence with the assistance of one (1) staff person. Section GG Functional Abilities and Goals Section GG0130 on admission was coded as independent for eating, oral hygiene, sit to lying, sit to stand, and lying to sitting on the side of the bed. However, set-up (resident completes activity, helper assists only prior to or following the activity) was discharge goal for transfers and toileting hygiene.  Admission Physician order [REDACTED]./or diastolic blood pressure is greater than 100 and less than 60 for three (3) consecutive readings, weight bearing on left leg as tolerated, left hip precautionary measures every shift, and On (MONTH) 16, (YEAR), the telephone orders for Occupational Therapy evaluate and treat five (5) times per week for four (4) weeks and Physical Therapy evaluate and treat for five (5) times per week for four (4) weeks. Occupational Therapy and Physical Therapy evaluations.  Nursing Admission Screening/History dated (MONTH) 15, (YEAR), at 11:58 PM showed limited range of motion due to left wrist fracture; left mid hip surgical site has 8 staples, left upper hip surgical site has 6 staples. Resident #37 had a hard  cast on the left wrist with limited range of motion on left lower extremity due to fracture on left hip, cannot bear weight at this time.  Review of care plans showed the facility staff initiated care plans for pressure ulcers, dental care, falls, ADL (Activities of Daily Living) function, [MEDICAL CONDITION] drug use, short-term rehab, and fracture to arm as follows:  Falls care plan initiated on (MONTH) 16, (YEAR), the interventions were documented as Be sure resident's call light is within reach and encourage the resident to use it for assistance as needed; and the resident needs prompt response to all requests for assistance.  ADL Function care plan initiated on (MONTH) 16, (YEAR), the interventions were documented as document/report any changes to MD, POA, Resident, initiate rehabilitation referral. Be sure resident's call light is within reach and encourage the  resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance.  [MEDICAL CONDITION] Drug Use care plan initiated on (MONTH) 23, (YEAR), the interventions were documented as Observe for  signs of behavior change and report to MD, POA, and Resident.  Short Term Rehab care plan initiated on (MONTH) 6, (YEAR), the interventions documented as assess need for any durable medical equipment, assess need for skilled home health services and assist in coordinating any needed services, assess resident's ability to return to her son's home in the community, complete all necessary discharge paperwork, empower resident to be involved in discharge planning, facilitate a home evaluation, meet with resident to discusser thoughts and feelings regarding her SW (social work) transition to her future living arrangements.  Fracture to arm r/t (related to) fall initiated on (MONTH) 23, (YEAR)- Interventions monitor/document/report PRN (as needed) s/sx. (signs and symptoms) of [MEDICAL CONDITION] complications; contracture formation, embolism, increased heart rate, tachypnea, difficulty breathing, infection at surgical site, impaired mobility, unrelieved pain, pneumonia/poor air  exchange, incontinence.  Potential for acute/chronic pain r/t (related to) generalized weakness initiated on (MONTH) 16, (YEAR), the interventions documented as evaluate the effectiveness of pain interventions review for compliance, alleviating of symptoms, dosing schedules and resident satisfaction with results, impact on functional ability and impact on cognition, identify and record  previous pain history and management of that pain and impact on function. Identify previous response to [MEDICATION NAME] including pain relief, side effects and impact on function.  Potential for impairment to skin integrity r/t (related to) fragile skin initiated on (MONTH) 16, (YEAR), the interventions included educate resident/family/caregivers of causative factors and measure to prevent skin injury, keep skin clean and dry. Use lotion on dry skin.  The care plans lacked person-centered goals and approaches to address use of assistive device (walker and wheelchair), interventions to manage left wrist cast, [MEDICATION NAME] 0.25 milligrams as needed for anxiety, staples to left hip area, hip precautions, and weight bearing status.  During a face to face interview conducted on (MONTH) 13, (YEAR) at 5:22 PM, Employee #7, reviewed the nursing documentation and confirmed the findings.  **Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.**  \*\*NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY\*\*  Based on record review and staff interview one (1) of 16 sampled residents, the facility failed to revise the care plan for changes in treatment plan related to weight bearing status and medication changes (Resident #37).  Findings included .  Resident #37 was admitted on (MONTH) 15, (YEAR) with [DIAGNOSES REDACTED]. Review of the medical record on (MONTH) 13, (YEAR) showed the following physician orders: March 28, (YEAR) at 4:00 PM, physician order [REDACTED].  On (MONTH) 20, (YEAR), the physician order [REDACTED].  May 8, (YEAR) (no time noted), the physician ordered a referral to the hematologist, [MEDICATION NAME] 5 milligram by mouth | | | |

FORM CMS-2567(02-99)

Previous Versions Obsolete

Event ID: YL1O11 Facility ID: 095038 If continuation sheet Page 2 of 7

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER  / CLIA IDENNTIFICATION NUMBER  **095038** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING 2. WING | | (X3) DATE SURVEY COMPLETED  **08/14/2018** |
| NAME OF PROVIDER OF SUPPLIER  **FOREST HILLS OF DC** | | | STREET ADDRESS, CITY, STATE, ZIP  **4901 CONNECTICUT AVENUE, NW WASHINGTON, DC 20008** | |
| For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. | | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | | |
| F 0657  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Few  F 0684  **Level of harm -** Actual harm  **Residents Affected -** Few | (continued... from page 2)  three (3) times a day for cough for five (5) days, and [MEDICATION NAME] 3 milligrams one tablet by mouth at bedtime for [MEDICAL CONDITION].  May 9, (YEAR) (no time noted), telephone order for chest x-ray for persistent cough rule out upper respiratory infection.  Review of the care plans failed to show the facility staff reviewed and revised the resident's care plans to address changes  to the resident's plan of care for [MEDICAL CONDITION] medications, ADL performance, and [MEDICAL CONDITION]. During a face to face interview conducted on (MONTH) 13, (YEAR) at 5:22 PM, Employee #7, reviewed the nursing documentation and confirmed the findings.  **Provide appropriate treatment and care according to orders, resident’s preferences and goals.**  \*\*NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY\*\*  Based on policy review, record review and staff interview for three (3) of 16 sampled residents, the facility failed address Resident #37's systolic blood pressure which remained over 160 millimeters of Mercury for three (3) consecutive days, failed to assess for physiological and behavioral signs and symptoms of distress to facilitate prompt interventions to address changes in condition such as cough and an unwitnessed fall preceding a death in the facility; and failed to show evidence of collaboration with hospice services to provide resident-directed care for two (2) residents to minimize the risk harm. (Residents #37, 11, 187)  Findings included .  A. The facility failed address Resident #37's systolic blood pressure which remained over 160 millimeters of Mercury for three (3) consecutive days and failed to assess for physiological and behavioral signs and symptoms of distress, to facilitate prompt interventions to address changes in condition, to minimize the risk for harm.  Facility's policy titled Neurological Assessments, not dated, states it is the policy of the facility to conduct neurological assessments on any resident who sustains an unwitnessed fall. As a part of the resident assessment after a fall and as otherwise indicated, the licensed nurse completes and documents a neurological assessment.  Facility's Documentation policy dated (MONTH) 26, (YEAR), states daily clinical notes are written by a licensed nurse for residents receiving Medicare benefits. These guidelines are also applicable for other required clinical notes. Clinical  notes for respiratory conditions . lungs sounds, nature of respirations, cough, temperature, hydration, medication to  include any new medication prescribed, changed, or discontinued, response to medications started, changed or discontinued, and changes in resident's condition.  Resident #37 was admitted on (MONTH) 15, (YEAR) with [DIAGNOSES REDACTED].  On (MONTH) 9, (YEAR), at approximately 4:30 PM, Resident #37 experienced an unwitnessed fall with injury of unknown source and subsequently expired at 4:46 PM.  Review of medical record on (MONTH) 13, (YEAR), at 11:00 AM showed a 30- Day Minimum Data Set (MDS) dated (MONTH) 11, (YEAR). Resident #37 was documented as requiring extensive assistance of one (1) staff for bed mobility, transfer,  locomotion on and off the unit, and personal hygiene, in Section G0110.  Nursing Admission Screening/History dated (MONTH) 15, (YEAR) at 11:58 PM showed limited range of motion of left upper extremity due to left wrist fracture; left mid hip surgical site has 8 staples, and left upper hip surgical site has 6  staples. Resident #37 wears a hard cast on her left wrist. Also, limited range of motion on left lower extremity due to fracture on left hip, cannot bear weight at this time.  Admission Physician order [REDACTED]. and/or diastolic blood pressure is greater than 100 and less than 60 for three (3) consecutive readings, weight bearing on left leg as tolerated, left hip precautionary measures every shift, and On (MONTH) 16, (YEAR), the telephone orders for Occupational Therapy evaluate and treat five (5) times per week for four (4) weeks and Physical Therapy evaluate and treat for five (5) times per week for four (4) weeks. Occupational Therapy and Physical Therapy evaluations.  Review of the Medication Administration Record [REDACTED].  The medical record lacked documented evidence of notification of the physician or interventions when the resident's systolic blood pressure was over 160 millimeters of Mercury for three (3) consecutive days.  On (MONTH) 28, (YEAR), Resident #37 was seen in follow-up with orthopedic with recommendation for full WB (weight bearing) in cast (left) wrist, full WB (weight bearing) L (left) hip, and follow-up in 3 weeks. In addition, the medical record  contained a handwritten prescription from the Orthopedist dated (MONTH) 28, (YEAR) with instructions as follows: left wrist full WBAT (weight bearing as tolerated), Please add platform to walker left side.  The medical record lacked documented evidence the facility staff notified the physician of the prescription for the addition of the platform to the walker. In addition, the physician progress notes [REDACTED].  Review of the physical therapy and occupational therapy notes from (MONTH) 28, (YEAR) to (MONTH) 2, (YEAR), failed to show the therapist acknowledged the recommendations for change in weight bearing status and addition of platform to left side of  walker from the orthopedic consult or adjust the treatment plan to reflect the platform walker.  Further review of the physical therapy notes from (MONTH) 3, (YEAR) through (MONTH) 9, (YEAR) (date of expiration) showed precautions/ Contraindications: L UE (left upper extremity) 50%/PWB (partial weight bearing) and L LE (left lower  extremity) WBAT (weight bearing as tolerated).  Review of care plans showed the facility staff initiated care plans for pressure ulcers, dental care, falls, ADL (Activities of Daily Living) function, [MEDICAL CONDITION] drug use, short-term rehab, and fracture to arm.  However, the care plans lacked documented evidence of person-centered goals and approaches to address use of assistive  device (walker and wheelchair), interventions to manage left wrist cast, [MEDICATION NAME] 0.25 milligrams as needed for anxiety, staples to left hip area, hip precautions, and weight bearing status.  The nursing note dated (MONTH) 8, (YEAR), at 4:30 PM, Resident #37 complained of intermittent non-productive cough. The physician was called and new order obtained for [MEDICATION NAME] (use to treat cough) 5 milliliters by mouth three (3) times a day for five (5) days, [MEDICATION NAME] 3 milligrams for [MEDICAL CONDITION].  Nursing note dated (MONTH) 9, (YEAR) at 1:39 PM, showed the resident's representative came into the facility to report Resident #37 complained of generalized weakness and did not have enough strength to pick up the phone in the morning when the resident representative called. The resident was assessed and noted to be alert and arousable, and reported not feeling  tired. The lungs were auscultated, and noted to be congested bilaterally (mild crackles) on upper lobes, lower lobes clear bilaterally, cough present, non-productive . The physician was notified and new telephone order obtained for chest x-ray to rule out an upper respiratory infection.  Review of The Respiratory Therapy/ Impaired Respiratory Status instructs the staff to describe accurately breaths sounds overall lung aspects, the respiratory rate, rhythm and quality, the effectiveness of any respiratory treatments given such as oxygen, resident's comfort level as it relates to respiratory status, any changes in level of consciousness, anxiety or other mental status changes, and the resident's overall condition as related to respiratory status and any skilled nursing interventions used to aid in comfort and improve overall status.  The medical record lacked documentation of a respiratory assessment performed by the direct care nurse, in accordance with the facility's impaired respiratory status assessment standards.  On (MONTH) 9, (YEAR), at 11:41 PM, the nursing staff documented that Resident #37 was found lying on the floor by the therapy staff at approximately 4:32 PM. On assessment, the resident skin was cold and clammy to touch, rapid respirations, cyanosis in color, non-verbal, and unresponsive but breathing. The vital signs were blood pressure ,[DATE], heart rate- 53, respiratory rate- 28, temperature- 95.6, blood sugar- 260 and oxygen saturation- 72% on room air. Physician notified at 4:32 PM and updated on the resident's condition. New orders were given and noted. Oxygen therapy initiated, oxygen was given at 5 liters per minutes via face mask for oxygen saturation less than 80%. Paramedics were called 4:33 PM. The son was notified at 4:35 PM and requested that his mother be transferred to (local) Hospital because it is much closer to his home. Paramedics arrived on unit at 4:37 PM and took over. The resident was pronounced at 4:46 PM by paramedics.  Physician orders [REDACTED].<80% (less than 80 percent), (2) change oxygen tubing and humidifier bottle every week on Tuesday's on ,[DATE] pm shift, when in use, transfer resident to nearest emergency room for further evaluation, monitor discoloration on forehead qshift til resolved.  During a face to face interview with Employee #7, Clinical Resource Nurse on (MONTH) 13, (YEAR), at 5:22 pm, the employee stated that he was called early in the morning by the Employee #4, Licensed Practical Nurse, because the resident's | | | |

FORM CMS-2567(02-99)

Previous Versions Obsolete

Event ID: YL1O11 Facility ID: 095038 If continuation sheet Page 3 of 7

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER  / CLIA IDENNTIFICATION NUMBER  **095038** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING 2. WING | | (X3) DATE SURVEY COMPLETED  **08/14/2018** |
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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | | |
| F 0684  **Level of harm -** Actual harm  **Residents Affected -** Few  F 0695  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Few | (continued... from page 3)  representative was in the building with a lot of questions. The son reported receiving a call from his mother saying she  was very weak and could not up the phone. After speaking with the son, Employee #7 went to assess the resident. Resident #37 lungs were pretty much clear with a little congestion. The employee placed a call to the physician and obtained an  order for [REDACTED].>When the employee returned to the unit, Employee #10, Certified Occupational Therapy Assistant, was running out of the room yelling for help. Employee #7 stated that he grabbed the crash cart and went to the resident's  room. Resident #37 was on the floor. Employee #7 performed an assessed of Resident #37. She was unresponsive but breathing. When queried about the performance of assessments by the primary nurse related to the change of condition experienced on (MONTH) 8, (YEAR) and (MONTH) 9, (YEAR), Employee #7 was unable to give further insight.  The medical record lacked documented evidence of the observation and assessment to include the recording of physiological and behavioral signs and symptoms of distress when the resident's condition declined before arrival of the paramedics and the resident's subsequent death. The facility staff's failure to assess, evaluate interventions and promptly intervene  placed Resident #37 at risk for harm.  During a face to face interview on (MONTH) 13, (YEAR), at 5:30 PM, Employee #7 reviewed and acknowledged the findings.  B. Failed to show evidence of collaboration with hospice services to provide resident-directed care for two (2) residents (Residents #11, 187)   1. Resident# 11 was admitted to the facility on [DATE] (original admitted ) with [DIAGNOSES REDACTED].   Review of the Annual Minimum Data set (MDS)dated [DATE] on [DATE] at 2:00 PM showed Section C1000 (Cognition Skills for Daily Decision Making) is coded as 3 which indicate severely impaired-never/rarely makes decisions. Section O (Special Treatments and Programs) is coded as Other-Hospice.  Review of the care plan on showed the resident is dependent on staff for meeting all emotional, intellectual, physical and social needs related cognitive deficits.  Review of a Social Worker Psychosocial note dated [DATE] showed a Resident Annual Care Conference was held today with (Hospice Name) resident continues on hospice.  A further review of the care plans showed Hospice Program Interventions/Tasks Collaborate with hospice nurse/physician re: effectiveness of treatment plan medication and care, communicate with hospice nurse/social worker when they visiting and updates treatment/plan of care and in corporate knowledge of hospice process into all care activities. (sic)  A review of Resident# 11 medical record failed to show documentation from hospice services.  During an interview on [DATE] at 2:30 PM Employee# 4 was asked to provide evidence of ongoing communication and collaboration between facility staff and hospice staff.  Employee# 4 stated they have a book they (hospice services) put their notes in and I don't see the book, I will call them (hospice) now.  Employee#4 failed to show evidence of ongoing communication and or collaboration with hospice services.  During an interview on [DATE] at 3:00 PM Employee# 4 stated the hospice book was on another floor, we just communicate with them (hospice) if there are any issues, I don't see a collaborative care plan with hospice.  Facility staff failed to show evidence of collaboration with the hospice services and or the implementation of hospice care plan interventions to provide resident-directed care.  During a face-to-face meeting on [DATE] at 3:00 PM Employee # 4 acknowledged the findings.   1. Resident #187 was admitted to the facility on (MONTH) 31, 2014 with [DIAGNOSES REDACTED]. Per documentation in the progress notes the resident was admitted into Hospice care in (MONTH) (YEAR) due to Advanced Dementia.   Review of the care plan shows notes indicating that the resident receives Hospice care. However, there is no documentation on the care plans or in the progress notes identifying what aspects of the resident's services will be provided by the  facility, which will be provided by Hospice and how all aspects of the resident's care will be coordinated.  During a face-to-face interview with Employee #7 on (MONTH) 8, (YEAR) at approximately 11:00 AM the employee was asked whether Resident #187 receives Hospice care. The employee responded that she did. The employee was then asked for Hospice' assessment and documentation of the care provided to the resident. Employee #7 responded that Hospice has a separate chart  for each resident and that all of their notes and care plans are kept in that chart.  Employee #7 gave me a chart which was labelled with the resident's name and the name of the Hospice group. The chart contained documentation from various members of the Hospice staff.  Another face-to-face interview was conducted with Employee#2 on (MONTH) 9, (YEAR) at approximately 2:00PM to discuss the absence of integration between the care provided by Hospice and the care provided by the facility.  The employee acknowledged that the care plans lacked integration between the two services but added that she is currently working with Hospice to resolve that problem.  **Provide safe and appropriate respiratory care for a resident when needed.**  \*\*NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY\*\*  Based on policy review, record review, and staff interview, the facility failed to document the assessment monitoring of Resident #37's respiratory condition to include response to new medication and oxygen therapy. (Resident #37) Findings included .  Review of The Respiratory Therapy/ Impaired Respiratory Status training instructs the staff to describe accurately breaths sounds overall lung aspects, the respiratory rate, rhythm and quality, the effectiveness of any respiratory treatments given such as oxygen, resident's comfort level as it relates to respiratory status, any changes in level of consciousness, anxiety or other mental status changes, and the resident's overall condition as related to respiratory status and any  skilled nursing interventions used to aid in comfort and improve overall status.  Facility's Documentation policy dated (MONTH) 26, (YEAR), states daily clinical notes are written by a licensed nurse for residents receiving Medicare benefits. These guidelines are also applicable for other required clinical notes. Clinical  notes for respiratory conditions . lungs sounds, nature of respirations, cough, temperature, hydration, medication to  include any new medication prescribed, changed, or discontinued, response to medications started, changed or discontinued, and changes in resident's condition.  Resident #37 was admitted on (MONTH) 15, (YEAR) with [DIAGNOSES REDACTED].  Review of the medical record on (MONTH) 13, (YEAR) showed a nursing note dated (MONTH) 8, (YEAR), at 4:30 PM, Resident #37  complained of intermittent non-productive cough. The physician was called and new order obtained for [MEDICATION NAME] (use  to treat cough) 5 milliliters by mouth three (3) times a day for five (5) days, [MEDICATION NAME] 3 milligrams for [MEDICAL CONDITION].  On (MONTH) 8, (YEAR) at 10:09 PM, the nursing note showed Resident received in bed awake and verbally responsive, no cough noted this shift. [MEDICATION NAME] 5mls given as ordered. [MEDICATION NAME] 3mg given for [MEDICAL CONDITION] with come  effect. Appetite good, fluids well tolerated. Lungs sounds clear bilaterally on auscultation with no wheezing or crackles noted. Bed in lowest position with call light within reach. No complaint of pain, respiratory distress or discomfort noted or voiced.  May 9, (YEAR) at 12:07 AM, the nursing note showed the nurse received Resident asleep in the bed and stable with no signs of a cough, respiratory distress or pain. [MEDICATION NAME] treatment appears to be effective. Bed is in the lowest position, call light within reach, side rails up and non-skid socks are on. Continued safety precautions and monitoring.  On (MONTH) 9, (YEAR) at 6:39 AM the nursing note showed Resident slept throughout the night with no complaints of pain/distress/sleep pattern. [MEDICATION NAME] appeared to be effective. Resident has a small bout of non-productive coughs when using the bathroom this morning but had no complaints. Bed is in the lowest position, call light within reach, nonskid  socks on, and side rails up. Continue to monitor.  Nursing note dated (MONTH) 9, (YEAR) at 1:39 PM, showed the resident's representative came into the facility to report Resident #37 complained of generalized weakness and did not have enough strength to pick up the phone in the morning when the resident representative called. The resident was assessed and noted to be alert and arousable, and reported not feeling  tired. The lungs were auscultated, and noted to be congested bilaterally (mild crackles) on upper lobes, lower lobes clear bilaterally, cough present, non-productive . The physician was notified and new telephone order obtained for chest x-ray to rule out an upper respiratory infection.  On (MONTH) 9, (YEAR), at 11:41 PM, the nursing staff documented that Resident #37 was found lying on the floor by the therapy staff at approximately 4:32 PM. On assessment, the resident skin was cold and clammy to touch, rapid respirations, | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER  / CLIA IDENNTIFICATION NUMBER  **095038** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING 2. WING | | (X3) DATE SURVEY COMPLETED  **08/14/2018** |
| NAME OF PROVIDER OF SUPPLIER  **FOREST HILLS OF DC** | | | STREET ADDRESS, CITY, STATE, ZIP  **4901 CONNECTICUT AVENUE, NW WASHINGTON, DC 20008** | |
| For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. | | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | | |
| F 0695  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Few  F 0711  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Few  F 0732  **Level of harm -** Potential for minimal harm  **Residents Affected -** Many  F 0756  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Few | (continued... from page 4)  cyanosis in color, non-verbal, and unresponsive but breathing. The vital signs were blood pressure 70/50, heart rate- 53, respiratory rate- 28, temperature- 95.6, blood sugar- 260 and oxygen saturation- 72% on room air. Physician notified at 4:32 PM and updated on the resident's condition. New orders were given and noted. Oxygen therapy initiated, oxygen was given at 55 liters per minutes via face mask for oxygen saturation less than 80%. Paramedics were called 4:33 PM. The son was notified at 4:35 PM and requested that his mother be transferred to (local) Hospital because it is much closer to his home. Paramedics arrived on unit at 4:37 PM and took over. The resident was pronounced at 4:46 PM by paramedics.  Physician orders [REDACTED].<80% (less than 80 percent), (2) change oxygen tubing and humidifier bottle every week on Tuesday's on 3-11 pm shift, when in use, transfer resident to nearest emergency room for further evaluation, monitor discoloration on forehead qshift til resolved.  During a face to face interview with Employee #7, Clinical Resource Nurse on (MONTH) 13, (YEAR), at 5:22 pm, the employee stated that he was called early in the morning on (MONTH) 9, (YEAR). The son reported receiving a call from his mother saying she was very weak and could not up the phone. After speaking with the son, Employee #7 went to assess the resident.  Resident #37 lungs were pretty much clear with a little congestion. The employee placed a call to the physician and  obtained an order for [REDACTED].>When the employee returned to the unit, Employee #10, Certified Occupational Therapy Assistant, was running out of the room yelling for help. Employee #7 stated that he grabbed the crash cart and went to the resident's room. Resident #37 was on the floor. Employee #7 performed an assessed of Resident #37. She was unresponsive but breathing. When queried about the performance of assessments by the primary nurse related to the change of condition experienced on (MONTH) 8, (YEAR) and (MONTH) 9, (YEAR), Employee #7 was unable to give further insight.  The medical record lacked documentation to support that the nursing staff consistently performed nursing assessments in accordance with the facility's policies, to include respiratory rate, rhythm and quality, and response to oxygen therapy after initiation during an unwitnessed fall with injury of unknown source and subsequent death.  During a face to face interview on (MONTH) 13, (YEAR), at 5:30 PM, Employee #7 reviewed and acknowledged the findings.  **Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit.**  \*\*NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY\*\*  Based on record review and staff interview one (1) of 16 records, the facility failed to review the resident's total program  of care as evidenced by an Admission History and Physical that did not accurately reflect resident's condition on admission and all pertinent related to assessed care needs (Resident #37).  Findings included .  Resident #37 was admitted on (MONTH) 15, (YEAR) with [DIAGNOSES REDACTED].  Review of the medical record on (MONTH) 13, (YEAR) at 11:00 AM, the History and Physical Exam Form dated (MONTH) 16, (YEAR),  showed admission [DIAGNOSES REDACTED]. The admission History and Physical Exam Form failed to show the physician reviewed  Resident #37 hospital discharge summary, medications and treatment, to reflect the physician's decisions about the continued appropriateness of the medication and treatment regimen in the nursing home.  The hospital discharge summary dated (MONTH) 15, (YEAR) showed Resident #37's Discharge Diagnoses- Active Problems listed as  Closed Left [MEDICAL CONDITION], Essential Hypertension, Anxiety, [MEDICAL CONDITION] Fibrillation with RVR, Systolic  Ejection Murmur, [MEDICAL CONDITION] due to Kyphoscoliosis, [MEDICAL CONDITION], Tachy-Brady Syndrome, Non- rheumatic  [DIAGNOSES REDACTED]. Past medical history included [MEDICAL CONDITION], Arthritis, and Cataract, Right Breast Lumpectomy.  Further review of the physician progress notes [REDACTED].#37 was seen by the Nurse Practitioner on (MONTH) 20, (YEAR). The SOAP (an acronym for subjective, objective, assessment, and plan) progress note showed O (Objective) blood pressure-  132/76, pulse- 68, afebrile, Extremities- left hip- upper incision staples in place, lower hip- staples in place- clean and  no drainage. A (Assessement)- status [REDACTED]. The P (Plan)- Repeat BMP (Basic Metabolic Panel) 7 CBC (Complete Blood Count) next lab day.  The medical record lacked documented evidence the physician reviewed Resident #37 Active Problems and Past Medical history to reflect the physician's decisions about the continuation or appropriateness of the resident's current medical regimen  related to Left Wrist Fracture, [MEDICAL CONDITION] due to Kyphoscoliosis, Tacy-Brady Syndrome, Cataract, and Arthritis. During a face to face interview on (MONTH) 13, (YEAR), at approximately 12:15 PM, Employee #4 acknowledged the findings.  **Post nurse staffing information every day.**  Based on observation, and staff interview, the facility failed to post daily nurse staffing information to include the identification, classification and assignment of all staff on duty on a daily basis.  The findings included.  On (MONTH) 7, (YEAR) at approximately 11:00 AM there was no posting of the staff on duty either on the first or the second floor nursing units in the facility.  The failed practice lack of posting of the staffing information, resident's family members and visitors were unable to determine the names, classifications and assignments of the staff that were on duty.  During a face-to-face interview on (MONTH) 7, (YEAR), Employee #2 stated that staffing information is usually kept in a binder at the nurses' station.  The facility failed to post daily nurse staffing information to include the identification, classification and assignment of all staff on duty on a daily basis. Employee #2 acknowledged the finding.  **Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.**  \*\*NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY\*\*  Based on record review and staff interview for one (1) of 15 sampled residents the physician failed to respond to a request from the pharmacist to review Resident #31's [MEDICAL CONDITION] medications.  Findings included .  Resident #31 was admitted to the facility on (MONTH) 30, 2014 with [DIAGNOSES REDACTED].  The resident was receiving the following medications [MEDICATION NAME] 0.25mg HS, [MEDICATION NAME] 10mg, [MEDICATION NAME]  15mg and [MEDICATION NAME] 300mg TID.  The pharmacist reviewed the resident's medications on (MONTH) 17, (YEAR) and left the following recommendation: Recommend re-evaluate all of the medications at this time to determine if any slow reductions are possible. If not, please document  clinical rationale. Of note, patient is on 2 antidepressants. The pharmacist also stated that the resident has been on  several psychoactive medications and that the most recent psych note from 3/2/18 only acknowledged [MEDICATION NAME] 10mg  and [MEDICATION NAME] 0.25mg. The area designated for the physician's response was blank and there was no documentation to address the recommended change in the medications in the physician's progress notes.  Review of Resident #31's Medication Administration Record [REDACTED]½ tab (0.25mg) by mouth every night at bed time for anxiety (2/21/2018), [MEDICATION NAME] 300mg cap 1 cap by mouth threee (3) times a day for anxiety (2/15/2018), [MEDICATION  NAME] 7.5mg 1 tab by mouth daily at bedtime for Depression.  The physician failed to acknowledge and/or respond to the pharmacist's recommendation regarding Resident #31's psychoactive medications.  During a face-to-face interview on (MONTH) 9, (YEAR), at approximately 5:00 PM, Employee #2 acknowledged the findings. | | | |

F 0758

**Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless**

**contraindicated, prior to initiating or instead of continuing psychotropic medication; Level of harm -** Minimal **and PRN orders for psychotropic medications are only used when the medication is** harm or potential for actual **necessary and PRN use is limited.**

harm

**Residents Affected -** Few

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| F 0758  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Few  F 0761  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Few  F 0812  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Many  F 0842  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Few | (continued... from page 5)  \*\*NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY\*\*  Based on medical record review and staff interview for two (2) of 16 sampled residents, the physician failed to provide a [DIAGNOSES REDACTED]. (Residents #13 and 37).  Findings included .   1. Failed to provide a [DIAGNOSES REDACTED].   Resident# 13 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED].  A review of the Quarterly Minimum Data Set ((MDS) dated [DATE] on 8/9/18 at 3:00 PM showed Section C (Cognition) Should Brief Interview for Mental Status (BIMS) be conducted? No is selected which indicates resident is rarely/never understood.  Section G (Functional Status) G0110 (Activities of Daily Living (ADL) Assistance) Bed Mobility, Transfer, Dressing, Eating, Toilet use and Personal Hygiene resident is scored as 4 which indicate total dependence on staff.  A review of the nursing care plan on 8/9/18 at 3:30 PM showed Focus Resident uses [MEDICAL CONDITION] medications related to  Behavior Management. Interventions/Tasks Administer [MEDICAL CONDITION] medications as ordered by physician, monitor for side effects.  A further review of the Physician order [REDACTED].  During a staff interview on 8/9/18 at 4:30 PM Employee#3 was unable to provide insight as to the clinical reason for the medication or what was meant by behaviors. Employee# 3 stated I will call the doctor.  During a staff interview with Employee# 3 on 8/9/18 at 4:40 PM, staff stated here is the new physician order.  A further review of the medical record showed a physician's orders [REDACTED]. Give Quetiapine 50 mg one tablet by mouth daily at bedtime for [MEDICAL CONDITION].  During a face-to-face interview on 8/9/19 at 4:45 PM Employee# 3 acknowledged the finding.   1. Failed to ensure PRN antipsychotic medications were not ordered for longer than 14 days without a documented rationale for contiued use.   Resident #37 was admitted on (MONTH) 15, (YEAR) with [DIAGNOSES REDACTED]. Admission Physician order [REDACTED].  Physician order [REDACTED].  Review of Psychiatry Progress Notes show Resident #37 was seen on (MONTH) 23, (YEAR) at 3:10 PM. The progress note showed no  major cognitive deficits, no severe mood instability; underlying anxiety/chronic; stable on [MEDICATION NAME]; Diagnosis: [REDACTED].#31 was stable at this point; D/C (discontinue) [MEDICATION NAME] PRN, continue to monitor her mood and behavior.  The Drug Regimen Review conducted on (MONTH) 19, (YEAR), showed RM-P (Recommedations made to Physician) see PRN (next  handwriting illegible) with a line drawn with a notation of D/C (discontinued) 4/20) from the (MONTH) 2, (YEAR) Drug Regimen Review box.  The Medication Administration Record [REDACTED]. However, the (MONTH) (YEAR) MAR indicated [REDACTED]. There was no evidence  the medication had been administered.  The medical record lacked documented evidence the physician ensured PRN [MEDICAL CONDITION] medication were not ordered longer than 14 days. [MEDICATION NAME] 0.25 milligrams was ordered for 35 days without rationale for the continued order.  On (MONTH) 13, (YEAR), Employee #3 confirmed and acknowledged the findings.  **Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.**  \*\*NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY\*\*  Based on an observation at approximately 9:50 AM on (MONTH) 7, (YEAR) facility staff failed to store all medications safely in accordance with State and Federal Laws as evidenced by leaving medications unattended and unlabeled in a resident's room. Resident #188  Findings included.  On (MONTH) 7, (YEAR) at approximately 9:50 AM I entered Resident #188's room to conduct an observation of the resident. The resident was sitting up in bed. An over-bed table was across the bed and she was eating her breakfast. A dresser was  located on the left side of the room, against the wall and approximately two (2) feet from the door of the room. A partially opened suppository (covering peeled halfway back) and a 30cc medication cup partially filled with white cream substance was sitting on a small tray on top of the dresser.  I remained in the room approximately ten minutes, talking to the resident and observing her as she ate. During those ten minutes no one came to the room. After ten minutes I engaged the call light. Someone responded to the light and I requested that the charge nurse should come to the room.  The charge nurse came to the room. I pointed to the medications and asked her to identify the items that were on the tray.  She responded that the suppository was Canasa and the cream was [MEDICATION NAME]. The employee added that she was waiting  for the resident to complete eating her breakfast before she administered the medications.  A review of the physician's revealed that the resident has an order for [REDACTED]. The [MEDICATION NAME] Cream was ordered  to be administered to the Periarea (Perineum) PRN every day as needed.  Employee #8 removed the medications and acknowledged that she should not have left them unattended in the resident's room.  **Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.**  Based on observations and staff interview, the facility failed to store and distribute foods under sanitary conditions as evidenced by documented low rinse (final) temperatures from the Dish Machine Temperatures logs on 95 of 366 opportunities. Findings included .  A review of the Dish Machine Temperatures logs for the main kitchen during the months of April, May, (MONTH) and (MONTH) (YEAR) show that on numerous occasions, rinse (final) temperatures were recorded at less than 180 degrees Fahrenheit (F).  There were no corrective actions initiated to address the low rinse temperatures.  According to the Dish Machine Temperatures logs, final rinse temperatures were documented as being less than 180 degrees F as follows:  On 23 of 90 opportunities in (MONTH) (YEAR) On 29 of 93 opportunities in (MONTH) (YEAR) On 21 of 90 opportunities in (MONTH) (YEAR) On 22 of 93 opportunities in (MONTH) (YEAR).  During a face-to-face interview with Employee #6 on (MONTH) 8, (YEAR), at approximately 11:45 AM, he explained that staff from dietary services contacts the maintenance department when a problem occurs with the dish machine. Maintenance will then assess the situation and call Ecolab (Dish machine repair contactor) if necessary.  Employee #6 confirmed there had not been any issues whatsoever with the dish machine which is new (February (YEAR)). During a face-to-face interview on (MONTH) 8, (YEAR), Employee #5 also confirmed no past or recent concerns with the dish machine and acknowledged the findings.  **Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.**  \*\*NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY\*\* | | | |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | | |
| F 0842  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Few  F 0867  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Some | (continued... from page 6)  Based on observation, record review and staff interview for one (1) of 16 sampled residents facility staff failed complete a resident Wandering Risk Assessment that accurately reflected the status of Resident# 23.  Findings included .  Resident#23 was admitted on [DATE] with [DIAGNOSES REDACTED].  Review of the medical record on 8/9 /18 at 10:00 AM showed an Admission Minimum Data Set ((MDS) dated [DATE]. Under Section  (Cognition) Brief Interview for Mental Status (BIMS) was recorded as 99 which indicates the resident was unable to complete the interview. C1000 Cognitive Skills for Decision Making (made decisions regarding daily tasks of daily life) resident is coded as 3 which indicates severely impaired-never rarely makes decisions. Section G (Functional Status) G0110 Activities of Daily Living Assistance resident is coded as 4 total full dependence for: bed mobility, transfer (how resident moves  from surfaces including to and from bed, chair, and wheelchair to standing position). G0600 (Mobility Devices) Wheelchair (automatic or electric) is selected.  Review if the medical record on 8/9/18 showed a Wandering Risk Scale dated 8/8/18, Section A (Not Applicable) The resident is comatose, dependent on ADL and cannot move without assistance and/or stuporous-yes is selected. Section C. Mobility is left blank and E. History of Wandering is also left blank (no response selected) Comments/Notes section Resident is non ambulatory  An observation on 8/9/18 at 1:00 PM of showed resident sitting in a wheelchair in the day room with a visitor. Resident#23 was not in a comatose or stuporous state at the time of the observation.  During an interview with on 8/9/18 at 1:30 PM with Employee#4, who wrote that the resident has never been comatose or stopourous, the resident needs blood pressure monitoring and management.  Resident#23 admitted to the facility on [DATE], a review of medical or nursing notes lacked evidence Resident# 23 was comatose or stoporous.  Facility staff failed to maintain a record with an accurately documented resident Wandering Risk Assessment. During a face-to-face interview on 8/9/18 at 1:30 PM Employee# 4 acknowledged the finding.  **Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.**  Based on record review and staff interview, the facility failed to implement an appropriate plan of action to correctly identify potential quality issues related to an unwitnessed fall with subsequent death in the facility. The facility census was 34.  Findings included .  Review of record showed Resident #37 experienced an unwitnessed fall and subsequent death in the facility on (MONTH) 9, (YEAR).  Review of the facility Quality Assurance and Performance Improvement showed the facility identified falls and incidents as quality measures.  During interview on (MONTH) 14, (YEAR), Employee #1 stated falls are announced at Stand Up meetings with the details to include etiology of fall, care plan, rehab interventions, and determination of new fall interventions. When queried about  the unwitnessed fall with injury for Resident #37 and the implementation of the quality improvement process and interventions. Employee #1 stated we missed it.  During a telephonic interview on (MONTH) 14, (YEAR), at 10:22 AM, Employee #9 stated all incidents are reviewed weekly and at the quality meetings falls are reviewed. However, rarely do we review a specific case. Employee #9 further stated, In  this case, I am unsure which happened first, there were no major medical problems.  During the face to face interview on (MONTH) 14, (YEAR), Employee #1 acknowledged the findings. | | | |

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| F 0278  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Some  F 0279  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Few  F 0323  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Few | **Make sure each resident receives an accurate assessment by a qualified health professional.**  \*\*NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY\*\*  Based on observations, record review and staff interview of three (3) of 22 sampled residents, the facility staff failed to  accurately code the Minimum Data Set (MDS) as follows: 1.) the active [DIAGNOSES REDACTED].) the functional status for one  (1) resident (Residents #6, 37, and 48). The findings include:  1. The facility staff failed to code visual [DIAGNOSES REDACTED].   1. A review of the medical record for Resident# 6 revealed Resident was admitted to the facility on (MONTH) 3, 2014, with admitting [DIAGNOSES REDACTED].   A further review of the medical record revealed a Report of Consultation (Ophthalmology) form dated (MONTH) 7, (YEAR), findings 1. [MEDICATION NAME] Degeneration and 2. Dry Eyes, recommendations: 1. No treatment necessary 2. Artificial Tears 1 gtt (drop) both eyes, Lacri-lube ophthalmic ointment left eye only thin ribbon at night.  On (MONTH) 21, (YEAR), at approximately 2:45 PM, a review of the medical record Minimum Data Set Assessments dated (MONTH)  14, (YEAR), revealed the facility staff failed to code Section I (Active Diagnoses) under Section I (Additional Active Diagnoses) Resident #6 Visual Diagnosis.  The medical record lacked documented evidence the MDS coding reflects the Resident's visual diagnosis.  During a face-to-face interview with Employee# 15 on (MONTH) 21, (YEAR), at approximately 3:15 PM, the Employee acknowledged  the findings.   1. A review of the medical record for Resident# 48, revealed Resident was admitted to the facility on (MONTH) 11, (YEAR), with admitting [DIAGNOSES REDACTED].   A further medical record review reveals a Report of Consultation (Ophthalmology) form dated (MONTH) 7, (YEAR), findings [MEDICATION NAME] Degeneration possible wet OD (right eye) continue with [MEDICATION NAME], recommended to come to the  office for [NAME]T, patient will decide whether to proceed with possible treatment .  On (MONTH) 21, (YEAR), at approximately 2:45 PM a medical record review reveals Minimum Data Set Assessments dated (MONTH)  11, (YEAR). The assessment reveals the facility staff failed to code Section I (Active Diagnoses) under Section I (Additional Active Diagnoses) Resident# 48 Visual Diagnosis.  The medical record lacked documented evidence the MDS coding reflects the Resident's visual diagnosis.  During a face-to-face interview conducted with Employee# 15 on (MONTH) 21, (YEAR), at approximately 3:15 PM. Employee #15 acknowledged the findings.  2. The facility staff failed to accurately code the bed mobility on the MDS.  Medical record review of Resident #37 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED].  On (MONTH) 20, (YEAR), at approximately 10:00 AM, Resident #37 was observed actively participating in a range of motion ball toss game.  On (MONTH) 21, (YEAR), at 11:39 AM, a clinical record review showed Minimum Data Set (MDS) dated (MONTH) 24, (YEAR).  The  facility staff code Section G Functional Status subsections for bed mobility as limited assistance (resident highly  involved in activity, staff provide guided maneuvering of limbs or other non-weight-bearing assistance) on (MONTH) 24, (YEAR).  Review of the nursing assistant's Documentation Survey Report for (MONTH) 18- 24, (YEAR), which corresponds to the Assessment Reference Date (ARD) of (MONTH) 24, (YEAR), showed the Resident required extensive assistance to total dependence for five (5) of 19 documented[\*\*\*] for bed mobility.  The medical record lacked documented evidence the facility staff accurately coded bed mobility to reflect the resident's status during the assessment reference period.  During a face-to-face interview conducted with Employee# 15 on (MONTH) 21, (YEAR), at approximately 3:15 PM. Employee #15 acknowledged the findings.  **Develop a complete care plan that meets all of a resident's needs, with timetables and actions that can be measured.**  \*\*NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY\*\*  Based on record review, resident and staff interviews for one (1) of 22 Stage 2 sampled residents,the facility staff failed to develop a hospice care plan with goals and approaches to address the coordination of care and services for Resident's #52.  The findings include:  A review of the admission information in the clinical record on (MONTH) 22, (YEAR), at approximately 10:00 AM revealed that Resident #52 was admitted to the facility on (MONTH) 24, (YEAR), with [DIAGNOSES REDACTED].  The resident was also coded for Hospice Care under Section O of the Comprehensive MDS (Minimum Data Set) dated (MONTH) 1, (YEAR).  A review of the care plan dated (MONTH) 2, (YEAR), lacked evidence of collaborative goals and approaches to manage the prescribed hospice care for Resident #52.  During a face- to- face interview with Employee # 2 on (MONTH) 22, (YEAR), at 2:00 PM, the Employee acknowledged the findings after reviewing the clinical record.  **Make sure that the nursing home area is free from accident hazards and risks and provides supervision to prevent avoidable accidents**  Based on observations made on (MONTH) 20, (YEAR) at approximately 10:00 AM, the facility failed to maintain resident's environment free of accident hazards as evidenced by a portable heater that was in use in one (1) of 21 resident's rooms.  The findings include: | | | |

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

TITLE (X6) DATE

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 0323  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Few F 0329  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Few  F 0371  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Few  F 0456  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Few | (continued... from page 1)  A portable heater was plugged in and in use in resident room #140, one (1) of 21 resident's rooms surveyed. This observation made in the presence of Employees #11 and #12 was acknowledged.  **1) Make sure that each resident's drug regimen is free from unnecessary drugs; 2) Each resident's entire drug/medication is managed and monitored to achieve highest well being.**  \*\*NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY\*\*  Based on record review and interview of one (1) of 22 sampled residents, the facility staff failed to include indications for the use of Klonopin (treatment of [REDACTED].>The findings include:  A review of the history and physical revealed Resident # 53 was admitted to the facility on (MONTH) 30, 2014, with a [DIAGNOSES REDACTED].  The clinical record for Resident #35 revealed a physician's orders [REDACTED]. A review of the current physician's orders [REDACTED].  There was no evidence of indications for use on the physician order [REDACTED].>During a face-to-face interview with Employee #2 on (MONTH) 22, (YEAR), at 10:00 AM, the Employee acknowledged the findings.  **Store, cook, and serve food in a safe and clean way**  Based on observations made on (MONTH) 20, (YEAR) at approximately 8:30 AM, the facility failed to serve foods under sanitary conditions as evidenced by one (1) of one (1) food warmer, one (1) of one (1) convection oven, and one (1) of one (1) stove  that were soiled throughout and the kitchen floor soiled with debris. The findings include:   1. One (1) of one (1) food warmer, one (1) of one (1) convection oven, and one (1) of one (1) stove located in the main kitchen soiled. 2. The entire kitchen floor soiled with debris.   The observations made in the presence of Employee #13 were acknowledged.  **Keep all essential equipment working safely.**  Based on observations made on (MONTH) 20, (YEAR) between 8:30 AM and 9:45 AM, the facility failed to maintain essential equipment in good working condition as evidenced by one (1) of one (1) food warmer with no temperature control knob, one  (1) of one (1) tilt skillet which failed to power up when turned on, and one (1) of one (1) dishwashing machine which failed to reach 180 degrees Fahrenheit at final rinse.  The findings include:   1. The temperature control knob for one (1) of one (1) food warmer was missing. 2. One (1) of one (1) tilt skillet failed to power up when the 'on' switch was activated. 3. The dishwashing machine in the main kitchen failed to reach a final rinse temperature of 180 degrees Fahrenheit during several consecutive rinse cycles. The dishwashing machine located in the dining room of the Healthcare 1 Unit was used to clean and disinfect all dishes.   The observations made in the presence of Employee #13 and Employee #14 were acknowledged. | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER  / CLIA IDENNTIFICATION NUMBER  **095038** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING 2. WING | | (X3) DATE SURVEY COMPLETED  **07/01/2016** |
| NAME OF PROVIDER OF SUPPLIER  **FOREST HILLS OF DC** | | | STREET ADDRESS, CITY, STATE, ZIP  **4901 CONNECTICUT AVENUE, NW WASHINGTON, DC 20008** | |
| For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. | | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | | |
| F 0162 | **Limit the charges against the personal funds of a resident for items or services for which payment is made under Medicare or Medicaid.**  Based on record review, staff and family interview for one (1) of 20 sampled Stage 2 residents, it was determined that facility staff failed to ensure that one (1) resident ' s representative was given a list of services and a list of items  that the resident would and would not be charged for if his/her relative was a Medicaid Resident. Resident #36. The findings include:  A family interview was conducted on (MONTH) 28, (YEAR) at approximately 3:19 PM. A query was made regarding if the resident is on Medicaid, did the staff give him/her (or you) a list of services and items that you would and would not be charged  for. The family member responded No .  A review of the facilities Admissions Agreement package signed by the Responsible Party on (MONTH) 12, (YEAR) revealed on page 16, List of typical additional charges which are payable by resident either to the Methodist Home or directly to providers/vendors. However, the sheet did not contain the cost of the items listed on the sheet.  A face-to-face interview was conducted with Employee #11 on (MONTH) 1, (YEAR) at approximately 11:30 AM, who acknowledged  that during the admissions process, items that the resident would and would not be charged for were discussed, however there is not a list containing the cost of the items.  A face-to-face interview was conducted with Employee #12 on (MONTH) 1, (YEAR) at approximately 11:00 AM who acknowledged the  findings.  **Provide necessary care and services to maintain the highest well being of each resident**  \*\*NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY\*\*  Based on record review and staff interviews for three (3) of 20 sampled residents, it was determined that facility staff failed to: monitor blood pressure in accordance with physician's order [REDACTED]. Residents #17, 22 and 23  The findings include:   1. Facility staff failed to follow physician orders [REDACTED].#17 ' s left upper extremity. According to the history and physical examination [REDACTED].   physician's order [REDACTED]. Remove when out of bed. Check skin on left hand for any redness or irritation; Elevate left arm on pillow when in bed and OOB (out of bed) for [MEDICAL CONDITION].  Resident #17 was observed lying in bed on (MONTH) 29, (YEAR) at approximately 4:30 PM in the company of Employee ' s #5 and #13. There was no evidence that the cone hand splint was applied and the left hand/arm was not elevated on pillows.  Employee #13 stated, he/she was not aware that the resident required a cone or elevation of the left arm. Employee #5 was unsuccessful in locating the cone for the resident.  Facility staff failed to follow physician's orders [REDACTED].#17.   1. Facility staff failed to monitor Resident #22 ' s blood pressure in accordance to physician's order [REDACTED]. According to the facility ' s policy Protocol for Blood Pressure Monitoring, revised date: 04/30/15 stipulates, II. Policy Implementation: A. Monitoring Protocol for Hypertensive Residents- 2. If the resident ' s systolic blood pressure is   greater than 160mmHg (millimeters of Mercury) or less than 100mmHg and the diastolic blood pressure is greater than 100mmHg or less than 60mmHg the reading will be considered abnormal. The resident must be monitored and two additional reading obtained at intervals not longer than 2 hours apart .3. The resident ' s physician will be notified if the blood pressure  is abnormal for three (3) consecutive readings .  The physician's orders [REDACTED]. Notify M.D. (Medical Doctor) if SBP (Systolic Blood Pressure) > (greater than) 160 or < (less than) 100mmHg or DBP (Diastolic Blood Pressure) (greater than) 100 or (less than) 60mmHg (times) 3 (three) consecutive readings . The (MONTH) (YEAR) MAR (Medication Administration Record) revealed Resident #22 ' s blood pressure on (MONTH) 21, (YEAR) at  10 AM was 164/78 and on (MONTH) 28, (YEAR) at 10:00AM it was 174/70.  A review of the nurses notes for (MONTH) 21, (YEAR) and (MONTH) 28, (YEAR) lacked documented evidence of three consecutive  blood pressure readings to determine the effectiveness of the blood pressure medications based on the parameters defined by the physician.  A face-to-face interview was conducted with Employees # 3 and #7 on (MONTH) 30, (YEAR) at approximately 2:00 PM regarding the aforementioned findings. Both acknowledged that consecutive blood pressure readings were not obtained. The clinical  record was reviewed on (MONTH) 30, (YEAR).  3. Facility staff failed to consistently conduct evaluation and reassessment of pain to include the intensity of pain for Resident #23.  According to the facility ' s policy Pain Assessment and Management, revised dated 6/1/16 stipulates, 1. Perform a pain assessment using the assessment form that is part of the protocol 2. Review the resident ' s current pain medication regiment to determine the following: 2 C. degree of relief experienced from this medication The Pain Management Risk Assessment Tool revealed Pain Intensity: 0- No pain; 1- Mild (1-3 self-report on scale of 10), 2 Moderate (4-6 self-report on scale of 10), 3-Severe (7-10 self-report on scale of 10) .  A review of the physician's order [REDACTED].  A review of the (MONTH) (YEAR) through (MONTH) (YEAR) MAR (Medication Administration Record) revealed that Resident #23  received Extra Strength Tylenol- 2 tablets on the following dates for body pain:  March 4, (YEAR) - 12AM - result: effective March 13, (YEAR)- 1:30 PM- result: helpful March 31, (YEAR)- 1:00 PM- result: effective March 16, (YEAR)- 1:10 AM - result: effective April 2, (YEAR)- 2:00AM- result: effective April 19, (YEAR)- 1:00 PM - result: helpful May 15, (YEAR) - 1:30 PM- result: effective  There was no evidence that facility staff consistently conducted an assessment that included a description of the intensity of the pain (e.g. numeric scale) before and after the administration of Extra Strength Tylenol for Resident #23.  A face-to-face interview was conducted with Employees # 3 and #7 on (MONTH) 30, (YEAR) at approximately 2:30 PM. Both acknowledged the aforementioned findings. The clinical record was reviewed on (MONTH) 30, (YEAR).  **Give residents proper treatment to prevent new bed (pressure) sores or heal existing bed sores.** | | | |
| **Level of harm -** Minimal harm or potential for actual harm |
| **Residents Affected -** Few |
| F 0309 |
| **Level of harm -** Minimal harm or potential for actual harm |
| **Residents Affected -** Few |
| F 0314 |
| **Level of harm -** Actual harm |
| **Residents Affected -** Few |

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

TITLE (X6) DATE

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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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER  / CLIA IDENNTIFICATION NUMBER  **095038** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING 2. WING | | (X3) DATE SURVEY COMPLETED  **07/01/2016** |
| NAME OF PROVIDER OF SUPPLIER  **FOREST HILLS OF DC** | | | STREET ADDRESS, CITY, STATE, ZIP  **4901 CONNECTICUT AVENUE, NW WASHINGTON, DC 20008** | |
| For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. | | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | | |
| F 0314  **Level of harm -** Actual harm  **Residents Affected -** Few  F 0371  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Few | (continued... from page 1)  \*\*NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY\*\*  Based on record review and staff interview for one (1) of 20 Stage 2 sampled residents, it was determined that facility staff failed to consistently assess and monitor Resident #17 ' s right heel to ensure that necessary treatment and services were provided. Subsequently, the resident developed an Unstageable Pressure Ulcer that was initially identified at an advanced stage. Resident #17.  The findings include:  Policy:  Skin Impairment, Effective Date (MONTH) 13, 2010, Revisions: (MONTH) 16, (YEAR) stipulated: Policy Statement: All residents will be assessed upon admission and then routinely for skin impairment. Skin impairment includes, but not restricted to:  Skin tears, Pressure Ulcers, Vascular Ulcers .  Policy Interpretation and Implementation: 1. Prevention (b) For those residents who are at Risk (a score of 18 or below) the following intervention will be instituted: (2) Resident will be turned and repositioned every 2 hours while in bed . (5) heels will be kept off mattress, (6) Skin will be moisturized at least twice a day . (7) Incontinent residents must have pericare with skin barrier at least once per shift. Licensed staff will assess skin and document weekly  The history and physical examination [REDACTED].  According to the quarterly Minimum Data Set (MDS) dated (MONTH) 3, (YEAR), Resident #17 was coded in Section C (Cognitive Patterns) as severely impaired; Section G0110 and G0120 (Functional Status) the resident was coded as totally dependent,  requiring assistance of one or two people for bed mobility, transfer, dressing, personal hygiene, bathing and wheelchair dependent for mobilization; Section H0300 (Urinary Continence) revealed resident was always incontinent. Section M (Skin Condition), the resident was coded as being at risk for developing pressure ulcers. In Section M 0210 (Current Number of Unhealed Pressure Ulcers) the resident was coded as 0 indicating that the resident did not have any unhealed pressure ulcer.  A review of the subsequent, Significant Change MDS dated (MONTH) 3, (YEAR) revealed under Section M, Skin Conditions, Resident #17 was coded as having one (1) Unstageable pressure ulcer.  The Pressure Ulcer care plan updated (MONTH) 9, (YEAR) revealed Goal: Resident will remain free of skin breakdown through next review; Approach: . Air alternating pad on mattress, Body/skin audit at least biweekly on bath days, Braden Scale assessment quarterly and PRN (as needed), Assess all skin during AM/PM care and prn, notify nurse/MD for any open or discolored areas  A review of the clinical record revealed the facility ' s Pressure Ulcer Risk Assessment tool combined with the Braden Scale  - For Predicting Pressure Sore Risk (a tool utilized by health professionals, especially nurses to assess a patient's risk  of developing a pressure ulcer) signed and dated by the Registered Nurse on (MONTH) 24, (YEAR), revealed Resident #17 was assessed as High Risk for pressure ulcer development.  A review of the Dietary Progress Notes dated (MONTH) 2, (YEAR) revealed that Resident #17 ' s skin integrity was intact and that the resident was at risk for pressure ulcer(s) (secondary) to immobility.  A review of nurse ' s notes revealed the following:  (MONTH) 20, (YEAR) -11:00 PM- Turned and repositioned q 2 (every 2 hours) as as needed .  March 21, (YEAR)- 6:52 AM- . skin warm and dry to touch. ADL (Activities of daily living) provided, turned and positioned as needed .  March 21, (YEAR)- 3:35 PM- . Turning and positioning per protocol. No skin breakdown noted. Skin warm and intact . March 21, (YEAR)- 11:18 PM- . incontinent care done .  March 22, (YEAR)- 7AM- . Turned and repositioned (every) 2 hours, also other needed ADL ' s and nursing care were attended to .  March 22, (YEAR)- 11:20 PM- . incontinent care done . March 23, (YEAR)- 7:02 AM- . incontinent care done . March 23, (YEAR)- 11:00 PM- . incontinent care done .  The clinical record lacked evidence of nurse ' s progress notes for the period of (MONTH) 23, (YEAR) through (MONTH) 27, (YEAR).  March 28, (YEAR) 7:30 AM nurse ' s entry: CNA (Certified Nursing Assistant) reported black area noted on the right heel during care. On assessment area noted with grayish black discoloration with intact skin measuring 2.3cm (centimeters) x (by) 1.8 cm. Surrounding area noted with redness. No facial expression of pain noted on palpitation to the area and no warmness noted on the area. MD (Medical Doctor) updated, order in place to apply skin prep to the area twice daily, and float the heel with Prevalon boot (pressure relieving heel protector) on while in bed. Order in place to turn and  reposition resident every two (2) hours. Resident remains alert and oriented to self. No change or deviation from (his/her) baseline noted .skin prep applied to right heel as ordered.  The clinical record lacked evidence that facility staff conducted body/skin assessments ' at least ' biweekly in accordance to the care plan. Through staff interview, it was determined that nursing staff were to utilize the facility ' s Weekly  Skin Checklist form to record weekly skin assessments that were usually conducted on shower days. However, there was no evidence in Resident #17 ' s clinical records that Weekly Skin Checklist forms were completed.  A review of the Pressure Ulcer Record revealed nursing staff recorded the following characteristics of the resident ' s right heel ulcer:  Date First Observed: (MONTH) 28, (YEAR), Stage: SDTI (Suspected Deep Tissue Injury), Color: grayish/black, Size: 2.3 cm x  1.8 cm, Granulation: No, Drainage: No, Odor: No .  A face-to-face interview was conducted with Employee #5 on (MONTH) 29, (YEAR) at approximately 3:00 PM. A query was made regarding the skin impairment of the resident ' s right heel. He/she stated the wound was first found unstageable then once  the scab came off, it was assessed as a Stage III pressure ulcer. The employee further stated, the resident ' s shower days were Mondays and Thursdays.  A telephone interview was conducted on (MONTH) 1, (YEAR) with Employee #13 at approximately 4:15 PM. Employee #13 indicated  that he/she works with the resident on the 7:00 AM to 3:00 PM shift and the day he/she saw the wound on the right heel (March 28, (YEAR)) was the day he/she reported it. Employee #13 also reported that the right heel was not open, it was dark and was getting to be black.  A telephone interview was conducted on (MONTH) 1, (YEAR) with Employee #14 at approximately 4:30 PM. Employee #14 indicated  that he/she works the evening shift from 3:00 PM to 11:00 PM and agreed that he/she was assigned to Resident #17 the  evening of (MONTH) 27, (YEAR). Employee #14 stated on our shift we put the resident to bed .we remove any clothes and wash the stockings for the morning. In response to a query regarding whether or not the resident was observed with any  abnormality in the skin of the right heel, he/she stated that no discoloration or abnormality was observed. The employee could not recall if the resident ' s heels were floated on pillows.  A face-to-face interview was conducted with Employee #1 on (MONTH) 1, (YEAR) at approximately 3:00 PM. who stated there are no shower/skin sheets (Weekly Skin Checklist) for the resident.  Resident #17 was assessed with [REDACTED]. The resident was assessed as high risk for developing skin impairment according to the Braden Scale. There was no evidence that facility staff consistently assessed and/or monitored the resident ' s skin  and subsequently, he/she was assessed with [REDACTED].  A face-to- face interview was conducted with the Employees #1 #2 and #3 on (MONTH) 1, (YEAR) at approximately 5:00 PM. After review of the clinical record, all acknowledged the aforementioned findings. The clinical record was reviewed on (MONTH) 1, (YEAR).  **Store, cook, and serve food in a safe and clean way**  Based on observations made on (MONTH) 27, (YEAR) at approximately 9:05 AM it was determined that the facility failed to store foods under sanitary conditions as evidenced by two (2) of two (2) soiled food warmers in the main kitchen.  The findings include:  Two (2) of two (2) food warmers located in the main kitchen were soiled at the bottom.  These observations were made in the presence of Employee #9 who acknowledged the findings. | | | |

FORM CMS-2567(02-99)

Previous Versions Obsolete

Event ID: YL1O11 Facility ID: 095038 If continuation sheet Page 2 of 3

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER  / CLIA IDENNTIFICATION NUMBER  **095038** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING 2. WING | | (X3) DATE SURVEY COMPLETED  **07/01/2016** |
| NAME OF PROVIDER OF SUPPLIER  **FOREST HILLS OF DC** | | | STREET ADDRESS, CITY, STATE, ZIP  **4901 CONNECTICUT AVENUE, NW WASHINGTON, DC 20008** | |
| For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. | | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | | |
| F 0371 (  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Few F 0456  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Many  F 0514  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Few | continued... from page 2)  **Keep all essential equipment working safely.**  Based on observations made on (MONTH) 27, (YEAR) at approximately 9:05 AM it was determined that the facility failed to maintain essential equipment in good working condition as evidenced by one (1) of one (1) dishwashing machine that failed to reach a minimum of 180 degrees Fahrenheit during five (5) consecutive final rinse cycles and a broken temperature gauge in one (1) of two (2) food warmers.  The findings include:   1. The dishwashing machine failed to reach a minimum final rinse temperature of 180 degrees Fahrenheit in five (5) of five (5) consecutive wash cycles. 2. The built-in temperature gauge to one (1) of two (2) food warmers was stuck and needed to be replaced.   These observations were made in the presence of Employee #9 who acknowledged the findings.  **Keep accurate, complete and organized clinical records on each resident that meet professional standards**  Based on record review and staff interview for one (1) of five (5) sampled residents who received Hospice services, it was determined that facility staff failed to maintain an accurate clinical record as evidenced by the lack of complete documentation related to the provision of Hospice care and services. Resident #52.  The findings include:  Resident #52 was admitted to Hospice Care on (MONTH) 28, (YEAR). A face-to-face interview was conducted with Employee #5 at approximately 2:30PM on (MONTH) 30, (YEAR). During the interview the employee was queried regarding the frequency of visits by the Hospice Nursing staff. The employee responded, Nursing Assistants visit several times each week (three to four days  per week) and the nurse visits at least once a week; sometimes twice.  A review of the Hospice section of the clinical record revealed that the documentation did not reflect weekly visits by the  Hospice Nurse. Review of documentation for the month of (MONTH) revealed Hospice Nurse's notes dated (MONTH) 06, (YEAR) and  (MONTH) 16, (YEAR). Review of the notes for (MONTH) revealed documentation for (MONTH) 6, (MONTH) 10 and (MONTH)  13. There  was no note for the week of (MONTH) 01, (MONTH) 20, and/or (MONTH) 27, (YEAR).  A face-to-face interview was conducted with Employee #11 (Hospice nurse) at approximately 10:30AM on (MONTH) 1, (YEAR). I visit at least once a week; sometimes twice and more often if needed. I always write a summary of my visit and place a copy  on the chart before I leave. I usually keep a copy for myself. I can show you my copy. The employee opened his/her bag and displayed copies of Hospice Nursing Notes that were dated (MONTH) 20 and (MONTH) 27, (YEAR). The employee concluded, I don't know what happened to the notes but I left them in the chart.  Another face-to-face interview was conducted with Employees #1, 2 and 3 at approximately 12:00 PM on (MONTH) 1, (YEAR). The employees acknowledged that the resident ' s clinical record lacked complete documentation of the provision of Hospice care  and services. The record was reviewed on (MONTH) 30, (YEAR). | | | |

### GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH

\* \* \*

### HEALTH REGULATION ADMINISTRATION

###### HEALTH CARE FACILITIES DIVISION PHONE:202-442-4737

FAX:202-442-9431

MS SANDY DOUGLASS METHODIST HOME OF DC 4901 CONNECTICUT AVE NW WASHINGTON DC 20008

Dear MS SANDY DOUGLASS

MAILING ADDRESS

899 NORTH CAPITOL ST, NE FIRST FLOOR WASHINGTON DC 20002

JUL 9 2014

Enclosed is your Certificate of Licensure for August 7, 2014 through August 6, 2015 . The staff of the Department of Health, Health Regulation Administration may visit your facility at a future date to determine continued compliance with both District and Federal laws.

If you have any questions, please cont.act me on 202-442-4737.

Sincerely,



Sharon Lewis Program Manager

Enclosure(s)

**GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH**

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**HEALTH REGULATION ADMINISTRATION**

### HEALTH CARE FACILITIES DIVISION

**Certificate of Licensure**

#### Pursuant to Title II, Section 1, of the D.C. Health Care Facilities Regulation, Licensure is Granted to:

METHODIST HOME OF DC

To Maintain and Operate A Health Care Facility which is located at:

Located at: 4901 CONNECTICUT AVE NW, WASHINGTON, D.C.

as a

### Nursing Facility

#### with an authorized total capacity of 50 beds for the period of 08/07/2014 through 08/06/2015 with the beds in the following categorie s:

|  |  |
| --- | --- |
| Skilled: | 0 |
| Nursing: | 0 |
| Dual: | 50 |

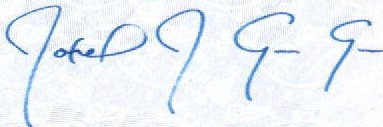
**License Number: HFD02-0004**

**Dr. Joxel Garcia Director**

### Date

JUL 9 2014

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This license is required to be framed under clear glass or plastic and posted in a co11s p ic uous place in the main lobby or administrative office of the licensed premises. It

**O 'f&l4** for the licensee(s) and premises named above, and only for the period specified and is not transferable.

###### This Facility has affirmed its compliance with Title VI of the Civil Rights Act of 1964.

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  **095038** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING 2. WING | | | (X3) DATE SURVEY  COMPLETED  **09/22/2017** | |
| NAME OF PROVIDER OR SUPPLIER  **FOREST HILLS OF DC** | | | | STREET ADDRESS, CITY, STATE, ZIP CODE  **4901 CONNECTICUT AVENUE, NW**  **WASHINGTON, DC 20008** | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | (X5) COMPLETION DATE |
| F 000 | INITIAL COMMENTS  An unannounced Quality Indicator Recertification Survey was conducted at Forest Hills of DC from September 20, 2017 through September 22, 2017. Survey activities consisted of a review of 19 residents' clinical records during Stage 1 and a review of 22 clinical records during Stage 2.  The following deficiencies are based on facility observations of staff practices; review of the facility's operating procedures and interviews with residents, families, and facility staff. After analysis of the findings, it was determined that the facility was not in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities.  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  cc - cubic centimeters  cm - Centimeters  CMS - Centers for Medicare and Medicaid Services  CNA- Certified Nurse Aide  D.C. - District of Columbia  DCMR- District of Columbia Municipal Regulations  D/C Discontinue | | F 000 | |  | |  |

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

# Mary Savoy

Administrator October 21, 2017

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.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: LG8411

Facility ID: METHODIST If continuation sheet Page 1 of 14

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  **095038** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING 2. WING | | | (X3) DATE SURVEY  COMPLETED  **09/22/2017** | |
| NAME OF PROVIDER OR SUPPLIER  **FOREST HILLS OF DC** | | | | STREET ADDRESS, CITY, STATE, ZIP CODE  **4901 CONNECTICUT AVENUE, NW**  **WASHINGTON, DC 20008** | | | |
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| F 000  F 278  SS=E | Continued From page 1  EMS - Emergency Medical Services (911) G-tube Gastrostomy tube  HVAC - Heating ventilation/Air conditioning ID - Intellectual disability  IDT - interdisciplinary team L - Liter  Lbs - Pounds (unit of mass)  LE- Lower Extremity  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 Neuro - Neurological  NP - Nurse Practitioner  O2- Oxygen  PASRR - Preadmission screen and Resident Review  PO- by mouth  PO2- Pulse oximetry  POS - physician ' s order sheet  Prn - As needed  Pt - Patient  Q- Every  QIS - Quality Indicator Survey Rp, R/P- Responsible party  Sol- Solution  S/P- Status Post  TAR - Treatment Administration Record Tx- Treatment  UE- Upper Extremity  483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED  (g) Accuracy of Assessments. The assessment | | F 000  F 278 | |  | |  |

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| F 278 | Continued From page 2  must accurately reflect the resident’s status.   1. Coordination   A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.   1. Certification 2. A registered nurse must sign and certify that the assessment is completed. 3. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.   (j) Penalty for Falsification   1. Under Medicare and Medicaid, an individual who willfully and knowingly-    1. Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or    2. Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than   $5,000 for each assessment.  (2) Clinical disagreement does not constitute a material and false statement.  This REQUIREMENT is not met as evidenced by:  Based on observations, record review and staff interview of three (3) of 22 sampled residents, the facility staff failed to accurately code the Minimum Data Set (MDS) as follows: 1.) the active diagnoses for two (2) residents with visual | | F 278 | | **F 278 – Failure to Accurately Code MDS:**  **A. Three Residents With Vision Diagnoses**   1. **Corrective Action for Deficient Practice:** MDS coding errors were corrected for three residents involved. 2. **Other Residents Potentially Affected by Deficient Practice:** External consultant has been contracted to complete retrospective audits of MDSs to determine if additional coding errors exist. Corrections will be made as necessary. 3. **Systemic Changes to Ensure Deficient Practice Does Not Recur:** 4. DON to complete weekly validation audits of MDS coding using EHR software; 5. MDS Coordinator in-serviced on methodology for validating MDS codes prior to submission; 6. policy updated to incorporate changes; 7. semi-annual review of MDSs by external consultants   **4. Performance Monitoring to Ensure Sustainability:** Audit results to be reported to QAPI quarterly. | | 10/23/17  10/23/17  10/23/17  10/26/17 |

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| F 278 | Continued From page 3  diagnoses, and 2.) the functional status for one (1) resident (Residents #6, 37, and 48).  The findings include:   1. The facility staff failed to code visual diagnosis on the MDS.   A. A review of the medical record for Resident# 6 revealed Resident was admitted to the facility on November 3, 2014, with admitting diagnoses of Essential (Primary) Hypertension, Muscle Weakness, Neuropathy, and Osteoarthritis.  A further review of the medical record revealed a Report of Consultation [Ophthalmology] form dated March 7, 2017, findings "1. Macular Degeneration and 2. Dry Eyes, recommendations: 1. No treatment necessary 2. Artificial Tears 1 gtt (drop) both eyes, Lacri-lube ophthalmic ointment left eye only thin ribbon at night".  On September 21, 2017, at approximately 2:45 PM, a review of the medical record Minimum Data Set Assessments dated June 14, 2017, revealed the facility staff failed to code Section I [Active Diagnoses] under Section I18000 [Additional Active Diagnoses] Resident #6 Visual Diagnosis.  The medical record lacked documented evidence the MDS coding reflects the Resident's visual diagnosis.  During a face-to-face interview with Employee# 15 on September 21, 2017, at approximately 3:15 PM, the Employee acknowledged the findings. | | F 278 | |  | |  |

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| F 278 | Continued From page 4  B. A review of the medical record for Resident# 48, revealed Resident was admitted to the facility on January 11, 2016, with admitting diagnoses of Chronic Obstructive Pulmonary Disease with (acute) exacerbation, Heart Failure, Pleural Effusion, and Hyperlipidemia.  A further medical record review reveals a Report of Consultation [Ophthalmology] form dated August 7, 2017, findings "Macular Degeneration possible wet OD (right eye) continue with Ocuvite, recommended to come to the office for OCT, patient will decide whether to proceed with possible treatment..."  On September 21, 2017, at approximately 2:45 PM a medical record review reveals Minimum Data Set Assessments dated July 11, 2017. The assessment reveals the facility staff failed to code Section I [Active Diagnoses] under Section I18000 [Additional Active Diagnoses] Resident# 48 Visual Diagnosis.  The medical record lacked documented evidence the MDS coding reflects the Resident's visual diagnosis.  During a face-to-face interview conducted with Employee# 15 on September 21, 2017, at  approximately 3:15 PM. Employee #15 acknowledged the findings.  2. The facility staff failed to accurately code the bed mobility on the MDS.  Medical record review of Resident #37 was admitted to the facility on 1/19/17 with diagnoses to include Dementia, Hyperlipidemia, Essential | | F 278 | | **F 278 – Failure to Accurately Code MDS:**  **B. Resident’s Bed Mobility**   1. **Corrective Action for Deficient Practice:** MDS coding error was corrected for resident involved. 2. **Other Residents Potentially Affected by Deficient Practice:** External consultant has been contracted to complete retrospective audits of MDSs to determine if additional coding errors exist. Corrections will be made as necessary. 3. **Systemic Changes to Ensure Deficient Practice Does Not Recur:** 4. Form used to monitor residents during ARD assessment period (which includes functional status) will be modified to require signatures of both the MDS nurse and the rehab director to ensure consistency in assessments. 5. Administrator, DON, MDS Coordinator, and rehab director will participate in monthly Triple Check meetings to avoid coding errors prior to MDS submissions. Errors identified will be corrected contemporaneously at the meetings. 6. DON will generate monthly findings from Triple Check meetings to monitor frequency and type of errors identified. 7. semi-annual reviews of MDSs by external consultants.   **4. Performance Monitoring to Ensure Sustainability:** Audit results to be reported to QAPI quarterly. | | 10/23/17  10/23/17  10/23/17  10/26/17 |

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| F 278  F 279  SS=D | Continued From page 5  Hypertension, Chronic Atrial Fibrillation, and Cerebral Infarct.  On September 20, 2017, at approximately 10:00 AM, Resident #37 was observed actively participating in a range of motion ball toss game.  On September 21, 2017, at 11:39 AM, a clinical record review showed Minimum Data Set (MDS) dated April 24, 2017. The facility staff code Section G Functional Status subsections for bed mobility as limited assistance (resident highly involved in activity, staff provide guided maneuvering of limbs or other non-weight-bearing assistance) on April 24, 2017.  Review of the nursing assistant's "Documentation Survey Report" for April 18- 24, 2017, which corresponds to the Assessment Reference Date (ARD) of April 24, 2017, showed the Resident required extensive assistance to total dependence for five (5) of 19 documented shits for bed mobility.  The medical record lacked documented evidence the facility staff accurately coded bed mobility to reflect the resident's status during the assessment reference period.  During a face-to-face interview conducted with Employee# 15 on September 21, 2017, at  approximately 3:15 PM. Employee #15 acknowledged the findings.  483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS | | F 278  F 279 | |  | |  |

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| F 279 | Continued From page 6 483.20  (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident’s active record and use the results of the assessments to develop, review and revise the resident’s comprehensive care plan.  483.21  (b) Comprehensive Care Plans   1. The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -    1. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and   1.   * 1. Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).   2. Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the | | F 279 | | **F 279 – Failure to develop a hospice care plan with goals and approaches to address the coordination of the resident’s care and services.**   1. **Corrective Action for Deficient Practice:** Hospice nurse was in-serviced by hospice administrator on how to clearly identify and develop a plan of care with the LTC team. Plan must contain common palliative interventions & palliative outcomes. 2. **Other Residents Potentially Affected by Deficient Practice:** Facility staff met with the contracted hospice provider and reviewed the current care plan integration process for all hospice residents to ensure that collaboration was addressed. An audit of all hospice records was conducted by the facility and shared with the contracted hospice provider. 3. **Systemic Changes to Ensure Deficient Practice Does Not Recur:** a) Facility staff and hospice staff will receive in-service training regarding communication processes and care plan integration that includes timely documentation of interventions (i.e., immediately after hospice visit and/or care plan participation). All documentation by hospice staff will be given to the MDS Coordinator immediately to scan into the EHR. 4. Monthly compliance audits of hospice records will be completed by both hospice and facility personnel to ensure compliance. Any deficiencies will be identified and corrected on the spot. 5. Hospice general manager will participate in quarterly QAPI meetings.   **Performance Monitoring to Ensure Sustainability:** Audit results will be reported quarterly to QAPI Committee. | | 10/2/17  10/9/17  10/9/17  10/15/17  10/26/17 |

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| F 279 | Continued From page 7  findings of the PASARR, it must indicate its rationale in the resident’s medical record.   1. In consultation with the resident and the resident’s representative (s)-    1. The resident’s goals for admission and desired outcomes.    2. The resident’s preference and potential for future discharge. Facilities must document whether the resident’s desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.    3. Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.   This REQUIREMENT is not met as evidenced by:  Based on record review, resident and staff interviews for one (1) of 22 Stage 2 sampled residents,the facility staff failed to develop a hospice care plan with goals and approaches to address the coordination of care and services for Resident's #52.  The findings include:  A review of the admission information in the clinical record on September 22, 2017, at approximately 10:00 AM revealed that Resident #52 was admitted to the facility on January 24, | | F 279 | |  | |  |

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| F 279  F 323  SS=D | Continued From page 8  2017, with diagnoses which included Alzheimer's Disease and Hypertension,  The resident was also coded for Hospice Care under Section O of the Comprehensive MDS (Minimum Data Set) dated February 1, 2017.  A review of the care plan dated August 2, 2017, lacked evidence of collaborative goals and approaches to manage the prescribed hospice care for Resident #52.  During a face- to- face interview with Employee # 2 on September 22, 2017, at 2:00 PM he/she acknowledged the findings after reviewing the clinical record.  483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  (d) Accidents.  The facility must ensure that -   1. The resident environment remains as free from accident hazards as is possible; and 2. Each resident receives adequate supervision and assistance devices to prevent accidents. 3. - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.    1. Assess the resident for risk of entrapment from bed rails prior to installation. | | F 279  F 323 | | **F 323 – Portable Heater in Resident’s Room**   1. **Corrective Action for Deficient Practice:**   heater was immediately removed from room.   1. **Residents Affected by Deficient Practice:**   No resident was affected by deficient practice.   1. **Systemic Changes to Ensure Deficient Practice Does Not Recur:** 2. Safety Rounds Checklist has been updated to include observation for portable heaters and other equipment in resident rooms that may pose safety hazards. . 3. Education was provided to all private duty caregivers regarding equipment safety and other safety measures to be maintained while caring for a resident. Emphasis included use of portable heaters.   **4. Performance Monitoring to Ensure Sustainability:** Results of bi-weekly safety rounds will be reported quarterly to QAPI | | 9/20/17  9/20/17  9/27/17  10/26/17 |

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| F 323  F 329 | Continued From page 9   1. Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. 2. Ensure that the bed’s dimensions are appropriate for the resident’s size and weight.   This REQUIREMENT is not met as evidenced by:  Based on observations made on September 20, 2017 at approximately 10:00 AM, the facility failed to maintain resident's environment free of accident hazards as evidenced by a portable heater that was in use in one (1) of 21 resident's rooms.  The findings include:  A portable heater was plugged in and in use in resident room #140, one (1) of 21 resident's rooms surveyed.  This observation made in the presence of Employees #11 and #12 was acknowledged.  483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS  483.45(d) Unnecessary Drugs-General.  Each resident’s drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used--   1. In excessive dose (including duplicate drug therapy); or 2. For excessive duration; or 3. Without adequate monitoring; or | | F 323  F 329 | |  | |  |

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| F 329 | Continued From page 10   1. Without adequate indications for its use; or 2. In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or 3. Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.   483.45(e) Psychotropic Drugs.  Based on a comprehensive assessment of a resident, the facility must ensure that--   1. Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; 2. Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;   This REQUIREMENT is not met as evidenced by:  Based on record review and interview of one (1) of 22 sampled residents, the facility staff failed to include indications for the use of Klonopin (treatment of anti-anxiety) on the POS (physician order form) for Resident # 35.  The findings include:  A review of the history and physical revealed | | F 329 | | **F 329 – Failure to include indications for the use of Klonopin (treatment of anti-anxiety) on the Physician Order Sheet**   1. **Corrective Action for Deficient Practice:** clarification order for medication in question was immediately obtained. 2. **Residents Affected by Deficient Practice:** Chat audits were conducted to identify other residents who may have experienced deficient practice. Based on audit, no other resident was affected. 3. **Systemic Changes to Ensure Deficient Practice Does Not Recur:** 4. Nurses were trained on policy which requires indication for use for each medication ordered. 5. Charge nurses are required to conduct chart checks daily. 6. Supervisors audit physician orders monthly to ensure indication for each medication is included as part of the order.   **4. Performance Monitoring to Ensure Sustainability:** Results of nursing audits will be reported quarterly to QAPI Committee. | | 9/25/17  9/25/17  9/27/17  10/26/17 |

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| F 329  F 371 | Continued From page 11  Resident # 53 was admitted to the facility on April 30, 2014, with a diagnosis which included Depression and Hypertension.  The clinical record for Resident #35 revealed a physician's order originated April 5, 2017, directed "Klonopin 0.25mg by mouth 2 times a day for anxiety".  A review of the current physician's orders signed September 12, 2017, stated: "Klonopin 0.25mg by mouth 2 times a day".  There was no evidence of indications for use on the physician order form.  During a face-to-face interview with Employee #2 on September 22, 2017, at 10:00 AM, the Employee acknowledged the findings.  483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY  (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.   1. This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. 2. This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. | | F 329  F 371 | |  | |  |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  **095038** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING 2. WING | | | (X3) DATE SURVEY  COMPLETED  **09/22/2017** | |
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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  **F371 – Unsanitary Conditions**  **A. Soiled Equipment**   1. **Corrective Action for Deficient Practice:** Equipment was cleaned thoroughly on September 21, 2017. 2. **Residents Affected by Deficient Practice:** There has been no indication to date that residents were affected by the deficient practice. 3. **Systemic Changes to Ensure Deficient Practice Does Not Recur:** 4. All Production and Utility staff were trained on the proper cleaning of equipment. 5. The Master cleaning schedule was revised to increase weekly cleanings to bi-weekly for all kitchen equipment.   4. **Performance Monitoring to Ensure Sustainability:** The Executive Chef will monitor compliance with the schedule and report findings quarterly to the QAPI Committee.  **B. Soiled Floor**   1. **Corrective Action for Deficient Practice:** Entire kitchen floor was deck scrubbed immediately. 2. **Residents Affected by Deficient Practice.**   No resident was affected by deficient practice.   1. **Systemic Changes to Ensure Deficient Practice Does Not Recur**.   Floor cleaning policy was reviewed with all utility staff. Assignment sheet was revised to include name of employee responsible for sweeping & mopping floor each shift to ensure accountability.   1. **Performance Monitoring to Ensure Sustainability**   The Dining Services Manager on duty will monitor the cleanness of the floor daily by checking out each utility person after the shift. Findings will be reported to the Director of Dining services weekly and reported at the Quarterly QAPI meeting. | | (X5) COMPLETION DATE  9/21/17  9/21/17  9/29/17  10/26/17  9/21/17  9/21/17  9/23/17  10/26/17 |
| F 371 | Continued From page 12 | | F 371 | |
|  | (iii) This provision does not preclude residents from | |  | |
|  | consuming foods not procured by the facility. | |  | |
|  | (i)(2) - Store, prepare, distribute and serve food in | |  | |
|  | accordance with professional standards for food | |  | |
|  | service safety. | |  | |
|  | (i)(3) Have a policy regarding use and storage of | |  | |
|  | foods brought to residents by family and other | |  | |
|  | visitors to ensure safe and sanitary storage, | |  | |
|  | handling, and consumption. | |  | |
|  | This REQUIREMENT is not met as evidenced by: | |  | |
|  | Based on observations made on September 20, | |  | |
|  | 2017 at approximately 8:30 AM, the facility failed | |  | |
|  | to serve foods under sanitary conditions as | |  | |
|  | evidenced by one (1) of one (1) food warmer, one | |  | |
|  | (1) of one (1) convection oven, and one (1) of one | |  | |
|  | (1) stove that were soiled throughout and the | |  | |
|  | kitchen floor soiled with debris. | |  | |
|  | The findings include: | |  | |
|  | 1. One (1) of one (1) food warmer, one (1) of one | |  | |
|  | (1) convection oven, and one (1) of one (1) stove | |  | |
|  | located in the main kitchen soiled. | |  | |
|  | 2. The entire kitchen floor soiled with debris. | |  | |
|  | The observations made in the presence of | |  | |
|  | Employee #13 were acknowledged. | |  | |
| F 456 | 483.90(d)(2)(e) ESSENTIAL EQUIPMENT, SAFE | | F 456 | |
| SS=D | OPERATING CONDITION | |  | |
|  | (d)(2) Maintain all mechanical, electrical, and patient | |  | |
|  | care equipment in safe operating condition. | |  | |

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| NAME OF PROVIDER OR SUPPLIER  **FOREST HILLS OF DC** | | | | STREET ADDRESS, CITY, STATE, ZIP CODE  **4901 CONNECTICUT AVENUE, NW**  **WASHINGTON, DC 20008** | | | |
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| F 456 | Continued From page 13 | | F 456 | | **L456 – Failure to Maintain Essential Equipment in Good Working Condition**  **A. Missing Temperature Control Knob**   1. **Corrective Action for Deficient Practice:** The knob was found and placed back on the warmer. 2. **Residents Affected by Deficient Practice:**   No resident was affected by deficient practice.   1. **Systemic Changes to Ensure Deficient Practice Does Not Recur:** The monthly Safety and Sanitation Audit Checklist has been updated to include checking the working condition of all equipment. 2. **Performance Monitoring to Ensure Sustainability:** The Assistant Director and the Executive Chef will monitor results recorded on the Checklist. Concerns will be discussed with the Director at weekly Managers’ meetings and presented to the QAPI Committee quarterly.   **B. Tilt Skillet Failed to Power Up**   1. **Corrective Action for Deficient Practice:** Written notice placed on skillet stating that it was not working. 2. **Residents Affected by Deficient Practice:**   No residents were affected.   1. **Systemic Changes to Ensure Deficient Practice Does Not Recur:**   Purchase of new tilt skillet has been approved by Administrator. Upon arrival, tilt skillet will be added to Safety Rounds Checklist.  **Performance Monitoring to Ensure Sustainability:** Results from safety rounds will be reported quarterly to QAPI Committee.  **C. Dishwashing Machine Failed to Reach Final Temperature of 1800**   1. **Corrective Action for Deficient Practice:** Ecolab was called, responded immediately. Assessed dish machine and made recommendations regarding process flow changes to prevent depletion of hot water in booster heater before rinse cycle is complete. 2. **Residents Affected by Deficient Practice:** No residents were affected. 3. **Systemic Changes to Ensure Deficient Practice Does Not Recur:** a) New process that incorporates Ecolab’s recommendations was developed, and all utility staff were in-serviced. b) Purchase of new dish machine has been approved by Administrator. c) Upon arrival, dish machine temperatures will be added to Safety Rounds Checklist. 4. **Performance Monitoring to Ensure Sustainability:** Results reported quarterly to QAPI. | |  |
|  | (e) Resident Rooms | |  | |  |
|  | Resident rooms must be designed and equipped for  adequate nursing care, comfort, and privacy of | |  | | 9/20/17 |
|  | residents. | |  | | 9/20/17 |
|  | This REQUIREMENT is not met as evidenced by: | |  | |  |
|  |  | |  | | 9/27/17 |
|  | Based on observations made on September 20, | |  | |  |
|  | 2017 between 8:30 AM and 9:45 AM, the facility | |  | |  |
|  | failed to maintain essential equipment in good  working condition as evidenced by one (1) of one | |  | | 10/26/17 |
|  | (1) food warmer with no temperature control knob, | |  | |  |
|  | one (1) of one (1) tilt skillet which failed to power up | |  | |  |
|  | when turned on, and one (1) of one (1) dishwashing | |  | |  |
|  | machine which failed to reach 180 degrees  Fahrenheit at final rinse. | |  | | 9/20/17 |
|  | The findings include: | |  | | 9/20/17 |
|  | 1. The temperature control knob for one (1) of one | |  | |  |
|  | (1) food warmer was missing. | |  | | 9/26/17 |
|  | 2. One (1) of one (1) tilt skillet failed to power up | |  | |  |
|  | when the 'on' switch was activated. | |  | | 10/26/17 |
|  | 3. The dishwashing machine in the main kitchen | |  | |  |
|  | failed to reach a final rinse temperature of 180 | |  | |  |
|  | degrees Fahrenheit during several consecutive | |  | |  |
|  | rinse cycles. The dishwashing machine located in  the dining room of the Healthcare 1 Unit was used | |  | | 9/20/17 |
|  | to clean and disinfect all dishes. | |  | |  |
|  | The observations made in the presence of Employee #13 and Employee #14 were | |  | | 9/20/17 |
|  | acknowledged. | |  | | 9/23/17 |
|  |  | |  | | 9/26/17 |
|  |  | |  | | 10/26/17 |

**FOREST HILLS of DC**

INCLUSIVE SENIOR LIVING

August 2. 2016

Veronica Longstreth. RN. MS

Interim Program Manager, Health Facilities Division Department of He alth

899 North Capitol Street, NE Washington. DC 20002

Dear Ms. Longstreth:

Enclosed please find the Plan of Correction for the Federal QIS Survey, conducted June 27 through July I, 2016 at Forest Hills of DC. The Statement of Deficiencies (2567) associated with this Plan was received today. Although you have advised that our date for submission of this Plan is not until August 12, we are responding immediately to avoid any concerns about denial of payment. This Plan of Correction is separate and in addition to our August I submission, which responded to the Statement of Deficiencies identified during our iiccnsure survey and which was provided to Forest Hills on July 22, 2016.

This Plan of Correction is submitted for purposes of regulatory compliance and as part of Forest Hills of DC's ongoing efforts to continuously maintain the high quality of care and services provided. As such, it does not constitute an admission of the facts or conclusions cited in the survey report for any purpose \\ hatsoever.

Ifyou have any questions. feel free to contact me directly at 202-777-3320, or by e-mail at msa voy @ foresth illsdc .o rg. Thank you.

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Mary

##### Adrninistmtor rnclosure (CMS-2567)

4901 Connecticut **Ave NW** Washington, DC 20008 [**www.foresthillsdc.org**](http://www.foresthillsdc.org/)

CENTERS FOR MEDICARE & MEDICAID SERVICES 0MB NO. 0938-0391\_

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIOER/SUPPLIER/CLIA IDENTIFICATION NUMBER  **095038** | (X2) MULTIPLE CONSTRUCTION  A BUILDING  **8.** WING | | | (XJ) DATE SURVEY  COMPLETED  **07/0112016** | |
| NAME OF PROVIDER OR SUPPLIER  **FOREST HILLS OF DC** | | | | STREET ADDRESS, CITY, STATE, ZIP CODE  **4901 CONNECTICUT AVENUE, NW**  **WASHINGTON, DC 20008** | | | |
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| F 000 | I INITIAL COMMENTS  An unannounced Quality Indicator Recertification Survey was conducted at Forest Hills of DC from June 27 through July 01, 2016.  Survey activities consisted of a review of 30 residents' clinical records during Stage 1 and a review of 20 clinical records during Stage 2.  The following deficiencies are based on facilityobservations of staff practices; review of the facility's operating procedures and interviews with residents, families and facility staff. After analysis of the fiudings, it was determined that the facility was not in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities.  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  CRF - Community Residential Facility  D.C. - District of Columbia  DCMR- District of Columbia Municipal Regulations  *DIC* Discontinue  DI - deciliter  DMH - Department of Mental Health | | FOOO | | Please start typing your responses here. | |  |

TITLE

*I?ti J.. AJ 14*

I ending with an erisk (\*) denotes a deficiency which the lnstltullon may be excused from correcting providing ii ls determined at her safeguards provide uffteient protection to the patients. (See Instructions.) Except for nursing homes, the findings staled above are dlsclosable 90 days following the date of su,vey 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 dale these documents are made available lo the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORMCMS-2567(02-99) Previous Versions Obso ete Event 10 KV5J11 Facility ID. METHODIST If continuation sheet Page 1 of 20

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIERICLIA IDENTIFICATION NUMBER  **095038** | (X2) MULTIPLE CONSTRUCTION  A BUILD NG  B. W ING | | | (X3) DATE SURVEY  COMPLETED  **07/01/2016** | |
| NAME OF PROVIDER OR SUPPLIER  FOREST HILLS OF DC | | | | STREET ADDRESS, CITY, STATE, ZIP CODE  **4901 CONNECTICUT AVENUE, NW**  **WASHINGTON, DC 20008** | | | |
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| FOOO  F 162 | Continued From page 1  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  Lbs - Pounds (unit of mass)  MAR - Medication Administration Record MD- Medical Doctor  MOS - Minimum Data Set  Mg - milligrams (metric system unit of mass)  ml­ milliliters (metric system measure of volume)  mg/di - milligrams per deciliter mm/Hg­ millimeters of mercury **MN** midnight  Neuro - Neurological  **NP** - Nurse Practitioner  **PASRR-** Preadmission screen and Resident  **Review**  Peg tube - Percutaneous Endoscopic Gastrostomy PO- by mouth  POS - physician ' s order sheet  Pm - As needed  Pt- Patient  Q- Every  QIS - Quality Indicator Survey Rp, RIP - Responsible party  sec Special Care Center  S/he she/he  Sol- Solution  SIC - quote transcribed as written TAR - Treatment Administration Record  I 483.10(c)(B) LIMITATION ON CHARGES TO | | FOOO  F 162 | |  | |  |

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| (X411D PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | (X5) COMPLETION DATE |
| F 162  5S=D | 1 Continued From page 2 PERSONAL FUNDS  The facility may not impose a charge against the personal funds of a resident for any item or services for which payment is made under Medicaid or Medicare (except for applicable deductible and coinsurance amounts). The facility may charge the resident for requested services that are more expensive than or in excess of covered services in accordance with §489.32 of this chapter.  (This does not affect the prohibition on facility charges for items and services for which Medicaid has paid. See §447.15, which limits participation in the Medicaid program to providers who accept, as payment in full, Medicaid payment plus any deductible, coinsurance, or copayment required by the plan to be paid by the individual.)  During the course of a covered Medicare or Medicaid stay, facilities may not charge a resident for the following categories of items and services: Nursing services as required at §483.30 of this subpart.  Dietary services as required at §483.35 of this subpart.  An activities program as required at §483.15(f) of this subpart.  Room/bed maintenance services.  Routine personal hygiene items and services as required to meet the needs of residents, including, but not limited to, hair hygiene supplies, comb, brush, bath soap, disinfecting soaps or specialized cleansing agents when indicated to treat special skin problems or to fight infection, razor, shaving cream, toothbrush, toothpaste, denture adhesive, denture cleaner, dental floss, | | F 162 | |  | |  |

CENTERS FOR MEDICARE & MEDICAID SERVICES

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| F 162 I | Continued From page 3  moisturizing lotion, tissues, cotton balls, cotton swabs, deodorant, incontinence care and supplies, sanitary napkins and related supplies, towels, washcloths, hospital gowns, over the counter drugs, hair and nail hygiene services, bathing, and basic personal laundry.  Medically-related social services as required at  §483.15(9) of this subpart.  Listed below are general categories and examples of items and services that the facility may charge to residents' funds if they are requested by a resident, if the facility informs the resident that there will be a charge, and if payment is not made by Medicare or Medicaid:  Telephone.  Television/radio for personal use.  Personal comfort items, including smoking materials, notions and novelties, and confections. Cosmetic and grooming items and services in excess of those for which payment is made under Medicaid or Medicare.  Personal clothing. Personal reading matter.  Gifts purchased on behalf of a resident. Flowers and plants.  Social events and entertainment offered outside the scope of the activities program, provided under  §483.15(f) of this subpart.  Noncovered special care services such as privately hired nurses or aides.  Private room, except when therapeutically required (for example, isolation for infection control).  Specially prepared or alternative food requested instead of the food generally prepared by the facility, as required by §483.35 of this subpart. | | F 162 | |  | |  |

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| STATEMENT OF DEFICIENCIES ANO PLAN OF CORRECTION | | (X1) PROVIOER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  **095038** | (X2) MULTIPLE CONSTRUCTION  A BUILDING  **B** WING \_ | | | (JO) DATE SURVEY  COMPLETED  **07/01/2016** | |
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| F 162 1 | Continued From page 4  The facility must not charge a resident (or his or her representative) for any item or service not requested by the resident. The facility must not require a resident (or his or her representative) to request any item or services as a condition of admission or continued stay. The facility must inform the resident (or his or her representative) requesting an item or service for which a charge will be made that there will be a charge for the item or service and what the charge will be.  This REQUIREMENT is not met as evidenced by:  Based on record review, staff and family interview for one (1) of 20 sampled Stage 2 residents, it was determined that facility staff failed to ensure that one (1) resident's representative was given a list of services and a list of items that the resident would and would not be charged for If his/her relative was a Medicaid Resident. Resident #36.  The findings include:  A family interview was conducted on June 28, 2016 at approximately 3:19 PM. A query was made regarding if the resident is on Medicaid, did the staff give him/her (or you) a list of services and items that you would and would not be charged for. The family member responded " No " .  A review of the facilities Admissions Agreement package signed by the Responsible Party on October 12, 2015 revealed on " page 16, List of typical additional charges which are payable by | | F 162 | | 1 **Failure to Ensure that 1 Resident's Representative Was Given a List of Services and a List of Items that the** Resident Would and Would Not be Charged for If His/her Relative Was A Medicaid **Resident.**   1. **Corrective Action for Resident With Deficient Practice.**   A list of items and services was provided to the resident's daughter that detailed each item/service available to the resident and the charges far each, if any.   1. **How Residents Potentially Affected by the Same Deficient Practice WIii Be Identified, and What Corrective Action Will Be Taken.**   A listing available from the Accounting Office that identified Medicaid residents was obtained. These residents and /or responsible parties were provided the list of items and services available to the resident and the charges far each, if any   1. **Measures or Systemic Changes to be Made to Ensure Deficient Practice Does Not Recur.**   An Appendix to the Admissions Agreement has been developed to include a list of items and services available to residents and the charges for each, if any. This list will be provided ta all newly admitted residents as part of the Admissions Agreement.   1. **Plan to Monitor Performance to Make Sure Solutions Are Sustained.**   Accounting will audit Admissions Agreements of residents admitted on or after 8/1/16 and report findings to the QAPI Committee quarterly. | | 7/5/16  7/15/16  7/15/16  7/28/16 |

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| NAME OF PROVIDER OR SUPPLIER  **FOREST HILLS OF DC** | | | | STREET ADDRESS, CITY, STATE, ZIP CODE  **49D1 CONNECTICUT AVENUE, NW**  **WASHINGTON, DC 20008** | | | |
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| F 162 I | Continued From page 5  resident either to the Methodist Home or directly to providers/vendors." However, the sheet did not contain the cost of the items listed on the sheet.  A face-to-face interview was conducted with Employee #11 on July 1, 2016 at approximately 11:30 AM, who acknowledged that during the admissions process, items that the resident would and would not be charged for were discussed, however there is not a list containing the cost of the items.  A face-to-face interview was conducted with Employee #12 on July 1, 2016 at approximately | | F 162  F309 | |  | |  |
| 11:00 AM who acknowledged the findings.  F 309 483.25 PROVIDE CARE/SERVICES FOR SS=D HIGHEST WELL **BEING**  Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.  This REQUIREMENT is not met as evidenced by:  Based on record review and staff interviews for three (3) of 20 sampled residents, it was determined that facility staff failed to: monitor blood pressure in accordance with physician's orders for one (1) | | |
|  | resident, consistently conduct evaluation and  reassessment of pain for one (1) | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | | (X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER  **09503B** | (X2) MULTIPLE CONSTRUCTION  A BUILDING  **B.** WING | | | (X3) DATE SURVEY  COMPLETED  **07/01/2016** | |
| NAME OF PROVIDER OR SUPPLIER  **FOREST HILLS OF DC** | | | | | STREET ADDRESS CITY, STATE, ZIP CODE  **4901 CONNECTICUT AVENUE, NW**  **WASHINGTON,** DC **2000B** | | | |
| (X4)1D PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | | 10  PREFIX TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | (X5J COMPLETION DATE |
| F 309 | Continued From page 6 | | | F309 | | **Failure to follow physician orders for application of adaptive devices for treatment of edema of Resident #17** ' **s left upper extremity.**   1. **Corrective Action for Resident With Deficient Practice.** A thorough search for resident's adaptive device was conducted to include the resident's room, laundry facilities, and the Therapy Department. Adaptive device was not located. Therapy provided replacement device for the resident. 2. **How Residents Potentially Affected by the Same Deficient Practice WIii Be Identified, and What Corrective Action Will Be Taken.** Residents who have adaptive devices of any type have been identified by Therapy. All have been assessed to have assistive devices, as ordered. Staff have been informed of the devices that are to be in place and the wearing/usage schedule ordered. 3. **Measures or Systemic Changes to be Made to Ensure Deficient Practice Does Not Recur.** Charge Nurses will ensure adaptive devices required for each resident are indicated on the CNAs' Daily Assignment Sheet. Use of adaptive devices will be included in the CNAs' documentation (e.g., Care Tracker) and on the TAR completed by nurses. 4. **Plan to Monitor Performance to Make Sure Solutions Are Sustained.** Care Tracker and TARs will be audited monthly by the Medical Records Secretary for compliance. Results will be reported quarterly to the QAPI Committee. | |  |
|  | resident and apply adaptive devices for the | | |  | |  |
|  | management of edema for one (1) resident. Residents #17, 22 and 23 | | |  | |  |
|  | The findings include: | | |  | |  |
|  | 1. Facility staff failed to follow physician orders for | | |  | |  |
|  | application of adaptive devices for the treatment  edema of Resident #17 ' s left upper extremity. | | |  | | 6/29/16 |
|  | According to the History and Physical examination signed by the physician on September 29, 2015 | | | | |  |
|  | revealed that Resident #17 ' s diagnoses included: | | | | |  |
|  | HTN (Hypertension), HLD (Hyperlipidemia), | | | | |  |
|  | Depression, and Edema. | | | | |  |
|  | Physician's orders dated June 16, 2016 [original  order dated 417/14] directed: Patient to wear cone splint on left hand when in bed. Remove when out | | | | | 7/5/16 |
|  | of bed. Check skin on left hand for any redness or | | | | |  |
|  | irritation; Elevate left arm on pillow when in bed and | | | | |  |
|  | 008 | [out of bed} for edema. " | |  | |  |
|  | Resident #17 was observed lying In bed on June  29, 2016 at approximately 4:30 PM in the company | | | | | 7/27/16 |
|  | of Employee ' s #5 and #13. There was no | | | | |  |
|  | evidence that the cone hand splint was applied and | | | | |  |
|  | the left hand/arm was not elevated on pillows. | | | | |  |
|  | Employee #13 stated, he/she was not **aware** that | | | | |  |
|  | the resident required a cone or elevation of the left | | | | | 7/28/16 |
|  | arm. Employee #5 was unsuccessful in locating the | | | | |  |
|  | cone for the resident. | | | | |  |
|  | Facility staff failed to follow physician's orders for | | | | |  |
|  | the use of adaptive devices for the treatment of | | | | |  |
|  | edema for Resident #17. | | | | |  |

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| STATEMENT OF DEFICIENCIES ANO PLAN OF CORRECTION | | (X1l PROVIOERISUPPLIER/CLIA IDENTIFICATION NUMBER  **095038** | (X2) MULTIPLE CONSTRUCTION  A BUILDING  **B.** WING | | | (X3) DATE SURVEY  COMPLETED  **07/01/2016** | | |
| NAME OF PROVIDER OR SUPPLIER  **FOREST HILLS OF DC** | | | | STREET ADDRESS, CITY, STATE, ZIP CODE  **4901 CONNECTICUT AVENUE, NW**  **WASHINGTON, DC 20008** | | | | |
| (X4jl0 PREFIX **TAG** | SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | 10  PREFIX TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | (X5)  COMP ETION  DATE | |
| F 309 I | Continued From page 7 | | F 309 | | 1 **Failure to monitor Resident #22's Blood Pressure** In **Accord with Physician's Order.**  **2. Corrective Action for Resident With Deficient Practice.**  Employee involved in the deficient practice was educated on the Blood Pressure policy. The meaning of the word ·consecutive" was also clarified with this employee.   1. **How Residents Potentially Affected by** the Same Deficient Practice WIii Be **Identified, and What Corrective Action Will Be Taken.**   Medical charts and MARs of residents receiving 8/P medications were reviewed. Based on this documentation review, no other residents experienced the deficient practice. Documentation was consistent with the Physician's Order.   1. **Measures or Systemic Changes to be Made to Ensure Deficient Practice Does Not Recur.**   Staff received Training/Education on the Policy and Procedure for abnormal Blood Pressure values. Special emphasis was placed on employees' comprehension of terminology included in the policy.   1. **Plan to Monitor Performance to Make**   **Sure Solutions Are Sustained.**  MARs will be audited by Nurse Manager for compliance. Results will be reported quarterly to the QAPI Committee | |  |  |
|  | 2. Facility staff failed to monitor Resident #22 ' s | |  | |  |  |
|  | blood pressure in accordance to physician ' s | |  | |  |  |
|  | orders. | |  | |  |  |
|  | According to the facility's policy "Protocol for Blood Pressure Monitoring," revised date: | |  | |  | 7/1/16 |
|  | 04/30/15 stipulates, " II. Policy Implementation: | |  | |  |  |
|  | A. Monitoring Protocol for Hypertensive | |  | |  |  |
|  | Residents- 2. If the resident ' s systolic blood | |  | |  |  |
|  | pressure is greater than 160mmHg (millimeters of | |  | |  |  |
|  | Mercury) or less than 100mmHg and the diastolic | |  | |  |  |
|  | blood pressure ls greater than 100mmHg or less | |  | |  |  |
|  | than 60mmHg the reading will be considered | |  | |  |  |
|  | abnormal. The resident must be monitored and two | |  | |  | 7/12/16 |
|  | additional reading obtained at intervals not longer | |  | |  |  |
|  | than 2 hours apart 3. The resident ' s physician | |  | |  |  |
|  | will be notified if the blood pressure is abnormal for | |  | |  |  |
|  | three (3) consecutive readings ... " | |  | |  |  |
|  | The physician's order dated May 26, 2016 [no time | |  | |  |  |
|  | indicated], directed: "Monitor blood pressure 2 | |  | |  |  |
|  | [times] a day on Tuesdays, Thursdays, and  Saturdays to determine the effectiveness of blood | |  | | I | 7/18/16 |
|  | pressure medications. Notify M.D. (Medical Doctor) | |  | |  |  |
|  | if SBP (Systolic Blood Pressure)> [greater than] | |  | |  |  |
|  | 160 or< [less than] 100mmHg or DBP (Diastolic | |  | |  |  |
|  | Blood Pressure) [greater than] 100 or [less than] | |  | |  |  |
|  | 60mmHg [times] 3 (three) consecutive readings ... " | |  | |  |  |
|  | The June 2016 MAR (Medication Administration | |  | | I | 7/28/16 |
|  | Record) revealed Resident #22 ' s blood pressure | |  | |  |  |
|  | on June 21, 2016 at 10 AM was 164/78 and on | |  | |  |  |
|  | June 28, 2016 at 10:00AM it was 174/70. | |  | |  |  |
|  | A review of the nurses notes for June 21, 2016 and | |  | |  |  |
|  | June 28, 2016 lacked documented evidence | |  | |  |  |

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| STATEMENT OF DEFICIENCIES ANO PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  **095038** | (X2) MULTIPLE CONSTRUCTION  A BUILDING  .8 WING | | | (XJ) DATE SURVEY  COMPLETED  **07/01/2Q\_16** | |
| NAME OF PROVIDER OR SUPPLIER  FOREST HILLS OF DC | | | | STREET ADDRESS, CITY, STATE, ZIP CODE  **4901 CONNECTICUT AVENUE, NW**  **WASHINGTON, DC 20008** | | | |
| (X4)10 PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | | PROVIDER'S Pl.AN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD **BE**  CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | (X5) COMPI.ETION OATE |
| F 309 Continued From page 8 | | | F 309I | | A (3): **Failure to Consistently Conduct Evaluation and Reassessment of Pain to Include the Intensity of Pain for Resident #23.**   1. **Corrective Action for Resident With Deficient Practice.** Corrective action is not Indicated, as pain medication had already been administered and documented as effective post administration. 2. **How Residents Potentially Affected by** the Same Deficient Practice WIii Be **Identified, and What Corrective Action Will Be Taken.** Residents receiving pain medication (regularly scheduled and PRN) are identified based on physician orders. Corrective action taken to ensure pain assessments are conducted before and after administration of analgesic include a) updating the facility's current pain policy/protocol and assessment tool to address Intensity, and 2) educate all staff on the correct Interpretation of the policy and use of the tool.   **J\_ Measures or Systemic Changes to be Made to Ensure Deficient Practice Does Not Recur.** Monthly audits of the **MARs** by Medical Records will be conducted to determine compliance with the **revised** policy and implementation of the training provided.  **4. Plan to Monitor Performance to Make Sure Solutions Are Sustained.** Results of the chart audits will be reported quarterly to the QAPI Committee. | |  |
| of three consecutive blood pressure readings to determine the effectiveness of the blood pressure medications based on the parameters defined by the physician. | | |  | |  |
| A face-to-face interview was conducted with Employees# 3 and #7 on June 30, 2016 at approximately 2:00 PM regarding the aforementioned findings. Both acknowledged that consecutive blood pressure readings were not obtained. The clinical record was reviewed on June 30, 2016. | | |  | | 6/30/16 |
| 3. Facility staff failed to consistenUy conduct evaluation and reassessment of pain to include the intensity of pain for Resident #23. | | |  | |  |
| According to the facility's policy "Pain Assessment and Management, " revised dated 6/1/16 stipulates, " 1. Perform a pain assessment using the assessment form that is part of the protocol 2. Review the resident ' s current pain  medication regiment to determine the following: 2 C. degree of relief experienced from this medication  ...." The " Pain Management Risk Assessment Tool" revealed. "Pain Intensity: 0- No pain;  1- Mild (1-3 self-report on scale of 10), 2 Moderate  (4-6 self-report on scale of 10). 3-Severe (7-10 self-report on scale of 10) " | | |  | | 7/15/16  7/18/16 |
| A review of the Physician • s Order Form signed and | | |  | |  |
|  | dated June 9, 2016 (order originated February 24,  2015) directed, "Acetaminophen 500mg (RPL Tylenol Extra strength)- 2 (two) tabs (tablets)- (1000 mg) by mouth every 6 hours as needed for body pain " | |  | | 7/28/16 |
| A review of the March 2016 through May 2016 MAR (Medication Administration Record) | |  | |  |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIOERISUPPLIERICLIA IDENTIFICATION NUMBER  **095038** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING 2. WING | | | (X3) DATE SURVEY  COMPLETED  **07/01/2016** | |
| NAME OF PROVIDER OR SUPPLIER  FOREST HILLS OF DC | | | | STREET ADDRESS, CITY, STATE, ZIP CODE  **4901 CONNECTICUT AVENUE, NW**  **WASHINGTON, DC 20008** | | | |
| (X4)1D PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | | PROVIDER'S **PLAN OF** CORRECTION (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | **(XS)** COMPLl!TION OAT£ |
| F 309  F 314I  SS•G | I Continued From page 9  revealed that Resident #23 received Extra Strength Tylenol- 2 tablets on the following dates for body pain:  March 4, 2016 - 12AM - result: effective March 13, 2016- 1:30 PM- result: helpful  March 31, 2016-1:00 PM- result: effective March 16, 2016-1:10 AM - result: effective April 2, 2016- 2:00AM- result: effective  April 19, 2016- 1:00 PM - result: helpful  May 15, 2016 -1:30 PM- result: effective  There was no evidence that facility staff consistently conducted an assessment that included a description of the intensity of the pain (e.g. numeric scale} before and after the administration of Extra Strength Tylenol for Resident #23.  A face-to-face interview was conducted with Employees# 3 and #7 on June 30, 2016 at approximately 2:30 PM. Both acknowledged the aforementioned findings. The clinical record was reviewed on June 30, 2016.  483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES  Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the Individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. | | f 309  F 314 | |  | |  |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER  **095038** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING \_ 2. WING | | | (X3) DATE SURVEY  COMPLETED  **07/01/20\_16** | |
| NAME OF PROVIDER OR SUPPLIER  **FOREST HILLS OF DC** | | | | STREET ADDRESS. CITY, STATE, ZIP CODE  4901 CONNECTICUT **AVENUE, NW**  **WASHINGTON, DC 20008** | | | |
| (X4)1D PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | to PREFIX TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | [XS) COMPLETION OATE |
| F 314 | Continued From page 10 | | F 314 | | **Failure to Consistently Assess and Monitor Resident #17's Right Heel to Ensure that** Necessary Treatment and Services **Were Provided. Subsequently, the Resident Developed an Unstageable Pressure Ulcer that was Initially ldentlfled at an Advanced Stage.**   1. **Corrective Action for Resident With Deficient Practice.**   Total body assessment was completed for the resident and related documentation updated accordingly.   1. **How Residents Potentially Affected by the Same Deficient Practice WIii Be Identified, and What Corrective Action WIii** Be Taken.   Skin Sheets and other documentation (e.g., Braden Scale, Weekly Skin Checklist) were reviewed for all residents identified with pressure ulcers. Where necessary, these documents were updated and/or revised.   1. **Measures or Systemic Changes to be Made to Ensure Deficient Practice Does Not Recur.** Policy will be revised to include:   1) Condition of each resident's skin is assessed weekly on shower days. 2) Assessment results are documented/signed by the licensed nurse on the Weekly Skin Assessment Sheet. 3) When there is a skin condition identified, the appropriate form (i.e., (Non- Pressure or Pressure Ulcer Record) will be instituted. 4) These documents will be updated weekly during wound rounds and audited for completion and accuracy on a monthly basis.  **4. Plan to Monitor Performance to Make Sure Solutions Are Sustained.**  The results of the Weekly Skin Rounds and an audit of the Skin Assessment sheets will be reported quarterly to the OAPI Committee. | |  |
|  | This REQUIREMENT is not met as evidenced by: | |  | |  |
|  | Based on record review and staff interview for one  (1) of 20 Stage 2 sampled residents, it was determined that facility staff failed to consistently assess and monitor Resident #17 ' s right heel to ensure that necessary treatment and services were provided. Subsequently, the resident developed an Unstageable Pressure Ulcer that was initially identified at an advanced stage. Resident #17. | |  | | 7/5/16 |
|  | The findings include: | |  | |  |
|  | Policy: | |  | |  |
|  | Skin Impairment, Effective Date May 13, 2010,  Revisions: May 16, 2016 stipulated:" Policy Statement: All residents will be assessed upon | |  | | 7/5/16 |
| admission and then routinely for skin impairment.  Skin impairment lncludes, but not restricted to: Skin tears, Pressure Ulcers, Vascular Ulcers ... | | | |
|  | Policy Interpretation and Implementation: 1. Prevention (b) For those residents who are at Risk (a score of 18 or below) the following intervention will be instituted: (2) Resident will be turned and repositioned every 2 hours while in bed ... (5) heels will be kept off mattress, (6) Skin will be moisturized at least twice a day ... (7) Incontinent residents  must have pericare with skin barrier at least once per shift. Licensed staff will assess skin and document weekly " | | | | 7/18/16 |
|  | The History and Physical examination signed and dated by the physician on September 29, 2015 revealed that Resident #17 diagnoses included: HTN (Hypertension), HLD (Hyperlipidemia), Depression, and Edema. | | | | 7/28/16 |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDERISUPPLIER/CLIA IDENTIFICATION NUMBER  **095038** | (X2) MULTIPLE CONSTRUCTION  A BUILDING  B. WING | | | (X3) DATE SURVEY  COMPLETED  **07/01/2016** | |
| NAME OF PROVIDER OR SUPPLIER  FOREST HILLS OF DC | | | | STREET ADDRESS, CITY, STATE, ZIP CODE  **4901** CONNECTICUT **AVENUE, NW**  **WASHINGTON,** DC **20008** | | | |
| (X4)ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | 10  PREFIX TAG | | PROVIDER'SPLAN OF CORRECT ON (EACH CORRECTIVE ACTION SHOULD BE  CROS,S REFERENCEDTO THE **APPROPRIATE**  DEFICIENCY) | | jX5) COMPLETON DATE |
| F 314 1 | Continued From page 11  According to the quarterly Minimum Data Set (MDS) dated February 3, 2016, Resident #17 was coded in Section C (Cognitive Patterns) as severely  impaired; Section GD110 and G0120 (Functional Status) the resident was coded as totally dependent, requiring assistance of one or two people for bed mobility, transfer, dressing, personal hygiene, bathing and wheelchair dependent for mobilization; Section H0300 (Urinary Continence) revealed resident was always incontinent. Section  M (Skin Condition), the resident was coded as being at risk for developing pressure ulcers. In Section M 0210 (Current Number of Unhealed Pressure Ulcers) the resident was coded as" O "indicating that the resident did not have any unhealed pressure ulcer.  A review of the subsequent, Significant Change MDS dated May 3, 2016 revealed under Section M, Skin Conditions, Resident #17 was coded as having one (1) Unstageable pressure ulcer.  The "Pressure Ulcer" care plan updated February 9, 2016 revealed "Goal: Resident will remain free of skin breakdown through next review; Approach: ... Air alternating pad on mattress, Body/skin audit at least biweekly on bath days, Braden Scale assessment quarterly and PRN (as needed), Assess all skin during AM/PM care and prn, notify nurse/MD for any open or discolored areas "  A review of the clinical record revealed the facility ' s Pressure Ulcer Risk Assessment tool combined with the "Braden Scale - For Predicting Pressure Sore Risk " [a tool utilized by health professionals, especially nurses to assess a | | F 314 | |  | |  |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  **095038** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING 2. W I NG | | | (X3) DATE SURVEY  COMPLETED  **07/01/2016** | |
| NAME OF PROVIDER OR SUPPLIER  FOREST HILLS OF DC | | | | STREET ADDRESS, ClTY, STATE, ZIP CODE  **4901 CONNECTICUT AVENUE, NW**  **WASHINGTON, DC 20008** | | | |
| (X4)1D PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PROVIDER'S PLAN OF CORRECTION I (X51  PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION  TAG CROSS-REFERENCED TO THE APPROPRIATE OA.TE  DEFICIENCY) | | | | |
| F 314 | 1 Continued From page 12  patient's risk of developing a pressure ulcer] signed and dated by the Registered Nurse on February 24, 2016, revealed Resident #17 was assessed as "High Risk " for pressure ulcer development.  A review of the Dietary Progress Notes dated February 2, 2016 revealed that Resident #17 ' s " skin integrity was intact" and that the resident was at "risk for pressure ulcer(s) [secondary] to immobility."  A review of nurse ' s notes revealed the following: March 20, 2016 -11:00 PM- Turned and  repositioned q 2 [every 2 hours] as as needed ...  March 21, 2016- 6:52 **AM-** skin warm and dry to  touch. AOL [Activities of daily living] provided, turned and positioned as needed ...  March 21, 2016- 3:35 PM- Turning and  positioning per protocol. No skin breakdown noted. Skin warm and intact ...  March 21, 2016- 11:18 PM- incontinent care  done ...  March 22, 2016- 7AM- Turned and repositioned  [every] 2 hours, also other needed AOL ' s and nursing care were attended to ...  March 22, 2016- 11:20 PM- incontinent care  done ...  March 23, 2016- 7:02 AM- incontinent care  done ...  March 23, 2016- 11:00 PM- incontinent care | | F 314 | |  | |  |

CENTERS FOR MEDICARE & MEDICAID SERVICES 0MB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (Xl I PROVIDER/SU PPLIER/CLIA IDENTIFICATION NUMBER.  **095038** | (X2) MULTIPLE CONSTRUCTION  A, BUILDING  **B.** WING | | | (X31 DATE SURVEY  COMPLETED  **07/01/2016** | |
| NAME OF PROVIDER OR SUPPLIER  **FOREST HILLS** OF DC | | | | STREET ADDRESS, CITY, STATE, ZIP CODE  **4901 CONNECTICUT AVENUE, NW**  **WASHINGTON, DC 20008** | | | |
| (X411D PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | (JC;) COMPLETION **DATE** |
| F 314 | Continued From page 13 done ...  The clinical record lacked evidence of nurse ' s progress notes for the period of March 23, 2016 through March 27, 2016.  March 28, 2016 7:30 AM nurse's entry: CNA [Certified Nursing Assistant] reported black area noted on the right heel during care. On assessment area noted with grayish black discoloration with intact skin measuring 2.3cm [centimeters] x [by] 1.8 cm. Surrounding area noted with redness. No facial expression of pain noted on palpitation to the area and no warmness  noted on the area. MD [Medical Doctor] updated, | | F 314 | |  | |  |
| order in place to apply skin prep to the area twice  daily, and float the heel with Prevalon boot [pressure relieving heel protector] on while in bed. Order in place to tum and reposition resident every two [2] hours. Resident remains alert and oriented to self. No change or deviation from [his/her] baseline noted ...skin prep applied to right heel as ordered."  The clinical record lacked evidence that facility staff conducted body/skin assessments ' at least ' biweekly in accordance to the care plan. Through staff interview, it was determined that nursing staff were to utilize the facility ' s " Weekly Skin Checklist" form to record weekly skin assessments that were usually conducted on shower days. However, there was no evidence in Resident #17 ' s clinical records that Weekly Skin Checklist forms were completed.  A review of the " Pressure Ulcer Record " revealed nursing staff recorded the following characteristics of the resident ' s right heel ulcer: | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER  **095038** | (X2) MULTIPLE CONSTRUCTION  A. BUILDING \_  **8.** WJNG | | | (X3) DATE SURVEY  COMPLETED  **07/01/2016** | |
| NAME OF PROVIDER OR SUPPLIER  **FOREST HILLS OF DC** | | | | STREET ADDRESS, CITY, STATE, ZIP CODE  **4901 CONNECTICUT AVENUE, NW**  **WASHINGTON, DC 20008** | | | |
| (X4)1D PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | (X51 COMPLETION DATE |
| F 314 | I Continued From page 14  "Date First Observed: March 28, 2016, Stage: SDTI (Suspected Deep Tissue Injury), Color: grayish/black, Size: 2.3 cm x 1.8 cm, Granulation: No, Drainage: No, Odor: No ... "  A face-to-face interview was conducted with Employee #5 on June 29, 2016 at approximately 3:00 PM. A query was made regarding the skin impairment of the resident ' s right heel. He/she stated " the wound was first found unstageable then once the scab came off, it was assessed as a Stage Ill pressure ulcer. " The employee further  stated, the resident ' s shower days were Mondays and Thursdays.  A telephone interview was conducted on July 1, 2016 with Employee #13 at approximately 4:15 PM. Employee #13 indicated that he/she works with the resident on the 7:00 AM to 3:00 PM shift and the day he/she saw the wound on the right heel [March 28, 2016] was the day he/she reported it.  Employee #13 also reported that the right heel was not open, it was dark and was getting to be black.  A telephone interview was conducted on July 1, 2016 with Employee #14 at approximately 4:30 PM. Employee #14 indicated that he/she works the evening shift from 3:00 PM to 11:00 PM and agreed that he/she was assigned to Resident #17 the evening of March 27, 2016. Employee #14 stated " on our shift we put the resident to bed ...we remove any clothes and wash the stockings for the morning. " In response to a query regarding whether or not the resident was observed with any  abnormality in the skin of the right heel, he/she stated that no discoloration or abnormality was observed. The employee could not recall if the resident ' s heels were floated on | | F 314 | |  | |  |

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| STATEMENT OF DEFICIENCIES ANO PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  **095038** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING \_ 2. WING | | | | (XJ) DATE SURVEY  COMPLETED  **07/01/2016** | |
| NAME OF PROVIDER OR SUPPLIER  **FOREST HILLS OF DC** | | | | STREET ADDRESS,  **4901 CONNECTIC**  **WASHINGTON,** | | CITY, STATE, ZIP CODE  **UT AVENUE, NW**  **DC 20008** | | |
| (X4)10 PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | | (X5f COMPLETION DATE |
|  |  | |  | |  | | |  |
| F 314 | 1 Continued From page 15  pillows.  A face-to-face interview was conducted with Employee #1 on July 1, 2016 at approximately 3:00 PM. who stated " there are no shower/skin sheets [Weekly Skin Checklist] for the resident." | | F 314 | |
|  | Resident #17 was assessed with a facility acquired, | |  | |  | | |
|  | unstageable pressure ulcer of the right heel on March 28, 2016, characterized as "grayish black discoloration. " The resident was assessed as " high risk " for developing skin impairment according to the Braden Scale. There was no evidence that facility staff consistently assessed  and/or monitored the resident ' s skin and subsequently, he/she was assessed with a facility acquired pressure ulcer of the right heel Initially identified at an advanced stage [unstageable]. | |  | |  | | |
|  | A face-to- face interview was conducted with the Employees #1 #2 and #3 on July 1, 2016 at approximately 5:00 PM. After review of the clinical record, all acknowledged the aforementioned findings. The clinical record was reviewed on July 1, **2016.** | |  | |  | | |
| F 371  SS=D | 1483.35(1) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY | | F 371 | |  | | |
|  | 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 | | | |

CENTERS FOR MEDICARE & MEQJCAIQSERVICES 0MB NO. 0938-0.3.9:1

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER  **095038** | (X21 MULTIPLE CONSTRUCTION  A BUILDING \_  B. WING | | | (X3) DATE SURVEY  COMPLETED  **07/01/2016** | |
| NAME OF PROVIDER OR SUPPLIER  FOREST HILLS OF DC | | | | STREET ADDRESS, CITY, STATE, ZIP CODE  **4901** CONNECTICUT AVENUE, NW  **WASHINGTON,** DC **20008** | | | |
| (X4)ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES  {EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | 10  PREFIX TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | (X5) COMPLETION DATE |
| F 371 | Continued From page 16  This REQUIREMENT is not met as evidenced by:  Based on observations made on June 27, 2016 at approximately 9:05 AM it was determined that the facility failed to store foods under sanitary conditions as evidenced by two (2) of two (2) soiled food warmers in the main kitchen.  The findings include:  Two (2) of two (2) food warmers located in the main kitchen were soiled at the bottom.  These observations were made in the presence of Employee #9 who acknowledged the findings.  I 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 observations made on June 27, 2016 at approximately 9:05 AM it was determined that the facility failed to maintain essential equipment in  good working condition as evidenced by one (1) of one (1) dishwashing machine that failed to reach a minimum of 180 degrees Fahrenheit during five (5) consecutive final rinse cycles and a broken  temperature gauge in one (1) of two (2) food warmers.  The findings include: | | F 371 | | **A (1): Failure to Store Foods Under Sanitary Conditions as Evidenced by Two (2) of Two** | |  |
|  |  | | **(2) Soiled Food Warmers** In **the Main** | |  |
|  |  | | **Kitchen.** | |  |
|  |  | | **1. Corrective Action for Deficient** | |  |
|  |  | | **Practice.** | |  |
|  |  | | Two of two warmer units were cleaned June  28, 2016. | | 6/28/16 |
|  |  | | 2. How Potentlal for the Same Deficient | |  |
|  |  | | Practice WIii Be Identified, and What | |  |
|  |  | | Corrective Action WIii Be Taken. | |  |
|  |  | | No resident or equipment was affected by | | 6/28/16 |
|  |  | | practice. | |  |
|  |  | | 3. **Measures or** Systemic Changes to be | |  |
|  |  | | **Made** to Ensure Deficient Practice Does Not | |  |
|  |  | | Policy will be updated ta include responsibility | |  |
| F 456 |  | | of Dining Services Management Team to  inspect the warmer equipment, as part of the | |  |
|  |  | | Safety and sanitation audit. The Master | |  |
|  |  | | cleaning schedule has been updated and | | 7/1/16 |
|  |  | | cleaning has been increased from bi-weekly ta | |  |
|  |  | | weekly or as needed. Weekly cleaning of the | |  |
|  |  | | warmer has been placed on the production | |  |
|  |  | | master cleaning schedule effective July 1, | |  |
|  |  | | 2016. | |  |
|  |  | | **4. Plan to Monitor Performance to Make** | |  |
|  |  | | **Sure Solutions Are Sustained. The**  **director of dining services will monitor the** | | 7/28/1 |
|  |  | | Results of the monthly Safety and sanitation | |  |
|  |  | | Audit will be reported quarterly to the QAPI | |  |
|  |  | | Committee. | |  |

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB\_NO. 0938-0391

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| STATEMENT OF DEFICIENCIES ANO PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION **NUMBER**  **095038** | (X2) MULTIPLE CONSTRUCTION (   1. BUILDING \_ 2. WING | | | X) DATE SURVEY  COMPLETED  **07/01/2016** | | |
| NAME OF PROVIDER OR SUPPLIER  FOREST HILLS OF DC | | | | STREET ADDRESS, CITY, STATE, ZIP CODE  **49D1 CONNECTICUT AVENUE, NW**  **WASHINGTON, DC 20008** | | | | |
| (X4)10 PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD **BE**  CROSS-REFERENCED TO THE APPROPRIATE  DEFICIENCY)  I | | | (X51  CO'-f'Ll!TION  **DA.TE** |
| F 456 | I Continued From page 17   1. The dishwashing machine failed to reach a | | F 456 | | I **Failure to Maintain All Essential** | |  | 6/27/16  6/27/16  7/5/16  7/28/16 |
|  |  | | **Mechanical,** Electrical, **and Patient Care** | |
|  |  | | Equipment **In a** Safe Operating Condition. | |
| minimum final rinse temperature of 180 degrees Fahrenheit in five (5) of five (5) consecutive wash cycles.  2. The built-in temperature gauge to one (1) of two  (2) food warmers was stuck and needed to be replaced.  These observations were made in the presence of Employee #9 who acknowledged the findings.  F 514 1 483.75(1)(1) RES  SS=D RECORDS-COMPLETE/ACCURATE/ACCESSIBLE  The facility must maintain clinical records on each  Iresident in accordance with accepted professional standards and practices that are complete;  accurately documented; readily accessible; and systematically organized.  The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.  This REQUIREMENT is not met as evidenced by:  Based on record review and staff interview for one  (1) of five (5) sampled residents who received  Hospice services, it was determined that facility staff failed to maintain an accurate clinical record as | | |  | | (1) Dlshwashlng machine **failed** to reach a | |
|  | | minimum **final rinse temperature of 180** | |
|  | | **degrees** F0 In **five (5) of five (5) consecutive** | |
|  | | **rinse cycles.** | |
|  | | **1. Corrective Action for Resident With** | |
|  | | **Deficient Practice.** | |
|  | | Manual sanitation policy was put into place. | |
|  | | Service company was called and came out | |
|  | | immediately. | |
|  | | **2. How Residents Potentially Affected by** | |
|  | | the Same Deficient Practice WIii **Be** | |
|  | | **Identified, and What Corrective Action Will** | |
|  | | **Be Taken.** | |
|  | | No resident or equipment was affected by | |
|  | | practice. | |
|  | | **3. Measures or Systemic Changes to be** | |
|  | | **Made to Ensure Deficient Practice Does Not** | |
|  | | **Recur.** | |
|  | | The dish machine log will be reviewed by | |
|  | | Management team before each meal. | |
|  | | Manager will initial by each temp taken. | |
|  | | **4. Plan to Monitor Performance to Make** | |
|  | | **Sure Solutions Are Sustained.** | |
|  | | Director of Dining Service will track any | |
|  | | findings and report results to quarterly to the | |
|  | | QAPI Committee. | |
|  | evidenced by the lack of complete documentation | |  | |  | |
| related to the provision of Hospice | |  | |  | |

CENTERS FOR MEDICARE & MEDICAID SERVICES 0MB NO. 0938".'.0\_391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDERISUPPLIERICLIA IDENTIFICATION NUMBER.  **095038** | (X2) MULTIPLE CONSTRUCTION  A BUILDING  **B.** WING | | | (XJ) DATE SURVEY  COMPLETED  **07/01/2016** | | |
| NAME OF PROVIDER OR SUPPLIER  **FOREST HILLS OF DC** | | | | STREET ADDRESS, CITY, STATE, ZIP CODE  **4901 CONNECTICUT AVENUE, NW**  **WASHINGTON, DC 20008** | | | | |
| (X4)ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | | PROVIDERS PLAN OF CORRECT1ON (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCEDTO THE APPROPRIATE DEFICIENCY) | | ( XS] COMPLETION DATE | |
| F 514 | 1 Continued From page 18  care and services. Resident #52.  The findings include: | | F 514 | | **Failure to Maintain an Accurate** Clinical **Record as Evidenced by the Lack of Complete Documentation Related to the Provision of Hospice Care and Services for Resident #52\_** | |  |  |
|  | Resident #52 was admitted to Hospice Care on December 28, 2015. A face-to-face interview was conducted with Employee #5 at approximately 2:30PM on June 30, 2016. During the interview the employee was queried regarding the frequency of visits by the Hospice Nursing staff. The employee responded, "Nursing Assistants visit several times each week [three to four days per week] and the nurse visits at least once a week; sometimes twice. "  A review of the Hospice section of the clinical record revealed that the documentation did not reflect weekly visits by the Hospice Nurse. Review of documentation for the month of May revealed Hospice Nurse's notes dated May 06, 2016 and May 16, 2016. Review of the notes for June revealed documentation for June 6, June 1O and June 13. There was no note for the week of June 01, June 20, and/or June 27, 2016.  A face-to-face interview was conducted with Employee #11 [Hospice nurse] at approximately 10:30AM on July 1, 2016. "I visit at least once a week; sometimes twice and more often if needed. I always write a summary of my visit and place a copy on the chart before I leave. I usually keep a copy for myself. I can show you my copy." The employee opened his/her bag and displayed copies of Hospice Nursing Notes that were dated June 20 and June 27, 2016. The employee concluded, "I don't know what happened to the notes but I left them in the chart. | |  | | 1. **Corrective Action for Resident With Deficient Practice.** The hospice documentation in question was retrieved from the Hospice provider and placed in the resident's record. 2. **How Residents Potentially Affected by the Same Deficient Practice Will Be Identified, and What Corrective Action WIii Be Taken.** All residents receiving hospice care will be identified. Their charts will be reviewed to ensure that documentation by hospice providers has been placed in the chart to reflect visit dates and services provided. 3. **Measures or Systemic Changes to be**   **Made to Ensure Deficient Practice Does Not Recur.** Medical charts of residents receiving | | I | 7 /5/16  7/15/16 |
| hospice care will be audited monthly by the Medical Records Secretary to determine presence of hospice documentation of visits made during the month. If documentation is found to be missing, the hospice provider will be contacted and requested to deliver the missing documentation.  **4. Plan to Monitor Performance to Make Sure Solutions Are Sustained.** Results of the monthly audits will be reported quarterly to the QAPI Committee. | |  | 7/25/16  7/28/16 |
|  | |  | |
|  | Another face-to-face interview was conducted | |  | |

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CENTERS FORMEDICARE\_ &\_MEDICAID SERVICES 0MB NO. 0938\_-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SU PPLIER/CLIA IDENTIFICATION NUMBER  **095038** | (X21 MULTIPLE CONSTRUCTION  **A** BUILDING  B. W I NG | | | (X3) DATE SURVEY  COMPLETED  **07/01/2016** | |
| NAME OF PROVIDER OR SUPPLIER  FOREST HILLS OF DC | | | | STREET ADDRESS CITY, STATE, ZIP CODE  **4901** CONNECTICUT AVENUE, NW  **WASHINGTON,** DC **20008** | | | |
| (X4)ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | 10 I  PREFIX TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE  CROSS•REFERENCEO TO THE APPROPRIATE DEFICIENCY) | | f X51 COMPLETIICN CATE |
| F 514 | 1 Continued From page 19  with Employees #1, 2 and 3 at approximately 12:00 PM on July 1, 2016. The employees acknowledged that the resident ' s clinical record lacked complete documentation of the provision of Hospice care and services. The record was reviewed on June 30, 2016. | | F 514 | |  | |  |
|  | | |

**FOREST**-H--ILLSoFoc

I N CLUSI VE SENIOR LIVING

August 26, 2016

Veronica Longstreth, RN, MS

Interim Program Manager, Health Facilities Division Department of Health

899 North Capitol Street NE Washington, DC 20002

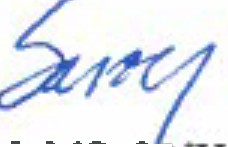
Dear Ms. Longstreth:

Enclosed please find the Plan of Correction for the Life Safety Survey, conducted on July 13, 2016 at Forest Hills of DC. Although you have advised that our date for submission of this Plan is not until September 1, we are responding prior to the deadline in anticipation of our survey file being completed for FY2016.

This Plan of Correction is submitted for purposes of regulatory compliance and as part of Forest Hills of DC's ongoing efforts to continuously maintain the high quality of care and services provided. As such, it does not constitute an admission of the facts or conclusions cited in the survey report for any purpose whatsoever.

Ifyou have any questions, feel free to contact me directly at 202-777-3320, or by e-mail at [msavoy@foresthillsdc.org.](mailto:msavoy@foresthillsdc.org) Thank you.

Sincerely,

*I /Utt/ * Mary Savo/, RN, MS, UNHA Administrator

cc: C. Kingsberry, RN, Supervisory Nurse Consultant

##### 4901 Connecticut Ave NW Washington, DC 20008 [www.foresthillsdc.org](http://www.foresthillsdc.org/)

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| STATEMENT OF DEFICIENCIES ANO PLAN OF CORRECTION | | (X1) PROVIDERJSUPPLIER/CLIA IDENTIFICATION NUMBER  **095038** | | (X2) MULTIPLE CONSTRUCTION  A. BUILDING **01** - **MAIN BUILDING 01**  **.8** WING | | | | | (X3) DATE SURVEY  COMPLETED  **07/13/2016** | | | | |
| NAME OF PROVIDER OR SUPPLIER  FOREST HILLS OF DC | | | | | | STREET ADDRESS  **4901 CONNECTI**  **WASHINGTON,** | | CITY, STATE, ZIP CODE  **UT AVENUE, NW**  **DC 20008** | | | | | |
| (X4110 PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | I | | ID PREFIX TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | | I | I | | (X51  CQr-.FLETION  DATE |
| I  K 000 1 lNITIAL COMMENTS  I | | | |  | | |  | | | | |  | |
| KOOO  **K018**  K 018 **1.Corrective Action for Affected Residents:**  Upon discovery of the two doors in both the Gift Shop and room 141, we immediately removed the wedge and shaved the door.  **2.ldentification of Other Residents Potentially Affected by the same Practice** A complete inspection of all doors in the basement and Health Care Center was  conducted.  I  I **3.Systemic Changes to Ensure Deficient Practice Does Not Recur:**  Inspection logs have been created for  bi-weekly inspection by maintenance staff of all fire doors in the Basement and Health Care Center.  Maintenance supervisor will review the logs and conduct random inspections to ensure ongoing compliance.  **4.Performance Monitoring to make Sure Solutions Are Sustained:**  Maintenance Supervisor will report  Findings quarterly to the QA committee. | | | | | | | |
| The following findings were observed during the  1 Life Safety Code Survey conducted on July 13, 1 2016. | | | |  | |
| K 018 NFPA 101 LIFE SAFETY CODE STANDARD | | | |  | |
| SS=D  Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. 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 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3  I This STANDARD is not met as evidenced by: | | | | 7/13/16  7/15/16 | |
|  | Based on observations during the Life Safety Code Inspection, it was determined that a wedge was placed under one (1) door to prevent the door from closing and one (1) entrance door failed to close and latch to prevent the passage of smoke in the event of a fire in two (2) of two (2) observations.  This observation was made in the presence of Maintenance Staff. | | | 8/13/16 | |
| The findings include: | | | 9/22/16 | |
| 1. A wedge was placed between the bottom of the | | |  | |

LABORATOR IRECTORS' OR P\_7VIOERJSUPPLIER REPRESENTATIVE'S SIGNATURE

/ *IJf!g/ ,f* ' *RAl. LLV#A*

TITLE

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( X61DATE

*K v /1?*

Any deficiency staten<ent ending with an'5tlrisk (•)denotes a deficiency which the institution may be excused from correcting providing ii Is determined that !her *I* safeguards provide sufficient protection to the patients. (See Instructions,) Except for nursing homes, the findings stated **above** are dlsclosable 90 days following the dale of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction **are** dlsclosable 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 pa rticipation.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID KV5J21 Facility ID· METHODIST If continuation sheet **Page** 1 of 4

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

FORM APPROVED

0MB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIERICLIA IDENTIFICATION NUMBER  **095038** | (X2) MULTIPLE CONSTRUCTION  **A** BUILDING **01** • **MAIN BUILDING 01**  **B** WING | | | (X3) DATE SURVEY  COMPLETED  **07/13/2j)16** | |
| NAME OF PROVIDER OR SUPPLIER  **FOREST HILLS OF DC** | | | | STREET ADDRESS CITY, STATE, ZIP CODE  **4901 CONNECTICUT AVENUE, NW**  **WASHINGTON, DC 20008** | | | |
| (X4)1D PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTI VE ACTION SHOULD BE  CROSS-REFERENCEDTO THE **APPROPRIATE**  DEFiC ENCY) | | (X51 COMPLETION DATE |
| K 018 I  K 062 I  SS=E | Continued From page 1  Gift Shop door and the floor to hold the door open: which would prevent the door from closing and allow the passage of smoke in the event of a fire in one (1) of one (1) observation at 10:11 AM on July | | K018 | |  | |  |
| 13, 2016.  2. The entrance door to Room 141 made contact with the floor and failed to close without assistance when tested in one (1) of one (1) observation at 10:15 AM on July 13, 2016.  The following findings were observed during the Life Safety Code Survey conducted on July 13, 2016.  NFPA 101 LIFE SAFETY CODE STANDARD K062  Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically.  19.7.6, 4.6.12, **NFPA** 13, NFPA 25, 9.7.5  This STANDARD is not met as evidenced by:  Based on observations during the Life Safety Code Inspection, it was determined that sprinklers were not maintained to ensure proper operation in the event of an emergency as evidenced by dust and/or paint observed on the surfaces of sprinkler heads, shafts and escutcheon rings in 52 of 60  observations. These findings were observed in the 1 | | | |
| presence of the Maintenance Staff.  The findings include:  Sprinklers were not maintained to ensure proper operation in the event of an emergency as evidenced by dust on sprinkler heads, and paint heads and escutcheon rings in the following | |  | |

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

FORM APPROVED

QMB NO. 0938-0391\_

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| STATEMENT OF DEFICIENCIES ANO PLAN OF CORRECTION | | (X1l PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER  **095038** | (X2l MULTIPLE CONSTRUCTION  A BUILDING **01** • **MAIN BUILDING 01**  **8.** WING | | | (XJI DATE SURVEY  COMPLETED  **07/13/2016** | |
| NAME OF PROVIDER OR SUPPLIER  FOREST HILLS OF DC | | | | STREET ADDRESS, CITY, STATE ZIP CODE  4901 CONNECTICUT AVENUE, NW  **WASHINGTON, DC 20008** | | | |
| (X4)ID PREFIX TAG | SUMMARY STATEMENT OF 0EFIOENCIES  (EACH 0EFIOENCY MUST SE PRECEDED SY FULL REGULATORY  OR LSC IDENTIFYING JI-EORMATIONI | | ID PREFIX | | PROVlDER S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE | | (X5 )  COMP\.EilO  DATE |
|  | | DEFICIENCY) | |
| K 062 I | Continued From page 2 areas. | | K 0621 | | **K062**  1. **Corrective Action** for **Affected**  Residents: | |  |
|  | | | |
|  | 1. Sprinkler heads and shaft surfaces were soiled with accumulated dust and debris on the head and shaft surfaces in the First Floor Dining Room two (2) of two (2) observations at 11:10 AM on July 13, 2016. I 2. Sprinklers head surfaces were soiled with dust in the 1st Floor Day Room in one (1) of four (4)   observations at 11:12 AM on July 13, 2016. | | | | A thorough inspection of all sprinkler heads in the Health Care Center and the basement was conducted for compliance.  One sprinkler head was found to have paint on the shaft and was immediately cleaned.  **2. Identification of Other Residents** | | 7/13/16 |
|  | 3. Sprinkler head surfaces were soiled with dust ln the Charting Area Bathroom in one (1) of one (1) observation at 11:15 PM on July 13, 2016. | | | | **Potentially Affected by the same Practice:** No residents were affected by this deficient practice. | | 7/15/16 |
|  | 4. The escutcheon and sprinkler head surfaces were soiled with dust In the bathroom in Room 247 in one (1) of one (1) observation at 11:25 AM on  July 13, 2016. | | | | **3.Systemlc Changes to Ensure Deficient Practice Does Not Recur:**  A bi-weekly inspection of all sprinkler heads in | |  |
|  | 5. Sprinkler head and shaft surfaces were soiled with dust in Room 252 in two (2) of two (2) observations at 11:35 AM on July 13, 2016. | | | | Health Care Center and the Basement will be conducted for paint and dust accumulation. The maintenance staff will immediately  Clean any sprinkler head with paint and dust. | | 8/13/16 |
|  | 6. Sprinkler head and shaft surfaces were soiled with dust in the 1st Floor Day Room In four (4) of four (4) observations at 12:30 PM on July 13, 2016. | | | | Findings will be logged for reporting.  **4.Performance Monitoring to make Sure** | |  |
|  | 7. Sprinkler head and shaft surfaces were soiled with dust in Dishwasher Area of the Main Kitchen In one (1) of two (2) observations at 12:45 PM on July  13, 2016. | | | | **Solutions Are Sustained:**  Maintenance supervisor will report results of the bi-weekly inspections to the QA committee | | 9/22/16 |
|  |  | | | | quarterly. | |  |
|  | |  | |
|  | 8. Paint was observed on the escutcheon plates  and sprinkler heads as follows: | |  | |  |
|  | Resident Rooms: | |  | |  |

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

FORM APPROVED

0MB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES ANO PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER  **095038** | (X2) MULTIPLE CONSTRUCTION  A BUILDING 01 • **MAIN** BUILDING 01  8. WING | | | (XJ) DATE SURVEY  COMPLETED  07/13/2016 | |
| NAME OF PROVIDER OR SUPPLIER  FOREST HILLS OF DC | | | | STREET ADDRESS, CITY. STATE, ZIP CODE  **4901** CONNECTICUT **AVENUE, NW**  **WASHINGTON, DC 20008** | | | |
| (X4)1D PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PROV DER **S PLAN** OF CORRECTION **(X5)**  PREFIX I IEACH CORRECTIVE ACTION SHOULD BE CO 'Pt.ETION  TAG CROSS-REFERENCED TO THE APPROPRIATE DATE | | | | |
|  | | OEF,CIENCY) | | |
| K 062 I | Continued From page 3  240 Toilet Room in one (1) of one (1) observation 242 Toilet Room in two (2) of two (2) observations 244 Toilet Room in one (1) of one (1) observation 245 Toilet Room in one (1) of one (1) observation 240 in one (1) of one (1) observation  251 in one (1) of one (1) observation  152 in two (2) of two (2) observations  142 in two (2) of two (2) observations  First Floor:  1st Floor Charting Bathroom in one (1) of one (1) observation;  1st Floor Day Room fn four (4) of four (4)  observations  1st Dining Room in five (5) of (8) observations  Second Floor  2nd Floor Physical Therapy in 13 of 13 observations 2nd floor Clean linen Room in two (2) of two (2) observations  2nd floor Staff lounge In two (2) of two (2) observations  Beauty Shop fn three (3) of four (4) observations  These findings were observed between 10:10 AM and 12:50 PM; in 52 of 60 observations on July 13,  2016. | | K062 | |  | |  |
| The following findings were observed during the Life  Safety Code Survey conducted on July 13, 2016.  I | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  **095038** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING **01 - MAIN BUILDING 01** 2. WING | | | (X3) DATE SURVEY  COMPLETED  **10/02/2017** | |
| NAME OF PROVIDER OR SUPPLIER  **FOREST HILLS OF DC** | | | | STREET ADDRESS, CITY, STATE, ZIP CODE  **4901 CONNECTICUT AVENUE, NW**  **WASHINGTON, DC 20008** | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | (X5) COMPLETION DATE |
| K 000 | INITIAL COMMENTS | | K 000 | |  | |  |
|  | The following findings were observed during a tour of your facility on September 30, 2017 and October 1, 2017. | |  | |  | |  |
| K 353  SS=E | NFPA 101 Sprinkler System - Maintenance and Testing  Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.  a) Date sprinkler system last checked | | K 353 | | 1. **Corrective Action for Deficient Practice:** Upon review of documents, we immediately informed BFPE (vendor) to start listing all devices on inspection reports. We have also signed a new contract for quarterly sprinkler inspections. 2. **Residents Affected by this Practice:**   No residents were affected by this practice.   1. **Systemic Changes to Ensure Deficient Practice Does Not Recur:** A monthly inspection of all sprinkler reports will be conducted by the Facility Manager for accuracy/compliance. | | 10/2/17  10/2/17  10/26/17 |
|  | 1. Who provided system test 2. Water system supply source | |  | | **4. Performance Monitoring to Ensure Solutions Are Sustained:**  Facility Manager will report findings quarterly to the QAPI committee. | | 10/26/17 |
|  | Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.  9.7.5, 9.7.7, 9.7.8, and NFPA 25  This STANDARD is not met as evidenced by: | |  | |  | |  |
|  | Based on record review during the Life Safety Code Inspection, the facility failed to demonstrate the testing of Water Flow Alarm Devices each quarter as required; such as Tamper and Flow Switches and Supervisor Valves in four (4) of four  (4) observations. The Director of Maintenance was present at the time of record review and acknowledged the findings. | |  | |  | |  |
|  | The findings include: | |  | |  | |  |

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

# Mary Savoy

Administrator

October 21, 2017

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.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: LG8421

Facility ID: METHODIST If continuation sheet Page 1 of 2

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  **095038** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING **01 - MAIN BUILDING 01** 2. WING | | | (X3) DATE SURVEY  COMPLETED  **10/02/2017** | |
| NAME OF PROVIDER OR SUPPLIER  **FOREST HILLS OF DC** | | | | STREET ADDRESS, CITY, STATE, ZIP CODE  **4901 CONNECTICUT AVENUE, NW**  **WASHINGTON, DC 20008** | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | (X5) COMPLETION DATE |
| K 353 | Continued From page 1  On September 30, 2017, record review and interview showed the documentation to support individual testing of Water Flow Devices; such as Flow Switches, Tamper Switches, and Supervisory Valves on a Quarterly basis, was unavailable.  Vendor log sheets showed a "y" for Yes; to indicate that all devices were tested, and passes the Quarterly Test. However, the report from the vendor's report failed to show the location of each Water Flow Devices and whether the devices passed the quarterly test in four (4) of four (4) observations. The Sprinkler Alarm Devices testing occurred on December 17, 2016, April 7, 2017, July  16, 2017, and September 01, 2017. NFPA 9.7,5,  9.7.8 and NFPA 25 5.3.3. | | K 353 | |  | |  |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: LG8421

Facility ID: METHODIST If continuation sheet Page 2 of 2

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  **HFD02-0004** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING: 2. WING | | (X3) DATE SURVEY  COMPLETED  **09/22/2017** | |
| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE  **FOREST HILLS OF DC 4901 CONNECTICUT AVENUE, NW WASHINGTON, DC 20008** | | | | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | (X5) COMPLETE DATE |
| L 000 | Initial Comments  An annual Licensure Survey was conducted on September 20, 2017 through September 22, 2017 at Forest Hills of DC. The deficiencies are based on observation, record review, resident and staff interviews for 22 sampled residents.  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  cc - cubic centimeters  cm - Centimeters  CMS - Centers for Medicare and Medicaid Services  CNA- Certified Nurse Aide  D.C. - District of Columbia  DCMR- District of Columbia Municipal Regulations  D/C Discontinue  Dl - deciliter  DMH - Department of Mental Health G-tube Gastrostomy tube  HVAC - Heating ventilation/Air conditioning ID - Intellectual disability  IDT - interdisciplinary team L - Liter  Lbs - Pounds (unit of mass)  LE- Lower Extremity  MAR - Medication Administration Record MD- Medical Doctor  MDS - Minimum Data Set  Mg - milligrams (metric system unit of mass)  mL - milliliters (metric system measure of | | L 000 |  | |  |

Health Regulation & Licensing Administration

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

# Mary Savoy

STATE FORM

6899

LG8411

Administrator October 21, 2017

If continuation sheet 1 of 5

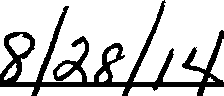
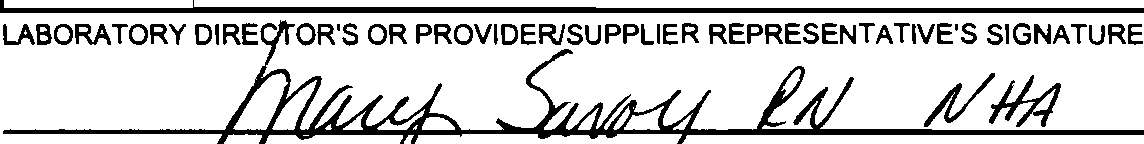
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  **HFD02-0004** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING: 2. WING | | (X3) DATE SURVEY  COMPLETED  **09/22/2017** | |
| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE  **FOREST HILLS OF DC 4901 CONNECTICUT AVENUE, NW WASHINGTON, DC 20008** | | | | | | |
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| L 000  L 051 | Continued From page 1  volume)  mg/dl - milligrams per deciliter mm/Hg - millimeters of mercury Neuro - Neurological  NP - Nurse Practitioner  O2- Oxygen  PASRR - Preadmission screen and Resident Review  PO- by mouth  POS - physician ' s order sheet  Prn - As needed  Pt - Patient  Q- Every  QIS - Quality Indicator Survey Rp, R/P- Responsible party  Sol- Solution  S/P- Status Post  TAR - Treatment Administration Record Tx- Treatment  UE- Upper Extremity  3210.4 Nursing Facilities  A charge nurse shall be responsible for the following:   1. Making daily resident visits to assess physical and emotional status and implementing any required nursing intervention; 2. Reviewing medication records for completeness, accuracy in the transcription of physician orders, and adherences to stop-order policies; 3. Reviewing residents' plans of care for appropriate goals and approaches, and revising them as needed; | | L 000  L 051 |  | |  |

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| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE  **FOREST HILLS OF DC 4901 CONNECTICUT AVENUE, NW WASHINGTON, DC 20008** | | | | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | (X5) COMPLETE DATE |
| L 051  L 099 | Continued From page 2   1. Delegating responsibility to the nursing staff for direct resident nursing care of specific residents; 2. Supervising and evaluating each nursing employee on the unit; and 3. 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:   3219.1 Nursing Facilities  Food and drink shall be clean, wholesome, free from spoilage, safe for human consumption, and served in accordance with the requirements set forth in Title 23, Subtitle B, D. C. Municipal Regulations (DCMR), Chapter 24 through 40.  This Statute is not met as evidenced by:  Based on observations made on September 20, 2017 at approximately 8:30 AM, the facility failed to serve foods under sanitary conditions as evidenced by one (1) of one (1) food warmer, one  (1) of one (1) convection oven, and one (1) of one  (1) stove that were soiled throughout and the kitchen floor soiled with debris.  The findings include:  1. One (1) of one (1) food warmer, one (1) of one  (1) convection oven, and one (1) of one (1) stove located in the main kitchen soiled.  2. The entire kitchen floor soiled with debris.  The observations made in the presence of Employee #13 were acknowledged. | | L 051  L 099 | **L099 – Soiled Equipment**   1. **Corrective Action for Deficient Practice:** Equipment was cleaned thoroughly on September 21, 2017. 2. **Residents Affected by Deficient Practice:** There has been no indication to date that residents were affected by the deficient practice. 3. **Systemic Changes to Ensure Deficient Practice Does Not Recur:** 4. All Production and Utility staff were trained on the proper cleaning of equipment. 5. The Master cleaning schedule was revised to increase weekly cleanings to bi-weekly for all kitchen equipment.   4. **Performance Monitoring to Ensure Sustainability:** The Executive Chef will monitor compliance with the schedule and report findings quarterly to the QAPI Committee.  **Soiled Floor**   1. **Corrective Action for Deficient Practice:** Entire kitchen floor was deck scrubbed immediately. 2. **Residents Affected by Deficient Practice.**   No resident was affected by deficient practice.   1. **Systemic Changes to Ensure Deficient Practice Does Not Recur**.   Floor cleaning policy was reviewed with all utility staff. Assignment sheet was revised to include name of employee responsible for sweeping & mopping floor each shift to ensure accountability.   1. **Performance Monitoring to Ensure Sustainability**   The Dining Services Manager on duty will monitor the cleanness of the floor daily by checking out each utility person after the shift. Findings will be reported to the Director of Dining services weekly and reported at the Quarterly QAPI meeting. | | 9/21/17  9/21/17  9/29/17  10/26/17  9/21/17  9/21/17  9/23/17  10/26/17 |

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| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE  **FOREST HILLS OF DC 4901 CONNECTICUT AVENUE, NW WASHINGTON, DC 20008** | | | | | | |
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| L 214  L 214  L 442 | Continued From page 3 3234.1 Nursing Facilities  Each facility shall be designed, constructed, located, equipped, and maintained to provide a functional, healthful, safe, comfortable, and supportive environment for each resident, employee and the visiting public.  This Statute is not met as evidenced by:  Based on observations made on September 20, 2017 at approximately 10:00 AM, the facility failed to maintain resident's environment free of accident hazards as evidenced by a portable heater that was in use in one (1) of 21 resident's rooms.  The findings include:  A portable heater was plugged in and in use in resident room #140, one (1) of 21 resident's rooms surveyed.  This observation made in the presence of Employees #11 and #12 was acknowledged.  3258.13 Nursing Facilities  The facility shall maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.  This Statute is not met as evidenced by:  Based on observations made on September 20, 2017 between 8:30 AM and 9:45 AM, the facility failed to maintain essential equipment in good working condition as evidenced by one (1) of one  (1) food warmer with no temperature control knob, one (1) of one (1) tilt skillet which failed to power up when turned on, and one (1) of one (1) dishwashing machine which failed to reach 180 degrees Fahrenheit at final rinse. | | L 214  L 214  L 442 | **L 214 – Portable Heater in Resident’s Room**   1. **Corrective Action for Deficient Practice:**   heater was immediately removed from room.   1. **Residents Affected by Deficient Practice:**   No resident was affected by deficient practice.   1. **Systemic Changes to Ensure Deficient Practice Does Not Recur:** 2. Safety rounds Checklist has been updated to include observation for portable heaters and other equipment in resident rooms that may pose safety hazards. . 3. Education was provided to all private duty caregivers regarding equipment safety and other safety measures to be maintained while caring for a resident. Emphasis included use of portable heaters.   **4. Performance Monitoring to Ensure Sustainability:** Results of bi-weekly safety rounds will be reported quarterly to QAPI Committee.  **L442 – Failure to Maintain Essential Equipment in Good Working Condition**  **A. Missing Temperature Control Knob**   1. **Corrective Action for Deficient Practice:** The Knob was found and placed back on the warmer. 2. **Residents Affected by Deficient Practice:**   No resident was affected by deficient practice.   1. **Systemic Changes to Ensure Deficient Practice Does Not Recur:** The monthly Safety and Sanitation Audit Checklist has been updated to include checking the working condition of all equipment. 2. **Performance Monitoring to Ensure Sustainability:** The Assistant Dining Director and the Executive Chef will monitor results recorded on the Checklist. Concerns will be discussed with the Director at weekly Managers’ meetings and presented to the QAPI Committee quarterly. | | 9/20/17  9/20/17  9/27/17  9/27/17  10/26/17  9/20/17  9/20/17  9/27/17  10/26/17 |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  **HFD02-0004** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING: 2. WING | | (X3) DATE SURVEY  COMPLETED  **09/22/2017** | |
| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE  **FOREST HILLS OF DC 4901 CONNECTICUT AVENUE, NW WASHINGTON, DC 20008** | | | | | | |
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| L 442 | Continued From page 4  The findings include:  1. The temperature control knob for one (1) of one  (1) food warmer was missing.   1. One (1) of one (1) tilt skillet failed to power up when the 'on' switch was activated. 2. The dishwashing machine in the main kitchen failed to reach a final rinse temperature of 180 degrees Fahrenheit during several consecutive rinse cycles. The dishwashing machine located in the dining room of the Healthcare 1 Unit was used to clean and disinfect all dishes.   The observations made in the presence of Employee #13 and Employee #14 were acknowledged. | | L 442 | **L442 – Failure to Maintain Essential Equipment in Good Working Condition (cont’d)**  **B. Tilt Skillet Failed to Power Up**   1. **Corrective Action for Deficient Practice:** Written notice placed on skillet stating that it was not working. 2. **Residents Affected by Deficient Practice:**   No residents were affected.   1. **Systemic Changes to Ensure Deficient Practice Does Not Recur:**   Purchase of new tilt skillet has been approved by Administrator. Upon arrival, tilt skillet will be added to Safety Rounds Checklist.   1. **Performance Monitoring to Ensure Sustainability:** Results from safety rounds will be reported quarterly to QAPI Committee.   **C. Dishwashing Machine Failed to Reach Final Temperature of 1800**   1. **Corrective Action for Deficient Practice:** Ecolab was called and responded immediately. Assessed dish machine and made recommendations regarding process flow changes to prevent depletion of hot water in booster heater before rinse cycle is complete. 2. **Residents Affected by Deficient Practice:**   No residents were affected.   1. **Systemic Changes to Ensure Deficient Practice Does Not Recur:** a) New process that incorporates Ecolab’s recommendations was developed, and all utility staff were   in-serviced.  b) Purchase of new dish machine has been approved by Administrator. c) Upon arrival, dish machine temperatures will be added to Safety Rounds Checklist.  **4. Performance Monitoring to Ensure Sustainability:** Results from safety rounds will be reported quarterly to QAPI | | 9/20/17  9/20/17  9/26/17  10/26/17  9/20/17  9/20/17  9/23/17  9/26/17  10/26/17 |

CENTERS FOR MEDICARE & MEDICAID SERVICES



0MB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER

FOREST HILLS OF DC

(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:

095038

(X2) MULTIPLE CONSTRUCTION

1. BUILDING **01** - **MAIN BUILDING 01**
2. WING \_

STREET ADDRESS, CITY, STATE, ZIP CODE **4901 CONNECTICUT AVENUE, NW WASHINGTON, DC 20008**

(X3) DATE SURVEY

COMPLETED

**07/28/2014**

(X4)ID PREFIX TAG

SUMMARY STATEMENT OF DEFICIENCIES

(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

ID PREFIX TAG

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE

CROSS-REFERENCED TO THE APPROPRIATE

DEFICIENCY)

(XS) COMPLETION DATE

###### K 000! INITIAL COMMENTS K0001

The following finding was observed during the Life Safety Code Survey at your facility on July 28, 2014.

K 144 NFPA 101 LIFE SAFETY CODE STANDARD

SS=D

Generators are inspected weekly and exercised

under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.

This STANDARD is not met as evidenced by:

Based on a review of records during the Life Safety Code Survey, it was determined that the Emergency Generator was not exercised under load for at least 30 minutes monthly for seven (7) of 12 months reviewed in nine (9) of 24 records reviewed on July 28, 2014.

* 1. Corrective action for **affected residents:** There were no negative outcomes to the residents.

Generator was exercised monthly in accordance with NFPA 99.

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K 144 1 2\_ **Identification of Other Residents**

**Potentially Affected by the Same Practice:** Residents are not affected by this practice and generator was exercised with load for at least 30 minutes per month.

1. **Measure of systematic changes to ensure deficient practice does not recur:**

Maintenance personnel were re-educated on accurately logging run hours on Power Generator service records as run times with load are automatically programed on the generator

by generator company.

1. **Performance monitoring to ensure solutions are sustained:**

The Maintenance Director will monitor the above through quality assurance- by reviewing logs

on a quarterly basis.

7/28/2014

7/28/2014

8/8/2014

8/8/2014

The findings include:

During a review of nine (9} of 24 Emergency Generator Log sheets, it was determined that the Emergency Generator was not exercised under load, for 30 minutes per month in seven (7) of 12 months reviewed. This requirement is according to NFPA 99 3.4.2.2.2.

The Emergency Generator was exercised less than 30 minutes on the following dates:

TITLE (X6) DATE

Any deficiency sta ement e mg with an asteri (\*) denotes a deficiency which the institution may be excused from correcting p vidin it is determined that other safeguards provide sufficie 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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: U97721 Facility ID: METHODIST If continuation sheet Page 1 of 3

CENTERS FOR MEDICARE & MEDICAID SERVICES 0MB NO. 0938-0391

STATEMENT OF DEFICIENCIES ANO PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER

FOREST HILLS OF DC

(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:

095038

(X2) MULTIPLE CONSTRUCTION

1. BUILDING **01** • **MAIN BUILDING 01**
2. WING

STREET ADDRESS., CITY, STATE, ZIP CODE

**4901 CONNECTICUT AVENUE, NW**

**WASHINGTON, DC 20008**

I

(X3) DATE SURVEY

COMPLETED

**07/28/2014**

(X4)1D PREFIX TAG

SUMMARY STATEMENT OF DEFICIENCIES

(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

ID PREFIX TAG

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE

CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

(X5) COMPLETION DATE

K 144 Continued From page 1

October 28, 2013 the log reflected an exercise of O.3 hours which is equivalent to 18 minutes

November 18, 2013 the log reflected an exercise 0.2 hours which is equivalent to 12 minutes

December 16, 2013 the log reflected an exercise of 0.4 hours which is equivalent to 24 minutes

December 23, 2013 the log reflected an exercise of 0.4 hours which is equivalent to 24 minutes

February 17, 2014 the log reflected an exercise of 0.3 hours which is equivalent to 18 minutes

February 24, 2014 the log reflected an exercise of 0.3 hours which is equivalent to 18 minutes

March 3, 2014 the log reflected an exercise of

0.3 hours which is equivalent to 18 minutes

April 14, 2014 the log reflected an exercise of

* 1. hours which is equivalent to 18 minutes

June 9, 2014 the log reflected an exercise of

* 1. hours which is equivalent to 24 minutes

The Emergency Generator was not exercised under load for 30 minutes per month for seven (7) of 12 months reviewed. The findings were acknowledged by the Director of Maintenance

K 144

CENTERS FOR MEDICARE & MEDICAID SERVICES 0MB NO. 0938-0391

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| NAME OF PROVIDER OR SUPPLIER  **FOREST HILLS OF DC** | | | | STREET ADDRESS, CITY, STATE, ZIP CODE  **4901 CONNECTICUT AVENUE, NW**  **WASHINGTON, DC 20008** | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | (X5) COMPLETION DATE |
| K 144 | Continued From page 2  and Maintenance Staff at the time of the review of records on July 28, 2014. | | K 144 | |  | |  |
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(Tags:  Trial attorney, nursing home lawyer, nursing home attorney, overmedication, medication error, pressure sores, bed sores, sepsis, wrongful death, wounds, falls, attorney handling medication errors, nursing home abuse attorney, assisted living attorney, assisted living accidents, dehydration, malnutrition, DC abuse attorney, nursing home injury, skilled rehab injury, skilled rehab attorney, drugs, pharmaceutical drugs, antipsychotic drugs, negligence attorney, nursing home abuse attorney, adult protective service lawyer, overdose, legal liability for overdose, nursing home abuse lawyer, , nursing home chains, statistics on nursing home abuse, Maryland abuse attorney, silver spring nursing home attorney, Methodist Home of DC, Forest Hills of DC wrongful death)