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

PRINTED: 03/20/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495239	A. BUILDING _____ B. WING _____	C 03/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE JEFFERSON	900 NORTH TAYLOR STREET ARLINGTON, VA 22203

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 03/04/2019 through 03/06/2019. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 03/04/2019 through 03/06/2019. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. One complaint was investigated during the survey. The census in this 31 certified bed facility was 26 at the time of the survey. The survey sample consisted of 17 resident reviews.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to ensure a complete and accurate MDS (minimum data set) assessment for one of 18 residents in the survey sample Resident #32. The facility staff failed to code the Medicare five day assessment accurately with the correct place of discharge for Resident #32.	F 641	F541 Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with federal and/or state law. 1. With respect to the specific observation cited: The 5/day/DRNA/End of PPS Part A Stay MDS (ARD 12/13) for resident #32 was modified, transmitted, and accepted into	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Deborah C. Wine, LNHA — TITLE: Administrator — (X6) DATE: 3/28/19

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 641	Continued From page 1 The findings include: Resident #32 was admitted to the facility on 12/7/2018. Diagnoses included but were not limited to: mitral valve insufficiency (1), high blood pressure, unsteadiness on feet and atherosclerotic heart disease (2). The most recent MDS (minimum data set), a Medicare five day assessment, with an ARD (assessment reference date) of 12/13/18 coded the resident as having a score of 15 out of 15 on the BIMS (brief interview for mental status) indicating the resident was cognitively intact to make daily decisions. Section A1800 documented the resident entered the facility from an acute hospital. Section A2100 documented the resident was being discharged to an acute hospital. Review of "Discharge Note", dated 12/13/18 documented in part, the resident was "Discharged to home." On 03/06/19 at approximately 12:27 p.m., an interview was conducted with LPN (licensed practical nurse) #1. When asked if LPN #1 remembered Resident #32. LPN #1 replied, "Yes, I discharged him. He was only here for a few days and then went home." When asked if Resident #32 was ever discharge from the facility to the hospital, LPN #1 replied, "No." On 03/06/19 at approximately 12:34 p.m., Resident #32's MDS was reviewed with RN #2, the MDS coordinator. When RN #2 was asked if she remembered Resident #32, RN #2 replied, "He was only here for about a week and was doing pretty good, then he went home." When asked why the resident did not have a discharge	F 641	the CMS database at the time of the survey. 2. With respect to how the facility will identify residents with the potential for the identified concern and take corrective action: An audit of MDS Discharge assessments for residents who discharged from the facility during the 30 days prior to 3/6/19 was conducted by the Resident Assessment Coordinator on 3/21/19. No discrepancies were identified. 3. With respect to what systemic measures have been put in place to address the stated concern: Refresher training on MDS coding instructions for discharged residents will be provided to Resident Assessment Coordinators by the Skilled Nursing Administrator or her designee by 3/31/19. 4. With respect to how the plan of corrective measures will be monitored: Over the next three months, MDS Discharge Assessments will be audited by the Resident Assessment Coordinator or her designee to verify that they are coded with the correct place of discharge. The findings of the audits will be	

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F 641	Continued From page 2 MDS assessment. RN #2 replied, "I will check that out and get back with you." On 03/06/19 at approximately 02:24 p.m., a follow up interview was conducted with RN #2, while reviewing Resident #32's MDS. RN #2 stated at that time "We did not do a discharge MDS because he was only here for a week. The RAI (resident assessment instrument) manual allows us to combine the five day assessment and discharge assessment." When asked about the discharge destination for Resident #32 on his Medicare five day assessment, RN #2 stated "It says he went to the hospital." When asked if this destination was accurate, RN #2 replied "It's not, he went home. I'm going to modify it now and send it in. I will let you know when it's done." On 03/06/19 3:16 p.m., RN #2 provided this surveyor with a document titled CMS Submission Report dated 3/6/19 at 15: 01 that documented section A2100 was changed to "Community" On 03/06/19 at approximately 3:20 p.m., this surveyor was told by ASM (administrative staff member) #1, the Associate Executive Director that the facility does not have a policy on MDS assessment but follows the RAI manual. On 3/6/19 at approximately 4:00 p.m., ASM (administrative staff member) #1 the Associate Executive Director and ASM #2, the Director of Nursing were made aware of the findings. RAI Manual October 2018 - Coding Instructions for Section A2100 Select the 2-digit code that corresponds to the resident's discharge status. o Code 01, community (private home/apt.,	F 641	reviewed at Quality Assurance / Performance Improvement (QAPI) meetings. During and at the conclusion of the three months, the QAPI committee will re-evaluate and initiate necessary action or extend the review period. The Executive Director and/or Administrator are responsible for confirming implementation and ongoing compliance with the components of this Plan of Correction, addressing, and resolving variances that may occur. The Executive Director and/or Administrator are responsible for confirming the status of this Plan of Correction is reviewed and discussed at QAPI meetings and action initiated if required. 5. Areas cited in F641 was corrected on 4/18/19	

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F 641	Continued From page 3 board/care, assisted living, group home): if discharge location is a private home, apartment, board and care, assisted living facility, or group home. o Code 02, another nursing home or swing bed: if discharge location is an institution (or a distinct part of an institution) that is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care or rehabilitation services for injured, disabled, or sick persons. Includes swing beds. o Code 03, acute hospital: if discharge location is an institution that is engaged in providing, by or under the supervision of physicians for inpatients, diagnostic services, therapeutic services for medical diagnosis, and the treatment and care of injured, disabled, or sick persons. o Code 04, psychiatric hospital: if discharge location is an institution that is engaged in providing, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill residents. o Code 05, inpatient rehabilitation facility: if discharge location is an institution that is engaged in providing, under the supervision of physicians, rehabilitation services for the rehabilitation of injured, disabled or sick persons. Includes IRFs that are units within acute care hospitals. o Code 06, ID/DD facility: if discharge location is an institution that is engaged in providing, under the supervision of a physician, any health and rehabilitative services for individuals who have intellectual or developmental disabilities. o Code 07, hospice: if discharge location is a program for terminally ill persons where an array of services is necessary for the palliation and management of terminal illness and CMS's RAI Version 3.0 Manual CH 3: MDS Items [A]	F 641		

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F 641	Continued From page 4 October 2018 Page A-30 A2100: OBRA Discharge Status (cont.) related conditions. The hospice must be licensed by the State as a hospice provider and/or certified under the Medicare program as a hospice provider. Includes community-based (e.g., home) or inpatient hospice programs. o Code 08, deceased: if resident is deceased. o Code 09, long term care hospital (LTCH): if discharge location is an institution that is certified under Medicare as a short-term, acute-care hospital which has been excluded from the Inpatient Acute Care Hospital Prospective Payment System (IPPS) under §1886(d)(1)(B)(iv) of the Social Security Act. For the purpose of Medicare payment, LTCHs are defined as having an average inpatient length of stay (as determined by the Secretary) of greater than 25 days. o Code 99, other: if discharge location is none of the above. No further information was obtained prior to exit. 1. A heart problem involving the mitral valve, which separates the upper and lower chambers of the left side of the heart. In this condition, the valve does not close normaly. This information was obtained from the website: https://medlineplus.gov/ency/article/000180.htm. 2. A disease in which plaque builds up inside your arteries. Plaque is a sticky substance made up of fat, cholesterol, calcium and other substances found in the blood. Over time, plaque hardens and narrows your arteries. That limits the flow of oxygen-rich blood to your body. This information was obtained from the website: https://medlineplus.gov/atherosclerosis.html.	F 641		

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F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) 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. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, it was determined that the facility staff failed to store a mop head and distribute food in a sanitary manner. 1. The facility staff failed to practice safe food handling techniques while taking foods temperatures on the steam table. 2. The facility staff failed to store a mop head in a sanitary manner, in the main kitchen. The findings included: 1. The facility staff failed to practice safe food handling techniques while taking foods	F 812	F812 Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with federal and/or state law. 1. With respect to the specific observation cited: The Food & Beverage Director confirmed with the nursing department that no residents experienced a negative outcome as a result of the thermometer used to take food temperatures. New food temperatures were obtained by the Dietary Aide at the time of survey and the temperatures were within required temperature zones. The used mop observed on top of the box of detergent was stored properly by the Chef at the time of survey. 2. With respect to how the facility will identify residents with the potential to be affected by the identified concern and take corrective action: The process for taking tray line food temperatures was observed for 24 hours by a member of the Dining management team to confirm	

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F 812	Continued From page 6 temperatures on the steam table. On 3/5/19 at approximately 11:35 a.m., an observation was made of OSM (other staff member) #3, the cook, taking tray line temperatures. OSM #3 was observed taking a thermometer off a supply table. OSM #3 then proceeded to remove the thermometer probe cover, get a paper towel from the paper towel dispenser, wet it with tap water, and then wiped the probe. OSM #3 then began to take temperatures on the steam table. OSM #3 then used the same paper towel to wipe the temperature probe between taking temperatures on different food items. On 3/5/19 at approximately 11:45 a.m., an interview was conducted with OSM #3. OSM #3 was asked to explain how temperatures are usually taken of food on the steam table. OSM #3 replied, "The food comes up from the kitchen I get my thermometer, clean it and then start taking temperatures." When asked how the thermometer is cleaned, OSM #3 replied, "I usually use alcohol pads, but we are out." On 3/5/19 at approximately 11:50 a.m., an interview was conducted with OSM #2, the Director of Dinning and Hospitality. When asked how a thermometer is supposed to be sanitized prior to taking temperatures of food items. OSM #2 replied, "We use thermometer alcohol probe wipes to sanitize the thermometer prior to use. We also clean the thermometer between taking temperatures." OSM #2 was asked why a thermometer should be sanitized prior to use. OSM #2 replied, "It helps prevent any infection." Review of the facility policy titled, "Food	F 812	that the thermometer probe was sanitized between each food item. No issues were observed. Janitor closets in the main kitchen and skilled nursing center were inspected by the Food & Beverage Director to confirm that mops were properly stored. No discrepancies were identified. 3. <u>With respect to what systemic measures have been put in place to address the stated concern</u>: Refresher training will be provided to dietary team members on the correct procedure for taking food temperatures and cleaning the thermometer and proper storage of mops and cleaning supplies by the Food & Beverage Director or his designee by 3/31/19. The kitchen manager or designee will observe tray line temperatures to confirm that dietary team members are sanitizing the thermometer probe between each food item, and will inspect janitor closets for proper storage of mops and cleaning supplies, once daily for the next month, and then weekly for 2 months. 4. <u>With respect to how the plan of corrective measures will be monitored</u>: Over the next three months, the findings from tray	

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F 812	Continued From page 7 Temperatures" dated 08/31/2018, documented in part "Wash, rinse and sanitize a dial face, metal probe type thermometer with alcohol wipe. A practical range of 0 - 220 degrees Fahrenheit is recommended. Re-sanitize the thermometer after each use." On 3/6/19 at approximately 4:00 p.m., ASM (administrative staff member) #1, the Associate Executive Director and ASM #2, the Director of Nursing were made aware of the findings. No further information was obtained prior to exit. 2. The facility staff failed to store a mop head in a sanitary manner, in the main kitchen. On 3/5/19 at approximately 10:25 a.m., an observation was made a storage closet in the main kitchen with OSM (other staff member) #2, the Director of Dinning and Hospitality. A used moist mop head was observed laying on top of box of detergent. The mop head was immediately picked up by OSM #2 who stated, "This mop does not belong here, it belongs hanging up in the mop closet." The mop head was then handed to another kitchen staff to take to the mop closet. OSM #2 then washed his hands. On 3/6/19 at approximately 10:36 a.m. an interview was conducted with OSM #2. OSM #2 was asked how mops are to be stored when not in use. OSM #2 replied, "The mops should be hanging up in the mop closet." The facility policy titled, 'Janitor Closet" dated 8/31/2018 documented, "Mops should be washed, rinsed, wrung out, and allowed to air dry	F 812	line temperature observations and janitor closet inspections will be reviewed at Quality Assurance / Performance Improvement (QAPI) meetings. During and at the conclusion of the three months, the QAPI committee will re-evaluate and initiate necessary action or extend the review period. The Executive Director and/or Administrator are responsible for confirming implementation and ongoing compliance with the components of this Plan of Correction, addressing, and resolving variances that may occur. The Executive Director and/or Administrator are responsible for confirming the status of this Plan of Correction is reviewed and discussed at QAPI meetings and action initiated if required 5. Areas cited in F812 will be corrected by 4/18/19.	

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F 812	Continued From page 8 before returning to the janitor's closet. The closet should be orderly at all times. Detergents and cleaning agents must be stored off the floor. This prevents the products from becoming damp and hardened when detergents are stored in containers that are subject to moisture absorption. " On 3/6/18 at approximately 4:00 p.m., ASM (administrative staff member) #1, the Associate Executive Director and ASM #2, the Director of Nursing were made aware of the findings. No further information was obtained prior to exit.	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following	F 880	F880 Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with federal and/or state law. 1. <u>With respect to the specific observation cited:</u> The drainage system in the ice machine was elevated by maintenance staff on 3/10/19 to allow the proper clearance above the floor drain. Following the survey observation, the	

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F 880	Continued From page 9 accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 880	reusable plastic medication trays were cleaned between each resident use during the survey. 2. With respect to how the facility will identify residents with the potential to be affected by the identified concern and take corrective action: The ice machines in the skilled nursing center pantry and activity room were inspected by the Food & Beverage Director on 3/6/19 and found to have an air gap for the drain. Immediate refresher training was provided to nursing staff by the Director of Nursing Services and Assistant Director of Nursing Services. Reusable plastic medication trays in use were then cleaned between uses with each resident on 3/6/19. 3. With respect to what systemic measures have been put in place to address the stated concern: Ice machine drains will be inspected on weekly kitchen rounds for three months by the Food & Beverage Director or his designee to confirm that a gap is maintained between the ice machine drain and the floor drain. Refresher training will be conducted for nursing staff regarding cleaning reusable medical equipment by	

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F 880	Continued From page 10 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, and review of facility documents, the facility staff failed to properly maintain an ice machine to prevent the spread of disease, for one of two facility ice machines, (the ice machine in the main kitchen); and the facility staff failed to implement infection control practices to prevent the spread of infection and communicable disease, on one of one nursing units. 1. The main kitchen ice machine did not have an air gap for the ice machine drain. 2. The facility staff failed to clean a reusable plastic medication tray in between residents during medication administration. The findings include: 1. The facility staff failed to maintain an ice machine drainage system in a sanitary manner for one of two ice machines, the one in the main kitchen. The ice machine in the main kitchen was observed on 3/5/19 at approximately 10:15 a.m., with OSM (other staff member) #2, the Director of Dining and Hospitality. The white PVC (polyvinyl chloride) drainpipe was visible below the surface of the floor drain. OSM #2 was asked how a drainage pipe should be maintained. OSM #2 replied, "It should be a distance above the floor." OSM #2 was asked why, OSM #2 replied, "To	F 880	the Director of Nursing or designee by 3/31/19. Use of the plastic medication trays was discontinued on 3/25/19. 4. With respect to how the plan of corrective measures will be monitored: Over the next three months, the findings from the weekly kitchen rounds will be reviewed at Quality Assurance / Performance Improvement (QAPI) meetings. During and at the conclusion of the three months, the QAPI committee will re-evaluate and initiate necessary action or extend the review period. The Executive Director and/or Administrator are responsible for confirming implementation and ongoing compliance with the components of this Plan of Correction, addressing, and resolving variances that may occur. The Executive Director and/or Administrator are responsible for confirming the status of this Plan of Correction is reviewed and discussed at QAPI meetings and action initiated if required. 5. Areas cited in F880 will be corrected by 4/18/19.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495269	A. BUILDING _____ B. WING _____	C 03/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE JEFFERSON	900 NORTH TAYLOR STREET ARLINGTON, VA 22203

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F 880	Continued From page 11 prevent water from backing up into the machine." OSM #2 was asked how the facility ensures that backflow of water does not flow into the drainage pipe. OSM #2 replied, "It's not but I will call maintenance to come and correct it." On 3/6/19 at approximately 3:45 p.m., a follow up observation and interview was conducted with OSM #2 of the ice machine in the main kitchen. Two large gray ice storage bins that were below the ice machine were removed to visualize the ice machine drainpipe system. A large gray pipe, which collects the drainage from the ice machine, connected to a white PVC pipe that descends at a gradient to the point it empties below the level of the floor. The white PVC had several white PVC pipes that empty into it. OSM #2 stated, "Were running into problems trying to elevate the drain pipe because we would lose the gradient that is used to drain the other pipes as well as the ice machine. We have a couple of options we can elevate the ice machine or elevate the gray pipe but then we could not fit the ice storage bins underneath the ice machine." The facility policy titled, "Ice Machine" dated 10/2018 documented, "Install and maintain machine per state and federal plumbing code regulations." On 3/6/18 at approximately 4:00 p.m., ASM (administrative staff member) #1, the Associate Executive Director and ASM #2, the Director of Nursing were made aware of the findings. No further information was obtained prior to exit. 2. The facility staff failed to clean a reusable plastic medication tray in between residents during medication administration.	F 880		

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F 880	Continued From page 12	F 880		

On 03/05/2019 at approximately 9:45a.m., an observation of the morning medication administration was conducted with RN (registered nurse) #1. During the medication pass, RN #1 used a small grey plastic tray to carry the cup of pills and cup of water into the residents' rooms. As the medications were administered to the residents, the plastic tray was placed on the bedside table. Upon finishing the medication administration for each resident, RN #1 carried the plastic tray out of the room and placed it on the medication cart while preparing the medications for the next resident. At no point during the observation did RN #1 wipe down or otherwise clean the plastic tray. The plastic tray was used in multiple resident rooms.

On the morning of 03/06/2019, a brief interview was conducted with Administrative Staff Member (ASM) #4, the Assistant Director of Nursing. ASM #4 was asked about the facility practice for reusable medical equipment. ASM #4 stated that any equipment that was re-used should be cleaned in between use with one resident and the next. She stated that sanitizing wipes were available to wipe down reusable equipment.

ASM #1, the Associate Executive Director, and ASM #2, the Director of Nursing, were informed of the findings at the end of day meeting on 03/06/2019. No further documentation was presented.