STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095015	A. BUILDING _____ B. WING _____	**06/19/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SERENITY REHABILITATION AND HEALTH CENTER LLC	**1380 SOUTHERN AVE SE WASHINGTON, DC 20032**

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 0726 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.** Based on observation, record review and interview, the facility's Licensed Practical Nurse (LPN) failed to maintain her competency and skillset to administer medications safely for three (3) of three (3) residents. Findings included: Medication Safety: Go beyond the basics .Verify any medication order and make sure it's complete. The order should include the drug name, dosage, frequency and route of administration. If any element is missing, check with the practitioner. Check the patient's medical record for an allergy or contraindication to the prescribed medication. If an allergy or contraindications exist, don't administer the medication and notify the practitioner. Prepare medications for one patient at a time . Reference https://www.nursingcenter.com/ncblog/may-2016/medication-safety-go-beyond-the-basics On 06/19/20 at 10:50 AM, medication observation revealed that the LPN administered medication to Resident #1 from a tray that also contained medications for Residents #2 and #3. During a face to face interview on 06/19/20 at 11:00 AM, the LPN was asked, why she had Resident #2 and Resident #3's medications on the tray? The LPN stated, I didn't want to leave them on the cart, so I left them on the tray. The LPN was also asked, how she would determine which medications belonged to each resident since the medications were not labeled? The LPN stated, I know the residents, and I know what medications they take. Review of the facility's Medication/Treatment Administration Record and Initials Policy dated 07/2019 failed to delineate how nurses were to use the tray when administering medication. Review of the LPN's personnel record on 06/19/20 at 1:30 PM revealed her date of hire was 9/10/18. Continued review of the personnel record showed that the LPN was provided training on medication administration on 08/29/19. At the time of the survey, the LPN failed to administer Resident #1's medication in a safe and acceptable professional manner.
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide and implement an infection prevention and control program.** Based on observations and interviews, the facility failed to have adequate trash receptacles to dispose of used personal protective equipment (PPE) on the Person Under Investigation (PUI) and COVID-19 Unit. Findings included: On 06/19/20 at approximately 1:00 PM, observation of the hallway on the PUI unit revealed a (one of one) white laundry basket with multiple holes. The laundry basket was lined with a red plastic bag that contained used PPEs including gloves and gowns. The laundry basket did not have a lid to cover the contaminiated discharged PPE. On 06/19/20 at approximately 1:10 PM, observation of the hallway on the COVID-19 unit revealed (three of three) white laundry baskets with multiple holes. The laundry baskets were lined with red plastic bags that contained used PPEs including gloves and gowns. The laundry basket did not have a lid to cover the contaminiated discharged PPE. During a face-to-face interview on 06/19/20 at approximately 1:15 PM, the unit manager was asked, how she would ensure that the environment is not contaminated with organisms from the used PPEs if the baskets are not covered with lids? The unit manager stated that the laundry baskets have lids, but she was unaware why the lids were not in place at the time of the observations. Also, the unit manager stated that she would locate the lids and placed them on the laundry baskets. During a face-to-face interview with on 06/19/20 at approximately 1:30 PM, the Administrator was asked, why were laundry baskets used instead of trash can receptacles? The administrator stated that she had ordered foot operated trash receptacles after the DC's Epidemiology Department recommended them the week prior to the observation. A second observation of the PUI and COVID units at approximately 2:00 PM on 06/19/20 revealed that 3 of 4 laundry baskets had lids. However, the lids had multiple holes in them. It should be noted that the laundry baskets and lids were not damaged but were designed with multiple holes in them. The facility failed to ensure that used PPEs were safely discarded in a trash receptacle on the PUI and COVID units.

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