| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 095024 | A. BUILDING _____ B. WING _____ | R 04/19/2007 |

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| SPECIALTY HOSPITAL OF WASHINGTON-HADLEY SNF | 4601 ML KING AVE SW WASHINGTON, DC 20032 |

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| {F 000} | INITIAL COMMENTS<br><br>A follow-up survey was conducted on April 19, 2007 (to the February 22, 2007 recertification survey). The following deficiencies were based on observations, staff and resident interviews and record review. The sample included nine (9) residents based on 60% of the standard survey sample and 15 supplemental residents. | {F 000} | F371<br>1. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**<br>All the spoons were thoroughly rewashed and checked by the supervisor prior to drying.<br>2. **How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken?**<br>All other spoons were checked for cleanliness. No other residents were affected by this deficient practice.<br>3. **What measure will be put in place or what systemic changes you will make to ensure the deficient practice does not recur?**<br>The same day the surveyor found the deficient practice the dish machine was inspected by Maintenance and found to have a water seal issue. The next day 4/20/07, a new water seal was installed and was brought to the attention of the surveyor. A new Dietary contractor (Morrison's) will start on May 19. New spoons have been placed in the capital budget for purchase. Daily spot checks will be conducted by the Production Manager/Dietary Supervisor and a log book was created to track the daily monitoring.<br>4. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur (i.e., what Quality Assurance Program will be put into place?**<br>All deficient practices will be reported by the Dietary Director to monthly Process Improvement and Quality Assurance. | May 19, 2007 |
| {F 371} SS=D | 483.35(i)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE<br><br>The facility must store, prepare, distribute and serve food under sanitary conditions.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on an observation during the inspection of the main kitchen, it was determined that dietary services failed to ensure that silverware was clean and ready for reuse. This observation was made in the presence of the Director of Dietary Services between 11:30 AM and 12:10 PM on April 19, 2007.<br><br>The findings include:<br><br>10 of 28 teaspoons, racked and ready for reuse, were observed to be soiled with food and debris after being washed in the mechanical dishwasher.<br><br>The Director of Dietary Services acknowledged the above observation. | {F 371} | | |
| {F 514} SS=B | 483.75(l)(1) CLINICAL RECORDS<br><br>The facility must maintain clinical records on each resident in accordance with accepted professional | {F 514} | | |

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

Rose Marie Cullen — Administrator — 5/2/07

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 514} | Continued From page 1<br>standards and practices that are complete; accurately documented; readily accessible; and systematically organized.<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff and resident interviews for three (3) of nine (9) sampled residents and 15 supplemental residents, it was determined that facility staff failed to consistently and completely include documentation in all areas on the "Patient Laboratory Test Log" for 18 residents and include documentation regarding a follow up dental consult in one (1) resident's record. Residents #7, 8, 9, H1, H2, H3, H4, S1, S3, S5, S6, S10, S11, S12, S13, S14, S15 and S16.<br><br>The findings include:<br><br>1. Facility staff failed to consistently and completely include documentation in all areas on the "Patient Laboratory Test Log" for Residents #7, 8, 9, H1, H2, H3, H4, S1, S3, S5, S6, S10, S11, S12, S13, S14, S15 and S16.<br><br>In the plan of correction for a deficiency cited during the recertification survey completed February 22, 2007, included the development of a form entitled, "Patient Laboratory Test Log." The log consisted of one piece of paper with a front | {F 514} | F514 (1)<br><br>1. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**<br>All lab forms were completed for the 18 residents identified.<br><br>2. **How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken?**<br>An audit was conducted for the remaining residents to see if lab sheet was appropriately filled out. No other residents were found to have this deficient practice.<br><br>3. **What measure will be put in place or what systemic changes you will make to ensure the deficient practice does not recur?**<br>The newly devised form was revised to have all information on one side. Staff was re-educated about form. RCC will follow up daily to ensure forms are being filled out appropriately.<br><br>4. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur (i.e., what Quality Assurance Program will be put into place?**<br>All deficient practices will be reported to monthly Process Improvement and Quality Assurance meeting. | May 19 2007 |

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| {F 514} | Continued From page 2<br>and back side. The front side of the log included, "Date of test, Resident name and room number, Test ordered, Draw date and Phlebotomist ' s signature." The back side of the log included, "Date result came in, Physician notified, Dosage/new order, and Comments/signatures."<br><br>Unit 3E<br>There were 11 entries on the log for April 5 through April 7, 2007 for Residents #8, S3, S5, S6 and S12. The front side of the log was consistently completed for all areas. The back side of the log was blank for 9 of the 11 entries.<br><br>There were 17 entries for April 8 through 18, 2006 for Residents #7, 8, S1, S10, S11, S13, S14, S15 and S16. The front side of the log was completed for all areas. The back side of the log was blank.<br><br>Unit 3W<br>There were six (6) entries on the log for April 5 through 18, 2007 for Residents #9, H1, H2, H3 and H4. The front side of the log was completed for all areas. The back side of the log was blank for four (4) of the six (6) entries. The results of two (2) of the laboratory studies arrived on the unit the day of the survey.<br><br>The laboratory studies for the residents listed on the "Patient Laboratory Test Log" were reviewed. All laboratory studies were on the resident's records with documentation that the physician was notified.<br><br>A face-to-face interview was conducted with the Resident Care Coordinator on April 19, 2007 at 11:30 AM. After reviewing the "Patient Laboratory Test Log," he/she stated, "The staff was in-serviced on how to use the form on March 5, | {F 514} | | |

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| {F 514} | Continued From page 3<br>2007. Each nurse is assigned five residents to follow-up on for labs. We were so intent on getting all the labs on the record that they (the staff) just didn't think to complete the form."<br><br>The "Patient Laboratory Test Logs" and resident's records were reviewed on April 19, 2007.<br><br>2. Facility staff failed to include documentation in Resident #9's record regarding a follow up dental consult.<br><br>A review of a telephone order dated April 9, 2007 revealed, "Schedule consultation with [Dentist] for dental consultation to assess gum swelling and soreness ASAP [as soon as possible] either send resident out or have [in house dentist] visit [him/her] here. "<br><br>A face-to-face interview was conducted with Resident # 9, on April 19, 2007 at 12:40 PM. He/she stated, " I have had dental problems all my life. I deal with the pain due to financial concerns. I manage the pain with pain medication and Anbesol. I schedule my own dental appointments. I don't know how to ask for help [to schedule my dental appointments]. I'm sure the staff will help me if I ask. The staff are doing all they can to help me. I don't have enough money to get my teeth fixed. I never asked the facility to help me pay to get my teeth fixed."<br><br>A review of the nursing notes lacked evidence that facility staff documented the reason why the dental consult had not occurred as ordered by the physician.<br><br>A face-to-face interview was conducted with the | {F 514} | F514 (2)<br><br>1. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**<br>The Surveyor spoke with the resident and the Medical Director, Dr. Potter. The Dentist Dr. Vaughn was also contacted immediately and saw resident on 4/23/07. Dr. Potter, Medical Director, followed-up with resident by coming in and documenting in his record. An appointment was scheduled for the resident to have tooth extractions on May 3, 2007 at 1:30pm at the Providence Hospital.<br><br>2. **How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken?**<br>An audit was conducted for the remaining residents to see if other residents were missing a follow-up dental consult. No other residents were found to have this deficient practice. | |

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| {F 514} | Continued From page 4<br>Resident Care Coordinator (RCC) on April 19, 2007 at 12:50 PM. He/she stated, "The staff nurse informed [resident] of the need to schedule the appointment. [Resident #9] stated that [he/she] would make the appointment. [Resident] doesn't like [facility dentist], so [he/she] chooses to go elsewhere."<br><br>The RCC acknowledged that the follow up information related to the resident's dental consult was not documented in the resident's record. The record was reviewed on April 19, 2007. | {F 514} | F514 (2)<br><br>3. **What measure will be put in place or what systemic changes you will make to ensure the deficient practice does not recur?**<br>In service education on Charting and documentation procedures was given as well as a review of the facility policy was conducted on 4/29/07 with all licensed staff. At the in-service we emphasized to the nursing staff the quality, timeliness, relevance and accuracy of documentation as well as the follow-up. A monitoring tool was developed and implemented by the 11-7 shift on 4/20/07<br><br>4. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur (i.e., what Quality Assurance Program will be put into place?**<br>All deficient practices will be reported to monthly Process Improvement and Quality Assurance meeting by the RCC. | May 23, 2007 |