STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING _____ B. WING _____	R 02/04/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPECIALTY HOSPITAL OF WASHINGTON - HADLEY SNF	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(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 A follow-up visit to the recertification survey completed November 20, 2009 was conducted on February 4, 2010. The following deficiencies were based on observations, record review and facility staff interviews. The sample size was nine (9) residents.	{F 000}	1) 1. The Phlebotomist was counseled by the Lab Manager. No harm was done to Resident #1 by this deficient practice. Resident was informed by Nurse Manager that resident has the right to privacy when lab work is taken. Resident should report lack of privacy to any nurse.	2/5/10 2/23/10
F 164 SS=B	483.10(e), 483.75(l) (4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e) (3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.	F 164	2. No other residents other than residents #1, #A1 and #A2 had blood drawn on February 4, 2010. All Residents will be informed at next Resident Council meeting of their right to privacy during lab work. 3. An in-service program for all Phlebotomists will be produced and Implemented by the Nurse Educator. The topic of resident privacy and dignity will be reviewed. 4. Nurse Managers will be informed when the Phlebotomist is on the Unit. The Nurse Manager will randomly observe if privacy was provided for the resident. Results will be provided at the monthly Quality Assurance meetings. If compliance Is maintained for three consecutive months, then reviews will be made quarterly.	3/4/10 3/8/10 2/26/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: ADMINISTRATOR | (X6) DATE: 2/23/10

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 164	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observations for three (3) of 9 sampled residents and two (2) supplemental residents, it was determined that facility staff failed to provide privacy by completely pulling the privacy curtain and/or close the door for three (3) residents during phlebotomy services. Residents #1, A1 and A2. The findings include: Facility staff failed to provide privacy to Residents #1, A1 and A2 during phlebotomy services. 1. The phlebotomist was observed on February 4, 2010 at 9:15 AM drawing Resident #1's blood. The phlebotomist failed to pull the privacy curtain and or close the door throughout the provision of the service. Resident #1's bed was located by the entry door to the room. The resident was within view of any visitor to the room, passer's-bye in the hallway and the roommate. 2. The phlebotomist failed to pull the privacy curtain and or close the door throughout the provision of the service. Resident #A1's bed was located by the window. The resident was within view of any visitor to the room, passer's-bye in the hallway and the roommate. 3. The phlebotomist failed to pull the privacy curtain and or close the door throughout the provision of the service. Resident #A2's bed was located by the window. The resident was within view of any visitor to the room, passer's-bye in the hallway and the roommate. A face-to-face interview was conducted with the phlebotomist on February 5, 2010 on at approximately 10:00 AM. He/she acknowledged that the privacy curtain was not pulled around the resident and the door was not closed while providing services to the residents. He/she said, "I should have closed the door."	F 164	2) 1. The Phlebotomist was counseled by the Lab Manager. No harm was done to Resident #A1 by this deficient practice. Resident was informed by Nurse Manager that resident has the right to privacy when lab work is taken. Resident should report lack of privacy to any nurse. 2. No other residents other than residents #1, #A1 and #A2 had blood drawn on February 4, 2010. All Residents will be informed at next Resident Council meeting of their right to privacy during lab work. 3. An in-service program for all Phlebotomists will be produced and Implemented by the Nurse Educator. The topic of resident privacy and dignity will be reviewed. 4. Nurse Managers will be informed when the Phlebotomist is on the Unit. The Nurse Manager will randomly observe if privacy was provided for the resident. Results will be provided at the monthly Quality Assurance meetings. If compliance Is maintained for three consecutive months, then reviews will be made quarterly.	2/5/10 2/23/10 3/4/10 3/8/10 2/26/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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			3) 1. The Phlebotomist was counseled by the Lab Manager. No harm was done to Resident #A2 by this deficient practice. Resident was informed by Nurse Manager that resident has the right to privacy when lab work is taken. Resident should report lack of privacy to any nurse.	2/5/10 2/23/10
			2. No other residents other than residents #1, #A1 and #A2 had blood drawn on February 4, 2010. All Residents will be informed at next Resident Council meeting of their right to privacy during lab work.	3/4/10
			3. An in-service program for all Phlebotomists will be produced and Implemented by the Nurse Educator. The topic of resident privacy and dignity will be reviewed.	3/8/10
			4. Nurse Managers will be informed when the Phlebotomist is on the Unit. The Nurse Manager will randomly observe if privacy was provided for the resident. Results will be provided at the monthly Quality Assurance meetings. If compliance Is maintained for three consecutive months, then reviews will be made quarterly.	2/26/10

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 095024	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: 2/4/201
NAME OF PROVIDER OR SUPPLIER: SPECIALTY HOSPITAL OF WASHINGTON – HADLEY	STREET ADDRESS, CITY, STATE, ZIP CODE: 4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC		

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 241	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review for one (1) of nine (9) residents, it was determined that facility staff failed to promote care in a manner and in an environment that maintains or enhances dignity. Resident #6. The findings include: Resident #6 was observed on February 4, 2010, at approximately 9:15 AM during the initial tour of the facility, seated up on the edge of the bed eating breakfast. The urinal was attached by the handle to the resident's bed rail next to the resident ' s left arm and appeared to be approximately three-quarter filled with yellow urine. Employee #3 acknowledged that the urinal hanging on the resident's side rail appeared to be three-quarter filled yellow urine. Employee # 3 acknowledged that the urinal with urine should have been emptied prior to serving the resident his/her meal. Employee # 3 stated that he/she drew the attention of the charge nurse to the urinal but that the charge nurse's attention was diverted by Resident # 6 ' s roommate call for assistance. At approximately 9:40 AM on February 4, 2010, Employee # 4 was observed removing the resident's breakfast tray. The urinal was observed hanging on the side rail next to the resident's left arm. The urinal was not emptied. According to an annual Minimum Data Set (MDS) completed on November 12, 2009 in the Resident #6' s clinical record, the resident ' s diagnosis included diabetes, congestive heart failure, peripheral vascular disease, arthritis, depression, chronic obstructive pulmonary disease (COPD), anemia, edema and shortness of breath. A face-to-face interview was conducted with Employees #3 on February 5, 2010 at approximately 9:55 AM. He/she acknowledged that the resident should not have been served breakfast with the urinal containing approximately three-quarter filled yellow urine hanging on the side rail next the resident's. He she said, "I thought that the charge nurse emptied it. I will get someone to empty it now. I will get someone to empty it now. " The record was reviewed on February 4, 2010
{F 514}	483.75(l) (1) RES RECORDS¿COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.

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

The above isolated deficiencies pose no actual harm to the residents

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 095024	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: 2/4/201
NAME OF PROVIDER OR SUPPLIER **SPECIALTY HOSPITAL OF WASHINGTON – HADLEY**	STREET ADDRESS, CITY, STATE, ZIP CODE **4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC**		

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
{F 514}	Continued From Page 1 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 nine (9) sampled residents, it was determined that facility staff failed to document an interim physician's order to transfer a Resident out of the facility to the emergency room. Resident #9. Review of the Nurses' Progress Notes dated and signed February 2, 2010 at 2:50AM revealed "Resident cont. (continued) lethargic. Risperdal not given. Call placed to PMD (Primary Medical Doctor) order received to transfer to nearest ER (Emergency Room) Dx (Diagnosis) Altered Mental Status. Responsible party aware." A review of the Physicians' Order Sheet (POS) and Physician's interim orders failed to reveal any documentation of an order to transfer the resident to the ER. Further review of the Nurses' Progress Notes dated and signed February 2, 2010 at 3:15PM revealed, "Transferred via 911 ambulance [He]/she is sluggishly responsive to verbal and tactile stimulation: vs (vital signs) 119/65-87-20 97. O2 sat (Oxygen saturation) 100% blood sugar 244mgdl". A nurse's note dated February 3, 2010 at 7:00AM revealed "Resident returned to unit at 6:30AM from ER escorted by two life star attendants, lethargic and sleepy on and off. Skin warm and dry to touch. Blood sugar on arrival 192mg/dl, vs 125/74, 67, 18, 98.7. Resident came with discharge instructions, if symptoms worsen or new symptoms develop return patient to ER immediately. Incontinent care provided". A face-to-face interview was conducted with Employees #2, 3, and 4on February 4, 2010 at approximately 2:00 PM. After review of the medical record both employees acknowledged that the record lacked evidence of a physician's order to transfer Resident #9 to the Emergency Room. The record was reviewed on February 4, 2010.