PRINTED: 08/07/2006 FORM APPROVED OMB NO. 0938-0391

(F 000) INITIAL COMMENTS A follow-up survey (to the annual recertification survey June 12 through 13, 2006) was conducted on August 1, 2006. The following deficiencies were based on observations, staff interview and record review. The sample was seven (7) records based on 60% of the standard survey sample. F 309 SS=D 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 observation, record review and staff interview for one (1) of seven (7) sampled residents, it was determined that facility staff failed to: ensure that Miacalcin nasal spray was available for administration and administer a pain medication according to the physician 's order. Resident #7. The findings include: The findings include: According to the annual MDS (Minimum Data Set) dated May 25, 2006, Section I, included the following diagnoses: Hypothyroidism, Osteoporosis and Pathological bone fracture.	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE S COMPLE	ETED .	
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAGY OR LSC IDENTIFYING INFORMATION) PREFIX TAGY REGULATORY OR LSC IDENTIFYING INFORMATION) TAGY PREFIX TAGY REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAGY REGULATORY OR LSC IDENTIFYING INFORMATION) TAGY PREFIX TAGY REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAGY REGULATORY OR LSC IDENTIFYING INFORMATION) TAGY PREFIX TAGY REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAGY REFERENCED TO THE APPROPRIATE DEFICIENCY DATE	V		095026	B. WIN	NG				
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION PREFIX TAG REFERENCED TO THE APPROPRIATE DEFICIENCY DATE					6:	200 OREGON AVE NW			
A follow-up survey (to the annual recertification survey June 12 through 13, 2006) was conducted on August 1, 2006. The following deficiencies were based on observations, staff interview and record review. The sample was seven (7) records based on 60% of the standard survey sample. F 309 SS=D 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 observation, record review and staff interview for one (1) of seven (7) sampled residents, it was determined that facility staff failed to: ensure that Miacalcin nasal spray was administered to Resident #7 at approximately 1:00 PM on 07/31/2006. (1) B. A stat dose of Oxycodone was administered to Resident #7 at approximately 1:00 PM on 07/31/2006. (2) A The pharmacy had been contacted on three (3) separate occasions to reorder Miacalcin nameas apray and failed to deliver the medication. The facility had already taken action with the pharmacy and cancelled the contract effective 09/07/2006. A medication error form was done for the missed dose of medication on 7/31/08. (2) B. All MAR's (Medication Administration Records) have been reviewed on all residents to assure that all residents have received their medication as ordered. A medication error form was done for the missed doses of medication on 7/31/06. (3) A The contract with the new pharmacy will begin 09/07/2006 in addition, nursing staff have been inserviced on medication errors. In addition, MAR's will continue to be reviewed between shifts by licensed nurses to assure that all residents have received all ordered medications. (3) B. Nursing staff has been inserviced on medication errors. In addition, MAR's will continue to be reviewed between shifts by licensed nurses to assure that all residents have received all ordered medications.	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOUL	D BE CROSS-	COMPLETION	
A. Facility staff failed to ensure that that Miacalcin nasal spray was available to administer	F 309	A follow-up survey survey June 12 thron August 1, 2006, were based on obsercord review. The records based on 6 sample. 483.25 QUALITY Contract the records based on 6 sample. 483.25 QUALITY Contract the records or maintain the high mental, and psychological provides the necess or maintain the high mental, and psychological provides accordance with the residents, it was defailed to: ensure the available for admin medication according to the arrow of the provided may 25, 20 following diagnoses of the provided may 25 following diagnoses of the provided ma	(to the annual recertification ough 13, 2006) was conducted. The following deficiencies servations, staff interview and example was seven (7) 50% of the standard survey. DF CARE It receive and the facility must sary care and services to attain thest practicable physical, posocial well-being, in the comprehensive assessment. NT is not met as evidenced by site of seven (7) sampled etermined that facility staff at Miacalcin nasal spray was instration and administer a paining to the physician 's order. The following deficiencies servations, staff at Miacalcin nasal spray was instration and administer a paining to the physician 's order. The following deficiencies servations, staff at Miacalcin nasal spray was instration and administer a paining to the physician 's order. The following deficiencies servations, staff at must be servation and servations and staff at Miacalcin nasal spray was instration and administer a paining to the physician 's order. The following deficiencies servations and servations at the servation and servations are servations.			to Resident #7 at approximately 07/31/2006. (1) B. A stat dose of Oxygadministered to Resident #7 at a 1:00 PM on 07/31/2006. (2) A. The pharmacy had been of three (3) separate occasions Miacalcin nasal spray and failed the medication. The facility had at action with the pharmacy and contract effective 09/07/2006. A error form was done for the mismedication on 7/31/06. (2) B. All MAR's (Medication A Records) have been reviewed on to assure that all residents have medication as ordered. A medication as ordered. A medication on 7/31/06. (3) A. The contract with the new predication on 7/31/06. (3) A. The contract with the new predication on 7/31/06. (3) B. Nursing staff has been in medication errors. In addition, continue to be reviewed between the predication errors. In addition, continue to be reviewed between the predication errors. In addition, continue to be reviewed between the predication errors assure that the predication errors are reconstituted as a service error	codone was approximately contacted on to reorder to deliver the lready taken cancelled the amedication all residents ecceived their lication error doses of charmacy will nursing staff e Director of not delivered conserviced on MAR's will en shifts by all residents ions.	regresh 8/4/86	

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

AUG-16-2006 09:13 From:HSC		2025410338	To:2024429431	P.2
DEPARTMENT OF HEALT	H AND HUMAN SERVICES E & MEDICAID SERVICES		Renset 66	PRINTED: 08/07/2006 FORM APPROVED OMB NO. 0938-0391
TATEMENT OF DEFICIENCIES NO PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE O	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095026	B WING		R 08/01/2006

		095026		06/01	72000
NAME OF PROVIDER OR SUPPLIER KNOLLWOOD HSC			STREET ADDRESS, CITY, STATE, ZIP GODE 8200 OREGON AVE NW WASHINGTON, DC 20015		
(X4) ID PREFIX TAG	(FACH DEFICIENCY MU	MENT OF DEFICIENCIES ST BE PRECEEDED BY FULL DENTIFYING 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} F 309 SS=D	survey June 12 throug on August 1, 2006. T were based on observe record review. The sa records based on 60% sample. 483 25 QUALITY OF Each resident must re provide the necessary or maintain the higher mental, and psychoso	CARE ceive and the facility must care and services to attain st practicable physical,	{F 000}	(1) A. Miacalcin nasal spray was administered to Resident #7 at approximately 1 00 PM on 07/31/2006. The pharmacy had been contacted on three (3) separate occasions to reorder Miacalcin nasal spray and failed to deliver the medication	8/02/2006
	Based on observation interview for one (1) or residents, it was dete failed to: ensure that available for administ medication according Resident #7. The findings include. According to the annuly dated May 25, 2006 following diagnoses of Osteoporosis and Para. A. Facility staff failed	rmined that facility staff Miacalcin nasal spray was ration and administer a pain to the physician's order. Ital MDS (Minimum Data Set , Section I, included the Hypothyroidism, thological bone fracture.		(2) B All MAR's (Medication Administration Records) have been reviewed on all residents to assure that all residents have received their medication as ordered. A medication error form was done for the missed doses of medication on 7/31/06. (3) A. The contract with the new pharmacy will begin 09/07/2006. In addition, nursing staff have been inserviced to alert the Director of Nursing if any medications are not delivered on a timely basis. (3) B. Nursing staff has been inserviced on medication errors. In addition, MAR's will continue to be reviewed between shifts by licensed nurses to assure that all residents have received all ordered medications. (4) A and B. Results of these findings will be incorporated into the Quality Assurance Program.	

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

(X8) DATE

A deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that or 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.

AND PLAN OF CORRECTION		(X2) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: A. BUILDING				COMPLETED R	
		095026	B. WIN	G_			1/2006
	ROVIDER OR SUPPLIER			62	EET ADDRESS, CITY, STATE, ZIP CODE 200 OREGON AVE NW (ASHINGTON, DC 20015		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	SOURCE TO THE PERSON OF THE PE	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE I	BE CROSS-	(X5) COMPLETION DATE
F 309	The July 2006 Physigned by the physigned by the physishe following order: use 1 spray alternations osteoporosis". During observation August 1, 2006 at a Resident #7's 9:00 spray was not admit A review of the July Administration Reconsal spray was not 2006. A face-to-face interdirector of Nursing approximately 1:15 pharmacy had been of the medication; Inot been delivered. The facility policy a Medication Delivery included: "9. Renew drug orders shor administration worder is transmitted."	per physician 's orders. sician's Order Sheet which was ician on July 11, 2006 included "Miacalcin nasal spray/pump ting nostrils daily for of the medication pass on approximately 9:00 AM, AM dose of Miacalcin nasal inistered. y 2006 MAR (Medication ord) revealed that Miacalcin of administered on July 31, view was conducted with the on August 1, 2006 at PM. He/She stated that the n contacted prior to running out nowever, the medication had and procedure entitled " y and Labeling System" exceiving Drugs. B. All other rould be received and available within 24 hours of the time the lato the pharmacy".	F3	309			
	was signed by the p	sician 's Order Sheet which ohysician on July 11, 2006 ng order: "Oxycodone 40 mg					

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUII	ULTIPLE CONSTRUCTION LDING	COMPLE		
		095026	B. WIN	IG		R 1/2006	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 6200 OREGON AVE NW WASHINGTON, DC 20015			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		HOULD BE CROSS-	(X5) COMPLETION DATE	
F 309	A review of the MA dose of Oxycodone box] on July 31, 20 medication was ad MAR indicated tha Oxycodone for the The "Controlled Nas reviewed and Oxycodone was signal."	every 12 hours for pain". AR revealed that the 9:00 AM e was not signed [initials in the 106 indicating that the 106 ministered to the resident. The 1 the resident received the	F3	309			
{F 371} SS=C	The facility must st serve food under s This REQUIREME: Based on observatit was determined to adequate to ensure served under sanita soiled sheet pans a These findings were the food service direction. The findings included. The inner and out the food service direction.	ore, prepare, distribute, and anitary conditions. NT is not met as evidenced by ions during the survey period, hat dietary services were not e that foods were prepared and ary conditions as evidenced by and grate surfaces of a grill. e observed in the presence of ector.	{F 37	(1) A. The inner and outer sheet pans were rewashed in wash area on 08/01/2006. could not be adequately discarded. (1) B. The grate surfaces of the cook's preparation area 08/01/2006. (2) A. Food Service staff educated to include demon proper washing techniques Staff has been instructed to Service Manager if the sheet appropriately cleaned and discarded. Management womonitor and spot check dishes as they come out of the pot and (2) B. Food Service staff educated with demonstration cleaning of the grate surface will continue to monitor and grate surfaces on a daily basis	a grill located in were cleaned on the cleaned on f has been restration on the of sheet pans. notify the Food pans cannot be need to be will continue to so on a daily basis ad pan area. If has been renon the proper s. Management spot check the	8/02/2006	
{F 371} SS=C	The facility must st serve food under s This REQUIREME: Based on observatit was determined to adequate to ensure served under sanita soiled sheet pans a These findings were the food service direction. The findings included. The inner and out the food service direction.	ore, prepare, distribute, and anitary conditions. NT is not met as evidenced by ions during the survey period, hat dietary services were not e that foods were prepared and ary conditions as evidenced by and grate surfaces of a grill. e observed in the presence of ector.	{F 37	sheet pans were rewashed in wash area on 08/01/2006. could not be adequately discarded. (1) B. The grate surfaces of the cook's preparation area 08/01/2006. (2) A. Food Service staff educated to include demon proper washing techniques Staff has been instructed to Service Manager if the sheet appropriately cleaned and discarded. Management womanitor and spot check dishes as they come out of the pot and (2) B. Food Service staff educated with demonstration cleaning of the grate surface will continue to monitor and	a grill located in were cleaned on the cleaned on f has been restration on the of sheet pans. notify the Food pans cannot be need to be will continue to so on a daily basis ad pan area. If has been renon the proper s. Management spot check the	8	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				
		095026	A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 6200 OREGON AVE NW WASHINGTON, DC 20015 FICIENCIES EEDED BY FULL SINFORMATION) FIRST TAG TAG (3) A and B. Food Service Management will monitor the above on a daily basis. The Director of Dining Services and Administrator will monitor this quarterly during grand rounds. (4) The results of management's findings will be incorporated into the Quality Assurance Program.			
	PROVIDER OR SUPPLIER		6	200 OREGON AVE NW		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHO	OULD BE CROSS-	(X5) COMPLETION DATE
{F 371}	washing in the pot a stored on a rack ar of 19 observations August 1, 2006. 2. The grate surfact cook's preparation	and pan wash area and were and ready for reuse by staff in 12 at approximately 9:30 AM on es of a grill located in the area were soiled with food and ne (1) of one (1) observations	{F 371}	monitor the above on a da Director of Dining Services ar will monitor this quarterly during (4) The results of management be incorporated into the Qu	ily basis. The nd Administrator g grand rounds. nt's findings will	
F 441 SS=D	infection control prosafe, sanitary, and to prevent the deve disease and infection an infection control investigates, control the facility; decides isolation should be resident; and maint corrective actions resident; and maint corrective actions resident and the same determined that transported through the food. The findings include At 8:05 AM, on Aug that a breakfast tray	tablish and maintain an ogram designed to provide a comfortable environment and lopment and transmission of on. The facility must establish program under which it als, and prevents infections in what procedures, such as applied to an individual ains a record of incidents and elated to infections. AT is not met as evidenced by vation during the initial tour, it a breakfast tray was the facility without a cover for	F 441	(1) Dining Services management that the breakfast tray was cow the kitchen. The resident has aide who reheated the resident failed to put the top back on the A new tray was ordered for the food on the previous tray work. (2) All private duty aides, food a nursing staff have been instacilities infection control program during transport. (3) Meal service will be monit Services management to as compliance. (4) The results of these finincorporated in the Quali Program.	ered when it left is a private duty its breakfast and its breakfast tray, his resident and as discarded. Service staff and tructed on the fam. All have st be covered to covered by Dining sure continued andings will be	08/02/2006

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED R		
		095026	B. WING	08/		01/2006	
NAME OF PROVIDER OR SUPPLIER KNOLLWOOD HSC			S	STREET ADDRESS, CITY, STATE, ZIP 6200 OREGON AVE NW WASHINGTON, DC 20015	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS- REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 441	17. The entree cormuffin and a hard b	nge 4 nsisted of meat, pancakes, poiled egg. The entree was not ray was transported.	F 44	11			