STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095026	A. BUILDING _____ B. WING _____	R 08/29/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KNOLLWOOD HSC	6200 OREGON AVE NW WASHINGTON, DC 20015

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 second follow-up survey (to the recertification survey June 13, 2006 and the first follow-up survey August 1, 2006) was conducted on August 29, 2006. The following deficiencies were based on observations, staff interviews and record review. The sample was seven (7) records based on 60% of the standard survey sample.	{F 000}		
{F 309} SS=E	483.25 QUALITY OF CARE 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, staff interview and record review for four (4) of seven (7) sampled residents, it was determined that facility staff failed to ensure that medications were available as per physician's orders. This is a repeat deficiency from the follow-up survey conducted August 1, 2006. Residents #1, 2, 5 and 6. The findings include: A face-to-face interview was conducted with the Director of Nursing on August 29, 2006 at 11:30 AM regarding the residents cited in this deficiency . He/she stated, "The pharmacy did not deliver any of the medication (cited below). We called and faxed each medication request at least twice.	{F 309}	(1) A. Clonazepam has been ordered, received and is being administered to Resident #1 per physician's order. The resident did not experience any untoward effects from the missed doses of this medication. (1) B. Prevacid has been ordered, received and is being administered to Resident #2 per physician's order. The resident did not experience any untoward effects from the missed doses of this medication. (1) C. Nitroglycerin has been ordered, received and is being administered to Resident #5 per physician's order. The resident did not experience any untoward effects from the missed doses of this medication. (1) D. Temazepam has been ordered, received and is being administered to Resident #6 per physician's order. The resident did not experience any untoward effects from the missed doses of this medication. (2) The facility had already taken action with the pharmacy and cancelled the contract effective 09/18/06. The contract with the new pharmacy will begin 09/18/06. A medication error form has been completed for the missed doses of the above medications on 8/29/06. All MAR's (Medication Administration Records) have been reviewed on all residents to assure that all residents have received their medication as ordered.	9/1/06

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Barbara O'Gastono, LNHA	Administrator	09/06/06

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
	095026	A. BUILDING _____ B. WING _____	R 08/29/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KNOLLWOOD HSC	6200 OREGON AVE NW WASHINGTON, DC 20015

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 309}	Continued From page 1 (Administrator) has spoken with the Director of the pharmacy. We still do not receive medications in a timely manner." There was no evidence that the facility notified the physician when medications were unavailable. 1. Facility staff failed to ensure that Clonazepam was available for administration to Resident #1 as per physician's orders. A review of Resident #1's record revealed a physician's order dated August 4, 2006, "Clonazepam 0.5 mg one tablet by mouth twice daily for leg spasms." A review of the August 2006 Medication Administration Record revealed that the resident did not receive the medication at 2:00 PM and 9: 00 PM on August 5, 2006. There was no evidence that the resident experienced any untoward effects from the missed doses of this medication. The record was reviewed August 29, 2006. 2. Facility staff failed to ensure that Prevacid was available for administration to Resident #2 as per physician's orders. A review of Resident #2's record revealed a physician's order dated August 2, 2006, "Prevacid 30 mg one tablet by mouth daily for gas reflux." A review of the August 2006 Medication Administration Record revealed that the resident did not receive the medication on August 14	{F 309}	(3) The contract with the new pharmacy will begin 09/18/06. For re-orders, the medication nurse has been instructed to inventory medications on a daily basis and re-ordering as necessary to assure that there are not any missed doses. In addition, a log has been developed and implemented to track the date and time the medication order was faxed to the pharmacy. Also, nursing staff will telephone the pharmacy to confirm that the order has been received and log the time the medication arrived. All medications will be called in as Stat. If medications do not arrive within the four (4) hour window or by the next dose, a private pharmacy will be called to assure that no doses are missed. All licensed nursing staff have been inserviced on 8/30/06 on this new procedure. (4) Results of these findings will be incorporated into the Quality Assurance Program.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095026	A. BUILDING _____ B. WING _____	R 08/29/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KNOLLWOOD HSC	6200 OREGON AVE NW WASHINGTON, DC 20015

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 309}	Continued From page 2	{F 309}		

through 24, 2006. There was no evidence that the resident experienced any untoward effects from the missed doses of this medication. The record was reviewed August 29, 2006.

3. Facility staff failed to ensure that a Nitroglycerin patch was available for administration to Resident #5 as per physician's orders.

A review of Resident #5's record revealed a physician's order dated August 4, 2006, "Nitrek 0 .4 mg/hr. Apply one patch topically every morning. Remove at bedtime for coronary artery disease and hypertension."

A review of the August 2006 Medication Administration Record revealed that the resident did not receive the patch on August 7 and 8, 2006 . There was no evidence that the resident experienced any untoward effects from the missed doses of this patch. The record was reviewed August 29, 2006.

4. Facility staff failed to ensure that Temazepam was available for administration to Resident #6 as per physician's orders.

A review of Resident #6's record revealed a physician ' s order dated August 1, 2006, "Temazepam 30 mg one tablet by mouth daily at bedtime for sleep."

A review of the August 2006 Medication Administration Record revealed that the resident did not receive the medication on August 10 through 14, 2006. There was no evidence that the resident experienced any untoward effects from the missed doses of this medication. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095026	A. BUILDING _____ B. WING _____	R 08/29/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KNOLLWOOD HSC	6200 OREGON AVE NW WASHINGTON, DC 20015

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 309}	Continued From page 3 record was reviewed August 29, 2006.	{F 309}		
{F 371} SS=C	483.35(i)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by : Based on observations during the survey period, it was determined that dietary services were not adequate to ensure that foods were prepared and served under sanitary conditions as evidenced by a soiled floor grate, a four (4) burner gas stove surface and the kitchen floor. These findings were observed in the presence of the Food Service Director. The findings include: 1. The floor grate by the cooking area was soiled with accumulated food particles in one (1) of one (1) observation on August 29, 2006 at 10:30 AM. 2. The surface of the four (4) burner gas stove was soiled with accumulated food, grease and carbon buildup in one (1) of one (1) observation at 10:35 AM on August 29, 2006. 3. The floor in the main kitchen, freezer and walk-in refrigerator was soiled with accumulated grease, food products and debris in one (1) of one (1) observation on August 29, 2006 at 10:40	{F 371}	(1) A. The floor grate by the cooking area was cleared of all food particles following survey. (1) B. The surface of the four (4)-burner gas stove was cleaned following survey and again by a specialized cleaning crew on 9/2/06 and 9/3/06. (1) C. A specialized cleaning crew on 9/2/06 and 9/3/06 cleaned the floors in the main kitchen, freezer and walk-in refrigerator. (2) Food service staff has been inserviced on 8/29/06 and 8/31/06 regarding the cleaning schedule and proper procedure for cleaning the stove, floor grates, and floors in the main kitchen, freezer and walk-in refrigerator. Management will continue to monitor and spot-check the floor grates, stove surfaces and floors on a daily basis. (3) Food Service Management will monitor the above on a daily basis. The Director of Dining Services or designee will monitor this on a daily basis and the Registered Dietitian and Administrator will monitor this weekly for 30 days and then monthly during grand rounds. (4) The results of management's findings will be incorporated into the Quality Assurance Program.	9/2/06

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095026	A. BUILDING _____ B. WING _____	R 08/29/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KNOLLWOOD HSC	6200 OREGON AVE NW WASHINGTON, DC 20015

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 371}	Continued From page 4 AM.	{F 371}		