8)25/06

PRINTED: 08/04/2006

FORM APPROVED OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING B. WING 095030 07/25/2006 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5255 LOUGHBORO ROAD NW SIBLEY MEM HOSP RENAISSANCE WASHINGTON, DC 20016 SUMMARY STATEMENT OF DEFICIENCIES ID **PROVIDER'S PLAN OF CORRECTION** (X4) ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-PREFIX **REGULATORY OR LSC IDENTIFYING INFORMATION)** DATE REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG TAG F253 - 483.15(h)(2) HOUSEKEEPING/MAINTENANCE F 000 INITIAL COMMENTS F 000 Sibley Memorial Hospital's Renaissance Skilled An annual recertificaton survey was conducted Nursing Facility (SNF) provides housekeeping and July 24 through 25, 2006. The following maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. During deficiencies were based on observations, staff the survey, a number of problem areas were and resident interviews and record review. The identified that have been cited in this report. The sample size was 11 residents based on a census following plan of correction addresses them. of 45 residents the first day of survey and one (1) Finding 1 supplemental resident. The corrective action that has been taken is 1 8/14/06 the installation of stainless steel door panels on the bottom half of the doors in rooms 302, F 253 483.15(h)(2) HOUSEKEEPING/MAINTENANCE F 253 303, 304, 307, 312, 323, 327 and 330. These SS=C panels cover those sections of the door that The facility must provide housekeeping and were marred and splintered. 2. Other residents having the potential to be 8/14/06 maintenance services necessary to maintain a affected by the same deficient practice will be sanitary, orderly, and comfortable interior. identified through regular environmental rounds and inspection of the doors. Doors found to be marred or splintered will be repaired. This REQUIREMENT is not met as evidenced by 3. The following systemic change has been 8/14/06 implemented. All SNF room doors have had Based on observations during the survey period, stainless steel panels installed that cover the bottom half of the door. This is the part of the it was determined that housekeeping and door that most often is damaged. The maintenance services were not adequate to installation of the door panels will ensure that ensure that the facility was maintained in a safe the deficient practice does not recur. and sanitary manner as evidenced by: marred Environmental rounds will be conducted regularly to ensure that the doors are not and splintered entrance doors and soiled splintered or marred. Any doors that are venetian blinds and closet and bathroom door marred or splintered will be repaired. louvers. These findings were observed in the 4. The quality assurance process will be utilized 9/7/06 presence of maintenance and nursing staff. to monitor and sustain compliance. The findings will be presented at the quarterly Quality Assurance committee meeting. The findings include: Findings 2 & 3 1. Entrance doors to residents' rooms were The following corrective action has been 7/26/06 1 taken. The slat surfaces of the Venetian blinds marred and splintered on the edges in rooms 302 in rooms 302, 304, 310, and 313 and the , 303, 304, 307, 312, 323, 327 and 330 in eight (8 louver surfaces of the closet and bathroom) of 12 observations between 10:20 AM and 4:10 doors in rooms 303, 304, 310 and 313 have PM on July 24, 2006. been cleaned. Other residents having the potential to be 8/8/06 2. affected by the same deficient practice will be 2. The slat surfaces of venetian blinds in identified by regular environmental rounds. residents' rooms were soiled with dust and debris Rooms that are found to be dusty or soiled in rooms 302, 304, 310 and 313 in four (4) of 12 with debris will be cleaned. LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER PROSERVICESEN Senior Josevices and (X6) DATE nu The Kengissgnice S OBOD

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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		AND HUMAN SERVICES		8/21/06	FORM	08/04/2006 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SU COMPLE	JRVEY
		095030	B. WING		07/2	5/2006
NAME OF P	ROVIDER OR SUPPLIER		STE	REET ADDRESS, CITY, STATE, ZIP CODE		M
SIBLEY	MEM HOSP RENAISS	ANCE	5	255 LOUGHBORO ROAD NW VASHINGTON, DC 20016)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD E REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETION DATE
F 253 F 279 SS=D	observations betwee July 24, 2006. 3. The louver surface doors were soiled w rooms 303, 304, 31 observations betwee July 24, 2006. 483.20(d), 483.20(H CARE PLANS A facility must use to to develop, review a comprehensive plan The facility must de	een 10:20 AM and 4:10 PM on ces of closet and bathroom with accumulated dust in 0 and 313 in four (4) of 12 een 10:20 AM and 4:10 PM on c)(1) COMPREHENSIVE the results of the assessment and revise the resident's	F 253 F 279	 The following systemic changes will place to ensure the same deficient p not recur: The Administrator will conduct a environmental rounds with the I Manager of the Environmental 3 Department and dusty or soiled on the blinds or door louvers the identified will be cleaned. Staff will be reminded to do hig and to utilize the 7 step cleanin. The Quality assurance process will b to monitor and sustain compliance. T findings will be presented at the qual Quality Assurance committee meetir F 279 - 483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS Comprehensive Care Plans are develope SNF residents. During the survey, a prob was identified that has been cited in this r following plan of correction addresses it. 	bractice will regular Day Services d surfaces at are h dusting g method. room e. the utilized The rterly ng.	9/7/06
	objectives and time medical, nursing, an needs that are iden assessment. The care plan must to be furnished to a highest practicable psychosocial well-b 25; and any service required under §483 to the resident's exe including the right to 10(b)(4). This REQUIREMEN	tables to meet a resident's and mental and psychosocial tified in the comprehensive describe the services that are ttain or maintain the resident's physical, mental, and eing as required under §483. s that would otherwise be 3.25 but are not provided due ercise of rights under §483.10, o refuse treatment under §483.		 The nurse who admitted the resident 22, 2006 failed to develop a care pla appropriate goals and approaches for resident with the diagnosis of Depress care plan for the diagnosis was deve July 25. It has been reinforced with the nursing staff the importance of imple of care plans for residents admitted with diagnosis of Depression. All residents having the potential to be affected by the same deficient practic identified upon admission to the facil through the initial nursing assessmen hour chart reviews, Physician orders shift reporting or by the Interdiscipling Team. A care plan for depression will developed for all appropriate resident are four residents currently on the ur were present during the licensure su Their charts have been reviewed and same deficient practice was not foun The following systemic changes will place to ensure the same deficient pro- not recur: 	n with or a ssion. A eloped or the mentation with the be ce will be lity nt, 24 a, inter- ary Care II be nts. There nit who rvey. d this d. be put in ractice will	9/7/06

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Facility ID: SIBLEY

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PRINTED: 08/09/2006 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 095030	(X2) M A. BUII B. WIN	DINC		(X3) DATE SURVEY COMPLETED 07/25/2006	
	ROVIDER OR SUPPLIER		-	52	EET ADDRESS, CITY, STATE, ZIP CODE 255 LOUGHBORO ROAD NW /ASHINGTON, DC 20016	07725	/2006
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES (MUST BE PRECEEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD BI REFERENCED TO THE APPROPRIATE DE	E CROSS-	(X5) COMPLETIO DATE
F 279 F 281 SS=D	one (1) of 11 samp determined that far plan for depression The findings include A review of Reside admission orders of included Wellbutrin Lithium 300 mg an for depression. A review of the car revealed that faciliti plan with appropria depression. A face-to-face inte charge nurse on Ju she acknowledged depression. The re 2006. 483.20(k)(3)(i) CO The services provie- must meet profess This REQUIREME Based on record re one (1) of 11 samp determined that the	oled residents, it was cility staff failed develop a care in for Resident #8. le: ent #8's record revealed dated July 22, 2006 that in 75 mg once per day and id Tofranil 150 mg at bedtime re plan, initiated July 22, 2006, ty staff failed to develop a care ate goals and approaches for rview was conducted with the uly 25, 2006 at 8:20 AM. He/ that there was no care plan for ecord was reviewed July 25, MPREHENSIVE CARE PLANS ded or arranged by the facility ional standards of quality. NT is not met as evidenced by eview and staff interview for oled residents, it was e facility staff failed to obtain		279	 conducted with the nursing staff the unit policy on comprehensiv planning. The MDS Coordinator provided service to the nursing staff on the importance of the comprehensiv plan process being implemented timely manner. The Director of Nursing (DON), nurse or her designee will monit Physician orders upon admissio daily thereafter as well as the m Kardex for the presence of antidepressant medications. The then ensure that a care plan has implemented, if necessary. The clinical pharmacist will prov of medications designated as antidepressants as a resource for licensed staff and it will be place each medication chart. Nursing staff will identify, as a p their inter-shift report, residents as having depression and ensur appropriate care plan has been implemented. Twenty-four hour chart checks a medication administration Karder reviews will be done to monitor ensure compliance. The quality assurance process will be to maintain and sustain compliance. findings will be presented at the Qual Quality Assurance Committee. F 281 – 483.20(k)(3)(i) COMPREHENSIV PLANS Comprehensive Care Plans are developed residents of the SNF. During the survey, a area was identified that has been cited in report. The following plan of correction ad it. Resident #1 Resident #1 	e care an in- be ve care d in a charge tor m and redication ey will s been ride a list or the ed on art of identified re that an and ex and art of identified refix and ex and ex and ex and are ob identified ar and ex and are ob identified ar and and ex and ar and ar ar ob identified ar and ar ar and ar ar and ar ar and ar ar and ar ar and ar ar and ar ar an an ar an ar an ar ar an ar ar ar ar an ar ar ar ar ar ar ar ar ar ar ar ar ar	9/7/06
	weekly weights per with weight loss. F	facility policy for a resident			per her Physician's order. It has bee reinforced with the nursing staff that weights will continue until the resider discharged or the Physician writes ar	n the nt is	•

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Facility ID: SIBLEY

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DEPARTMENT OF HEALTH AND H **CENTERS FOR MEDICARE & MED**

STATEMENT OF DEFICIENCIES

NAME OF PROVIDER OR SUPPLIER

SIBLEY MEM HOSP RENAISSANCE

June 14, 2006 136 lbs

July 14, 2006

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AND PLAN OF CORRECTION

(X4) ID PREFIX

TAG

F 281

				Plusi sad		
	H AND HUMAN SERVICES			8/2.106	FORM	08/04/2006 APPROVED 0938-0391
DF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SU COMPLE	
	095030	B. WI	NG		07/25/2006	
ROVIDER OR SUPPLIER	SANCE		5	REET ADDRESS, CITY, STATE, ZIP CODE 255 LOUGHBORO ROAD NW VASHINGTON, DC 20016		
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION REFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS- TAG REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
Resident Weights" weight change of g pounds within 30 d hours on the same resident shall be w	le: cility policy "Monitoring effective August 5, 2005," Any preater than or less than five (5) ays will be retaken within 48 scale If indicated, a eighed weeklyThe clinical g dietitian will chart the weights	F	281	 discontinue weekly weights. The contract of the designee will review the chart that weekly weights are taken as contract of the designee will review the chart that weekly weights are taken as contract of the designee will review the chart of the designee will review the chart of the designee weight loss will be weighed weekly accordance with the facility's polic four residents currently on the unit present during the licensure surver charts have been reviewed and thin deficient practice was not found. 	art to ensure ordered. al to be ctice will be initial and ident of weight risk for y. There are who were y. Their	8/14/06
The resident was admitted on April 14, 2006 with diagnoses that included clostridium difficile. The			Contractions and and and	 The following systemic changes w place to ensure the deficient practi recur: 		8/14/06

The DON, charge nurse or her designee

will monitor the graphic sheet, 30 day weight record and treatment

weights are documented in the clinical

The DON provided an in-service for the

The DON and the charge nurse provided

in-service training for the staff on how to complete the 30 day weight record with

subsequent documentation of follow-up

Residents identified as being at risk for

weighed weekly for the first four weeks to

The charge nurse will identify residents at risk for weight loss from the nutrition QA

track weight loss or gains, or until they

are discharged from the facility.

4. The quality assurance process will be utilized

findings will be presented at the Quality

to maintain and sustain compliance. The

weight loss or identified as needing a nutritional screen or consult, will be

nursing staff on the policy "Monitoring

administration record to ensure all

record as indicated.

Resident Weights".

weights as indicated.

tool.

Assurance Committee.

A review of Resident #1's "Medical Surgical Graphic Record(s)" revealed the resident's weights as follows: April 14, 2006 183 lbs May 17, 2006 149 lbs May 24, 2006 140 lbs

144 lbs

admission weight was 183 lbs (pounds).

The resident's record does not reflect that the facility staff obtained weekly weights after May 17, 2006 when the resident had a significant weight loss of 34 pounds. Additionally, weights were not obtained after July 14, 2006 when the resident had an eight (8) pound weight gain.

According to nutritional progress notes, the dietician monitored the resident weekly during April and May 2006. Interventions included adding Megace, Prosource and changing the diet from regular to mechanical soft.

A face-to-face interview was conducted on July

Event ID: RVZ911

Facility ID: SIBLEY

9/7/06

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	F OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDI		(X3) DATE SU COMPLE	
		095030	B. WING		07/2	5/2006
	ROVIDER OR SUPPLIER	ANCE		REET ADDRESS, CITY, STATE, ZIP CODE 5255 LOUGHBORO ROAD NW WASHINGTON, DC 20016		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETION DATE
F 281	24, 2006 at 10:45 A she acknowledged not obtained after t	age 4 AM with the facility staff. He/ that the weekly weights were he resident had a significant ecord was reviewed on July 24,	F 28	1		
F 329 SS=D	Each resident's dru unnecessary drugs drug when used in duplicate therapy); without adequate m indications for its us adverse consequer should be reduced combinations of the This REQUIREMEN : Based on staff inter three (3) of 11 sam supplemental recor facility staff failed to of multiple pain me and S1. The findings include 1. Facility staff faile use of six (6) pain me The physician's ord directed the followir intramuscular] q 4-6	Ig regimen must be free from An unnecessary drug is any excessive dose (including or for excessive duration; or nonitoring; or without adequate se; or in the presence of nees which indicate the dose or discontinued; or any e reasons above. NT is not met as evidenced by rview and record review for pled residents and one (1) d, it was determined that o clarify the indication for use dications. Residents #3, 7, 11	F 329	 F 329 – 483.25(I)(1) UNNECESSARY DI The Renaissance SNF provides services professional standards of quality. During survey, a number of problems were ident have been cited in this report. The follow correction addresses them. Findings for Resident #3, 7, 11 and S1 There are no further corrective action residents #3, #11 and S1 as these r have been discharged from the facil indication for pain medication for res has been clarified with the Physiciar Other residents having the potential affected by the same deficient pract identified by direct observation and all Physician orders for pain medications for the pain medications will be clarified wit Physician if necessary. There are for residents currently on the unit who v present during the licensure survey. charts have been reviewed and this deficient practice was not found. The following systemic changes will place to ensure the same deficient pr not recur: The charge nurse will monitor I orders related to pain medication administration on a daily basis. The charge nurse, staff nurses secretaries will not transcribe p medication orders without an ir and pain severity rating. For pa receiving multiple pain medication at the pain severity scale rating physician's order will specify th indications for the medication at to the pain severity scale rating pain, moderate pain, and severity 	that meet the the tified that ving plan of ons for residents lity. The sident #7 n. to be sident #7 n. to be review of tion ne use of the use of the use of the use of the use o	7/26/06 8/14/06 9/1/06

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Facility ID: SIBLEY

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7		& MEDICAID SERVICES			OMB NO	. 0938-039
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL B. WIN		(X3) DATE S COMPLE	
		095030	D. WIN	· · · · · · · · · · · · · · · · · · ·	07/2	5/2006
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 5255 LOUGHBORO ROAD NW WASHINGTON, DC 20016	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION S REFERENCED TO THE APPROP	HOULD BE CROSS-	(X5) COMPLETIO DATE
	PRN Pain; and Mo Vicodin 5/500 po q h PRN; and Tylend . There was no cla which medication to complained of pain A face-to-face inter 24, 2006 at approx charge nurse. He/s was no clarification different pain media reviewed July 24, 2 2. Facility staff faile the use of one (1) of for Resident #7. The physician's ord directed, "Ultram 50 every six (6) hours was no clarification one (1) or two (2) ta record was reviewe 3. Facility staff faile use of Tylenol and 1 The physician's ord indicated, "Tylenol of for pain, and Dilaud for a pain." There w determine when to a The record was reviewe 4. Facility staff failed	mg IM q3h [every 3 hours] rphine 6mg IM q3h PRN Pain; 4hr Pain; Tylenol 650mg po q4 0 650mg po q4h PRN mild Pain infication to direct staff as to o administer when the resident view was conducted on July imately 2:30 PM with the she acknowledged that there as to when to give the cations. The record was 2006. d to clarify the indication for or two (2) Ultram tablets ler, dated July 21, 2006, Dmg 1-2 tablets po (by mouth) as needed for pain." There to direct staff when to give ablets of the Ultram. The	F 3	 The DON provided in-s the nursing staff on the range orders. The DON, charge nursi- will monitor medication daily basis and alert nu Physicians as indicated developed a Pain Medi Monitoring tool to moni- the presence of indicati- pain medications. A letter will be sent to a admitting privileges to t SNF, indicating that for admitted to the SNF, pa- cannot be written with r that the medication dos classified according to i moderate, severe). The charge nurse will k informed of issues relat compliance of Physician multiple pain medication indications and severity The quality assurance proce to maintain and sustain comp findings will be presented at Quality Assurance Committe 	policy related to e or her designee Kardexes on a rising staff and d. The DON cation Quality tor compliance for ions for multiple all Physicians with the Renaissance residents ain medications range orders and rage must be it's severity (mild, eep the DON red to non- n orders related to n usage, providing y. ss will be utilized pliance. The the quarterly	9/7/06

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- 2,

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 095030	(X2) M A. BUI B. WIN	LDIN	IPLE CONSTRUCTION (X3) DAT	E SURVEY PLETED 7/25/2006
	ROVIDER OR SUPPLIER	SANCE		5	REET ADDRESS, CITY, STATE, ZIP CODE 255 LOUGHBORO ROAD NW VASHINGTON, DC 20016	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROS REFERENCED TO THE APPROPRIATE DEFICIENC	(X5) S- COMPLETION (Y) DATE
F 329 F 371 SS=E	Resident S1. A review of Reside admission orders of directed, "Vicodin & q 4 hrs PRN pain (pain.)." There was no clari when to administer tablets. A face-to-face inter was conducted on 10:35 AM. He/she how sever the pain tablets according to reviewed July 25, 2 483.35(i)(2) SANIT	ent S1's record revealed dated July 19, 2006 that 5/500 po (by mouth) 1 - 2 tabs every 4 hours as needed for fication to direct staff as to rone (1) or two (2) Vicodin rview with the medication nurse July 25, 2006 at approximately stated,"The patient tells us is and then we give 1 or 2 to that." The record was 2006.		329	<u>F 371 – 483.35(i)(2) SANITARY CONDITIONS –</u> FOOD PREP & SERVICE Sibley Memorial Hospital stores, prepares,	
	The facility must st serve food under s	ore, prepare, distribute, and anitary conditions.			 distributes and serves food under sanitary conditions. During the survey, a number of probler areas were identified that have been cited in this report. The following plan of correction addresses them. 1. No Specific residents were identified in the survey report as being affected by the deficient practices. The following corrective 	n
	: Based on observat it was determined t adequate to ensure served in a safe an evidenced by soiled flat grill, compresso	NT is not met as evidenced by ions during the survey period, hat dietary services were not that foods were prepared and d sanitary manner as d floor and shelf surfaces, the or fan covers and the inner ans and a large fan was			 Finding 1: The following corrective actions have been taken to address the surver findings: Finding 1: The floor surfaces in the Bake Shop, behind equipment, ice machine and pan wash area will be cleaned daily if needed. Finding 2: The shelf surfaces in the main kitchen and Bake Shop, salad room, thaw box and storage room will be cleaned on a daily basis if needed. Finding 3: When cleaning the grill surface, the sides and rear surfaces will 	8/17/06

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUIL		(X3) DATE SI COMPLE	
		095030	B. WING	٥	07/2	5/2006
K	ROVIDER OR SUPPLIER	SANCE		STREET ADDRESS, CITY, STATE, ZIP 5255 LOUGHBORO ROAD NW WASHINGTON, DC 20016	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTION REFERENCED TO THE APPRO	SHOULD BE CROSS-	(X5) COMPLETION DATE
F 371	 operating in the diswere observed in the manager. The findings include 1. Floor surfaces in along walls in the brefrigerator, ice maarea were soiled word observations betwee July 24, 2006. 2. The shelf surfact were soiled with action shop, salad preparestorage room in for between 9:15 AM at 3. The top, side an were soiled with action one (1) observation 4. Compressor farr refrigerator were so and debris in four (between 9:30 AM at 5. The inner surfact pans (14 x 24 x 6 pans (8 x 12 x 8 int food and were not on a rack for reuse 	hwashing area. These findings he presence of the operations e: the rear of equipment and bake shop, bake shop tchine and pot and pan wash ith debris in four (4) of four (4) een 8:50 AM and 9:00 AM on es of racks in the main kitchen cumulated debris in the bake ation room, thaw box and ur (4) of four (4) observations and 9:30 AM on July 24, 2006. d rear surfaces of the flat grill cumulated grease in one (1) of h at 9:30 AM on July 24, 2006. h covers in the walk in biled with accumulated dust 4) of four (4) observations and 9:50 AM on July 24, 2006. es of four (4) of nine (9) hotel inches) and 14 of 19 hotel ches) were soiled with leftover allowed to dry before placing at 2:30 PM on July 24, 2006.	F 3	 also be cleaned if new walk-in refrigerator w dusted bi-weekly. Finding 5: Each pot a inspected before they Additional drying rach. Finding 6: The fan in be cleaned bi-weekly The monthly Food Safety identify other potential resi affected by the deficient procorrective actions listed in used to address any deficit these areas. The following measures w make sure that the deficien recur: Finding 1: Inspection be included in the defood safety Auditant inspections. Finding 3: Inspection will be included in the defood safety Auditant inspections. Finding 3: Inspection will be included in the defood safety Auditant inspections. Finding 3: Inspection will be included in the defood safety Auditant inspections. Finding 3: Inspection will be included in the defood safety Auditant inspections. Finding 3: Inspection will be included in the defood safety and the defood s	ressor fan in the ill be vacuumed and and pan will be y are stored. ks will be puronased. the dish room will Audit will be used to idents who could be ractices. The same 1 above will be iencies found in ill be put in place to nt practices do not of floor surfaces will ily walk throughs, d monthly self of shelf surfaces e daily walk by Audit and monthly p grill will be e supervisor. of compressor fan tions. s of pots and pans Safety audit. The ct pots and pans g. ill be inspected onthly food and tored through regular checklists. Progress the quarterly Quality	8/18/06 9/7/06 8/14/06 8/10/06 8/10/06
	on the clean side o	a soiled cover was operating f the dish room in one (1) of n at 1:50 PM on July 24, 2006.				۵

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Facility ID: SIBLEY

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		PLE CONSTRUCTION G	(X3) DATE S COMPL	
		095030	B. WI	NG		07/2	25/2006
NAME OF I	PROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE		
SIBLEY	MEM HOSP RENAISS	ANCE		5	255 LOUGHBORO ROAD NW VASHINGTON, DC 20016		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	1212	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETION DATE
F 371			F	371	 also be cleaned if needed. Finding 4: The compressor fan walk-in refrigerator will be vacu 	in the numed and	8/18/06
	were observed in the manager.	hwashing area. These findings the presence of the operations			 dusted bi-weekly. Finding 5: Each pot and pan w inspected before they are store Additional drying racks will be 	ed. purchased.	9/7/06
	The findings include	9:			 Finding 6: The fan will be remother the dish room. The monthly Food Safety Audit will it 		9/7/06
9 -	along walls in the ba refrigerator, ice mad area were soiled with observations between	the rear of equipment and ake shop, bake shop chine and pot and pan wash th debris in four (4) of four (4) en 8:50 AM and 9:00 AM on			 The finding root safety Addit with identify other potential residents why affected by the deficient practices, T corrective actions listed in 1 above v used to address any deficiencies for these areas. The following measures will be put i make sure that the deficient practice 	o could be The same will be und in n place to	9/7/06
	 were soiled with acc shop, salad prepara storage room in four between 9:15 AM and 3. The top, side and were soiled with acc one (1) observation 4. Compressor fan refrigerator were soi and debris in four (4 between 9:30 AM and 5. The inner surface pans (14 x 24 x 6 in pans (8 x 12 x 8 inch food and were not al on a rack for reuse and 6. A large fan with a on the clean side of the 	es of racks in the main kitchen cumulated debris in the bake tion room, thaw box and r (4) of four (4) observations and 9:30 AM on July 24, 2006. rear surfaces of the flat grill cumulated grease in one (1) of at 9:30 AM on July 24, 2006. covers in the walk in led with accumulated dust) of four (4) observations and 9:50 AM on July 24, 2006. s of four (4) of nine (9) hotel ches) and 14 of 19 hotel hes) were soiled with leftover lowed to dry before placing at 2:30 PM on July 24, 2006.			 Finding 1: Inspection of floor suberincluded in the daily walk the Food Safety Audit and monthly inspections. Finding 2: Inspection of shelf suberincluded in the daily walk throughs, Food Safety Audit and self inspections. Finding 3: The flat top grill will the inspected daily by the supervise. Finding 4: Inspection of compreduting weekly inspections. Finding 5: Inspections of pots and during monthly Food Safety audit cooks will also inspect pots and regularly before using. Finding 6: The fan will be removate the dish room. 	urfaces will roughs, self urfaces k id monthly be or. essor fan and pans dit. The gans ved from gh regular Progress	9/7/06

Event ID: RVZ911

Facility ID: SIBLEY

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PRINTED: 08/04/2006 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		IPLE CONSTRUCTION	(X3) DATE S COMPLI	
		095030	B. WIN	NG _		07/2	25/2006
	PROVIDER OR SUPPLIER	ANCE	1	5	REET ADDRESS, CITY, STATE, ZIP CODE 2555 LOUGHBORO ROAD NW NASHINGTON, DC 20016		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHOU REFERENCED TO THE APPROPRIAT	LD BE CROSS-	(X5) COMPLETION DATE
F 492 SS=D	483.75(b) ADMINIS The facility must op compliance with all local laws, regulation accepted profession that apply to profess such a facility. This REQUIREMENT: Based on staff inter one (1) supplement that the Physician's with State and local controlled substance The findings include A review of Resider admission orders si Assistant dated July OxyContin 20 mg p day) and Vicodin 5// hours PRN pain (ev	STRATION berate and provide services in applicable Federal, State, and ons, and codes, and with nal standards and principles sionals providing services in NT is not met as evidenced by rview and record review for tal resident, it was determined Assistant failed to comply I laws by ordering Schedule II ses for Resident S1.		492		L ce Skilled s services in state and ng the that has been of correction July 28, 2006 s applicable. rvises the ntacted and governing the ing prescribing nces. The will not order is for SNF with SNF resident who a Physicians y the same corrective and a letter to rm them ice under ential to be ent practice initial -hour chart	DATE 8/8/06 8/31/06
	dated July 24, 2006 orally twice daily." T by the physician.	the Physician's Assistant , directed, "OxyContin 10 mg The order was not co-signed t of Columbia Title 17,			 place to ensure the same deficient not recur: Nursing staff will receive instraining about the scope of Funder D.C. law and regulation be directed not to fill orders substances if written by a P. 	nt practice will service PA practice ons and will for controlled A.	
	Chapter 49, "Prescr Section 4912.6, "A p dispense or prescrib	ibing and Dispensing Drugs", obysician assistant shall not be controlled substances"	1		 24 hour chart checks of Phy will be done to monitor and compliance. 4. The Quality Assurance process v to maintain and sustain complian findings will be presented at the or 	ensure vill be utilized ce. The	9/7/06
	A face-to-face interv	view was conducted with the			Quality Assurance Committee.		

Event ID: RVZ911

Facility ID: SIBLEY

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL		DNSTRUCTION	(X3) DATE S COMPL	
		095030	B. WIN			07/2	5/2006
	ROVIDER OR SUPPLIER	SANCE		5255 LC	DDRESS, CITY, STATE, ZIP CODI DUGHBORO ROAD NW INGTON, DC 20016		.572000
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	((EA REF	PROVIDER'S PLAN OF CORR CCH CORRECTIVE ACTION SHOU ERENCED TO THE APPROPRIAT	LD BE CROSS-	(X5) COMPLETION DATE
F 492 F 514 SS=D	Physician's Assista He/she was aske practice. He/she st long as [physician] DEA and DC Contr Schedule II drugs." The Physician's As the scope of his/he Schedule II drugs. 25, 2006. 483.75(I)(1) CLINIC The facility must m resident in accorda standards and prac accurately docume systematically orga The clinical record information to ident resident's assessm services provided; preadmission scree and progress notes This REQUIREMEN Based on staff inter (2) of 11 sampled re	ant on July 25, 2006 at 7:45 AM ed about the scope of his/her ated, "I can order anything, as co-signs. I use [physician] fol Substance license to order esistant was acting outside of r practice by prescribing The record was reviewed July CAL RECORDS aintain clinical records on each ince with accepted professional ctices that are complete; inted; readily accessible; and nized. must contain sufficient ify the resident; a record of the eents; the plan of care and the results of any ening conducted by the State;	F 4	14 F 514 The R each r profes numbé been c correc Findin 1. It 1. I	- 483.75(I)(1) CLINICAL RECO tenaissance SNF maintains climi resident in accordance with accordance with accordance with accordance with accordance with accordance are of problem areas were identificited in this report. The followin totion addresses them. In the second se	cal records on epted invey, a ied that have g plan of ursing staff eceive Physician entation tial to be actice will be cord reviews. ill be taken. e will instruct by lication was ts currently ing the ve been practice was will be put in	9/7/06
	#5 and 6.			•	ecur: The DON implemented a po "missed medications." The DON presented an in-s nursing staff on the "missed	ervice to the	٥

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RVZ911

Facility ID: SIBLEY

If continuation sheet Page 10 of 12

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		AND HUMAN SERVICES			OMB NO.	APPROVE 0938-03
	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SU COMPLE	
		095030	B. WING		07/2	5/2006
	ROVIDER OR SUPPLIER	SANCE	5	REET ADDRESS, CITY, STATE, ZIP COD 5255 LOUGHBORO ROAD NW WASHINGTON, DC 20016	E	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SHO REFERENCED TO THE APPROPRIA	ULD BE CROSS-	(X5) COMPLET DATE
F 514	 Facility staff faile Resident #5's Top administered. A review of Reside physicians's orders Toprol XL 25 mg p hypertension] and 20 mg po q [every] According to the M 2006 OxyContin windicating the medio On July 16, 17, 24 initialed and circled was not administer side of the kardex medication" was bl medications were not A review of the nur 25, 2006, failed to were not administer The record was review 2. Facility staff faile Resident #6's treat A review of Reside physician's order d (right) axillary wour According to the Tr was administered s 18, 19 and 20, 200 his/her initials, india 	ed to document the reason that rol XL and OxyContin were not ant #5's record revealed s dated May 11, 2006 for " o [by mouth] daily for HTN [June 28, 2006 for "OxyContin 12 hours for pain". Iedication Kardex, on July 16, as initialed and circled, ication was not administered. and 25, 2006 Toprol XL was d, indicating that the medication red. The area on the reverse entitled, "Nurse's Notes on lank, failing to note why the not administered. rses' notes for July 16 through explain why the medications ered.	F 514	 policy. The charge nurse will mor on a daily basis to ensure documentation of the clini adherence to policy. She nurse to compete the doct that time. Nursing staff will update en intershift reports with the presidents who have specific that are not being carried reasons they have not been The charge nurse will doct reason for holding medicat follow-up with the Physiciat The quality assurance process to maintain and sustain complific findings will be presented at the Quality Assurance Committee. Finding for Resident #6 It has been reinforced with the that any resident who does not treatments and/or procedures is by the Physician, will have the documentation placed in the clinical The following corrective action The charge nurse or her desig the nurse to complete the Treat Administration Kardex by docu reason the treatment was not g four residents currently on the present during the licensure su charts have been reviewed and deficient practice was not foun 3. The following systemic change place to ensure the deficient p recur: The DON developed a po treatments". The DON presented an in nursing staff on the "miss policy. The charge nurse will mot daily basis to ensure app documentation on the clinical adherence to the policy. 	appropriate cal record and will instruct the umentation at ach other via names of fic medications out and the en given. ument the titions and an. will be utilized ance. The e quarterly nursing staff receive as prescribed appropriate inical record. ential to be practice will be record reviews. will be taken. nee will instruct timent menting the given. There are unit who were unit who were unity. Their d. ss will be put in ractice will not bicy on "missed n-service to the ed treatments" nitor the. Kardexes on a ropriate nical record and	9/7/06 9/7/06 9/7/06

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED 07/25/2006		
	095030						
NAME OF PROVIDER OR SUPPLIER SIBLEY MEM HOSP RENAISSANCE				STREET ADDRESS, CITY, STATE, ZIP CODE 5255 LOUGHBORO ROAD NW WASHINGTON, DC 20016			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION SHO REFERENCED TO THE APPROPRI	OULD BE CROSS-	(X5) COMPLETIC DATE	
F 514	Continued From page 11 the kardex entitled, "Nurse's Notes on Treatment" was blank, failing to note why the treatments were not administered. A review of the nurses' notes for July 18 through 20, 2006, failed to explain why the treatments were not administered. A face-to-face interview was conducted with the Director of Nursing on July 24, 2006 at 3:20 PM. He/she acknowledged that there should have been an explanation as to why the treatments were not administered either on the back of the kardex or in the nurses' notes. The record was reviewed July 24, 2006.		F 514	 the nurse to compete the documentation at that time. The nurse will notify the Physician of the reasons treatments or procedures are not being done as ordered. The DON, charge nurse, or her designee, will monitor the treatment Kardex to ensure that it is completed appropriately when a treatment or procedure is not given, i.e., the date is circled, initialed, and the reason the treatment was not administered is written on the other side of the form. The quality assurance process will be utilized to maintain and sustain compliance. The findings will be presented at the quarterly Quality Assurance Committee. 		9/7/06	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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