POC accepted 8/25/06

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095030	A. BUILDING _____ B. WING _____	07/25/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIBLEY MEM HOSP RENAISSANCE	5255 LOUGHBORO ROAD NW WASHINGTON, DC 20016

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F 000	INITIAL COMMENTS An annual recertificaton survey was conducted July 24 through 25, 2006. The following deficiencies were based on observations, staff and resident interviews and record review. The sample size was 11 residents based on a census of 45 residents the first day of survey and one (1) supplemental resident.	F 000	**F253 – 483.15(h)(2) HOUSEKEEPING/MAINTENANCE** Sibley Memorial Hospital's Renaissance Skilled Nursing Facility (SNF) provides housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. During the survey, a number of problem areas were identified that have been cited in this report. The following plan of correction addresses them. Finding 1 1. The corrective action that has been taken is the installation of stainless steel door panels on the bottom half of the doors in rooms 302, 303, 304, 307, 312, 323, 327 and 330. These panels cover those sections of the door that were marred and splintered. 2. Other residents having the potential to be affected by the same deficient practice will be identified through regular environmental rounds and inspection of the doors. Doors found to be marred or splintered will be repaired. 3. The following systemic change has been implemented. All SNF room doors have had stainless steel panels installed that cover the bottom half of the door. This is the part of the door that most often is damaged. The installation of the door panels will ensure that the deficient practice does not recur. Environmental rounds will be conducted regularly to ensure that the doors are not splintered or marred. Any doors that are marred or splintered will be repaired. 4. The quality assurance process will be utilized to monitor and sustain compliance. The findings will be presented at the quarterly Quality Assurance committee meeting. Findings 2 & 3 1. The following corrective action has been taken. The slat surfaces of the Venetian blinds in rooms 302, 304, 310, and 313 and the louver surfaces of the closet and bathroom doors in rooms 303, 304, 310 and 313 have been cleaned. 2. Other residents having the potential to be affected by the same deficient practice will be identified by regular environmental rounds. Rooms that are found to be dusty or soiled with debris will be cleaned.	8/14/06 8/14/06 8/14/06 9/7/06 7/26/06 8/8/06
F 253 SS=C	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by : Based on observations during the survey period, it was determined that housekeeping and maintenance services were not adequate to ensure that the facility was maintained in a safe and sanitary manner as evidenced by: marred and splintered entrance doors and soiled venetian blinds and closet and bathroom door louvers. These findings were observed in the presence of maintenance and nursing staff. The findings include: 1. Entrance doors to residents' rooms were marred and splintered on the edges in rooms 302 , 303, 304, 307, 312, 323, 327 and 330 in eight (8) of 12 observations between 10:20 AM and 4:10 PM on July 24, 2006. 2. The slat surfaces of venetian blinds in residents' rooms were soiled with dust and debris in rooms 302, 304, 310 and 313 in four (4) of 12	F 253		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Vice President for Senior Services and Administrator of the Renaissance SNF — (X6) DATE: 8/21/2006

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 253	Continued From page 1 observations between 10:20 AM and 4:10 PM on July 24, 2006. 3. The louver surfaces of closet and bathroom doors were soiled with accumulated dust in rooms 303, 304, 310 and 313 in four (4) of 12 observations between 10:20 AM and 4:10 PM on July 24, 2006.	F 253	3. The following systemic changes will be put in place to ensure the same deficient practice will not recur: • The Administrator will conduct regular environmental rounds with the Day Manager of the Environmental Services Department and dusty or soiled surfaces on the blinds or door louvers that are identified will be cleaned. • Staff will be reminded to do high dusting and to utilize the 7 step cleaning method. • The Day Manager will conduct room inspections at time of discharge. 4. The quality assurance process will be utilized to monitor and sustain compliance. The findings will be presented at the quarterly Quality Assurance committee meeting.	8/8/06 9/7/06
F 279 SS=D	483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483. 25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483. 10(b)(4). This REQUIREMENT is not met as evidenced by : Based on staff interview and record review for	F 279	**F 279 -- 483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS** Comprehensive Care Plans are developed for all SNF residents. During the survey, a problem area was identified that has been cited in this report. The following plan of correction addresses it. Finding for Resident #8 1. The nurse who admitted the resident on July 22, 2006 failed to develop a care plan with appropriate goals and approaches for a resident with the diagnosis of Depression. A care plan for the diagnosis was developed on July 25. It has been reinforced with the nursing staff the importance of implementation of care plans for residents admitted with the diagnosis of Depression. 2. All residents having the potential to be affected by the same deficient practice will be identified upon admission to the facility through the initial nursing assessment, 24 hour chart reviews, Physician orders, inter-shift reporting or by the Interdisciplinary Care Team. A care plan for depression will be developed for all appropriate residents. There are four residents currently on the unit who were present during the licensure survey. Their charts have been reviewed and this same deficient practice was not found. 3. The following systemic changes will be put in place to ensure the same deficient practice will not recur: • An in-service training session was	7/25/06 8/14/06 9/7/06

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F 279	Continued From page 2 one (1) of 11 sampled residents, it was determined that facility staff failed develop a care plan for depression for Resident #8. The findings include: A review of Resident #8's record revealed admission orders dated July 22, 2006 that included Wellbutrin 75 mg once per day and Lithium 300 mg and Tofranil 150 mg at bedtime for depression. A review of the care plan, initiated July 22, 2006, revealed that facility staff failed to develop a care plan with appropriate goals and approaches for depression. A face-to-face interview was conducted with the charge nurse on July 25, 2006 at 8:20 AM. He/ she acknowledged that there was no care plan for depression. The record was reviewed July 25, 2006.	F 279	~~conducted with the nursing staff to review~~ the unit policy on comprehensive care planning. • The MDS Coordinator provided an in-service to the nursing staff on the importance of the comprehensive care plan process being implemented in a timely manner. • The Director of Nursing (DON), charge nurse or her designee will monitor Physician orders upon admission and daily thereafter as well as the medication Kardex for the presence of antidepressant medications. They will then ensure that a care plan has been implemented, if necessary. • The clinical pharmacist will provide a list of medications designated as antidepressants as a resource for the licensed staff and it will be placed on each medication chart. • Nursing staff will identify, as a part of their inter-shift report, residents identified as having depression and ensure that an appropriate care plan has been implemented. • Twenty-four hour chart checks and medication administration Kardex reviews will be done to monitor and ensure compliance. 4. 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
F 281 SS=D	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by : Based on record review and staff interview for one (1) of 11 sampled residents, it was determined that the facility staff failed to obtain weekly weights per facility policy for a resident with weight loss. Resident #1.	F 281	**F 281 – 483.20(k)(3)(i) COMPREHENSIVE CARE PLANS** Comprehensive Care Plans are developed for all residents of the SNF. During the survey, a problem area was identified that has been cited in this report. The following plan of correction addresses it. Findings for Resident #1 1. Resident #1 continues to require weekly weights. Her weight was taken on 8/10 and will be taken weekly for the next four weeks per her Physician's order. It has been reinforced with the nursing staff that the weights will continue until the resident is discharged or the Physician writes an order to	8/14/06

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F 281	Continued From page 3 The findings include: According to the facility policy "Monitoring Resident Weights" effective August 5, 2005," Any weight change of greater than or less than five (5) pounds within 30 days will be retaken within 48 hours on the same scale ... If indicated, a resident shall be weighed weekly. ...The clinical designee/consulting dietitian will chart the weights on the weight graph." The resident was admitted on April 14, 2006 with diagnoses that included clostridium difficile. The admission weight was 183 lbs (pounds). 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 June 14, 2006 136 lbs July 14, 2006 144 lbs 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	F 281	discontinue weekly weights. The charge nurse or her designee will review the chart to ensure that weekly weights are taken as ordered. 2. Other residents having the potential to be affected by the same deficient practice will be identified upon admission through initial and ongoing nursing assessments, resident medical history identifying history of weight loss and nutritionist/Physician recommendations. All residents at risk for weight loss will be weighed weekly in accordance with the facility's policy. There are four residents currently on the unit who were present during the licensure survey. Their charts have been reviewed and this same deficient practice was not found. 3. The following systemic changes will be put in place to ensure the deficient practice will not recur: • The DON, charge nurse or her designee will monitor the graphic sheet, 30 day weight record and treatment administration record to ensure all weights are documented in the clinical record as indicated. • The DON provided an in-service for the nursing staff on the policy "Monitoring Resident Weights". • 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 weights as indicated. • Residents identified as being at risk for weight loss or identified as needing a nutritional screen or consult, will be weighed weekly for the first four weeks to track weight loss or gains, or until they are discharged from the facility. • The charge nurse will identify residents at risk for weight loss from the nutrition QA tool. 4. The quality assurance process will be utilized to maintain and sustain compliance. The findings will be presented at the Quality Assurance Committee.	8/14/06 8/14/06 9/7/06

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F 281	Continued From page 4 24, 2006 at 10:45 AM with the facility staff. He/ she acknowledged that the weekly weights were not obtained after the resident had a significant weight loss. The record was reviewed on July 24, 2006.	F 281		
F 329 SS=D	483.25(l)(1) UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. This REQUIREMENT is not met as evidenced by : Based on staff interview and record review for three (3) of 11 sampled residents and one (1) supplemental record, it was determined that facility staff failed to clarify the indication for use of multiple pain medications. Residents #3, 7, 11 and S1. The findings include: 1. Facility staff failed to clarify the indication for use of six (6) pain medications for Resident #3. The physician's order dated May 23, 2006, directed the following: Morphine 4-6 mg IM [intramuscular] q 4-6h, [every 4 to 6 hours] PRN Breakthrough pain; Vicodin 5/500 po [by mouth] q	F 329	**F 329 – 483.25(I)(1) UNNECESSARY DRUGS** The Renaissance SNF provides services that meet professional standards of quality. During the survey, a number of problems were identified that have been cited in this report. The following plan of correction addresses them. Findings for Resident #3, 7, 11 and S1 1. There are no further corrective actions for residents #3, #11 and S1 as these residents have been discharged from the facility. The indication for pain medication for resident #7 has been clarified with the Physician. 2. Other residents having the potential to be affected by the same deficient practice will be identified by direct observation and review of all Physician orders for pain medication administration. The indications for the use of pain medications will be clarified with the Physician if necessary. There are four residents currently on the unit who were present during the licensure survey. Their charts have been reviewed and this same deficient practice was not found. 3. The following systemic changes will be put in place to ensure the same deficient practice will not recur: • The charge nurse will monitor Physician orders related to pain medication administration on a daily basis. • The charge nurse, staff nurses and secretaries will not transcribe pain medication orders without an indication and pain severity rating. For patients receiving multiple pain medications, the Physician's order will specify the indications for the medication according to the pain severity scale rating, i.e., mild pain, moderate pain, and severe pain.	7/26/06 8/14/06 9/1/06

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F 329	Continued From page 5 4-6 hr; Morphine 4mg IM q3h [every 3 hours] PRN Pain; and Morphine 6mg IM q3h PRN Pain; Vicodin 5/500 po q 4hr Pain; Tylenol 650mg po q4 h PRN; and Tylenol 650mg po q4h PRN mild Pain . There was no clarification to direct staff as to which medication to administer when the resident complained of pain. A face-to-face interview was conducted on July 24, 2006 at approximately 2:30 PM with the charge nurse. He/she acknowledged that there was no clarification as to when to give the different pain medications. The record was reviewed July 24, 2006. 2. Facility staff failed to clarify the indication for the use of one (1) or two (2) Ultram tablets for Resident #7. The physician's order, dated July 21, 2006, directed, "Ultram 50mg 1-2 tablets po (by mouth) every six (6) hours as needed for pain." There was no clarification to direct staff when to give one (1) or two (2) tablets of the Ultram. The record was reviewed on July 24, 2006. 3. Facility staff failed to clarify the indication for use of Tylenol and Dilaudid for Resident #11. The physician's orders dated June 15, 2006 indicated, "Tylenol 650mg po every six (6) hours for pain, and Dilaudid 2mg IM every six (6) hours for a pain." There were no clarifications to determine when to administer the medications. The record was reviewed on July 24, 2006. 4. Facility staff failed to clarify the indication for the use of one (1) or two (2) Vicodin tablets for	F 329	• The DON provided in-service training to the nursing staff on the policy related to range orders. • The DON, charge nurse or her designee will monitor medication Kardexes on a daily basis and alert nursing staff and Physicians as indicated. The DON developed a Pain Medication Quality Monitoring tool to monitor compliance for the presence of indications for multiple pain medications. • A letter will be sent to all Physicians with admitting privileges to the Renaissance SNF, indicating that for residents admitted to the SNF, pain medications cannot be written with range orders and that the medication dosage must be classified according to it's severity (mild, moderate, severe). • The charge nurse will keep the DON informed of issues related to non-compliance of Physician orders related to multiple pain medication usage, providing indications and severity. 4. 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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F 329	Continued From page 6 Resident S1. A review of Resident S1's record revealed admission orders dated July 19, 2006 that directed, "Vicodin 5/500 po (by mouth) 1 - 2 tabs q 4 hrs PRN pain (every 4 hours as needed for pain.)." There was no clarification to direct staff as to when to administer one (1) or two (2) Vicodin tablets. A face-to-face interview with the medication nurse was conducted on July 25, 2006 at approximately 10:35 AM. He/she stated,"The patient tells us how sever the pain is and then we give 1 or 2 tablets according to that." The record was reviewed July 25, 2006.	F 329		
F 371 SS=E	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 in a safe and sanitary manner as evidenced by soiled floor and shelf surfaces, the flat grill, compressor fan covers and the inner surfaces of hotel pans and a large fan was	F 371	**F 371 – 483.35(i)(2) SANITARY CONDITIONS – FOOD PREP & SERVICE** Sibley Memorial Hospital stores, prepares, distributes and serves food under sanitary conditions. During the survey, a number of problem 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 actions have been taken to address the survey 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 8/11/06 8/10/06

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F 371	Continued From page 7 operating in the dishwashing area. These findings were observed in the presence of the operations manager. The findings include: 1. Floor surfaces in the rear of equipment and along walls in the bake shop, bake shop refrigerator, ice machine and pot and pan wash area were soiled with debris in four (4) of four (4) observations between 8:50 AM and 9:00 AM on July 24, 2006. 2. The shelf surfaces of racks in the main kitchen were soiled with accumulated debris in the bake shop, salad preparation room, thaw box and storage room in four (4) of four (4) observations between 9:15 AM and 9:30 AM on July 24, 2006. 3. The top, side and rear surfaces of the flat grill were soiled with accumulated grease in one (1) of one (1) observation at 9:30 AM on July 24, 2006. 4. Compressor fan covers in the walk in refrigerator were soiled with accumulated dust and debris in four (4) of four (4) observations between 9:30 AM and 9:50 AM on July 24, 2006. 5. The inner surfaces of four (4) of nine (9) hotel pans (14 x 24 x 6 inches) and 14 of 19 hotel pans (8 x 12 x 8 inches) were soiled with leftover food and were not allowed to dry before placing on a rack for reuse at 2:30 PM on July 24, 2006. 6. A large fan with a soiled cover was operating on the clean side of the dish room in one (1) of one (1) observation at 1:50 PM on July 24, 2006.	F 371	also be cleaned if needed. • Finding 4: The compressor fan in the walk-in refrigerator will be vacuumed and dusted bi-weekly. • Finding 5: Each pot and pan will be inspected before they are stored. Additional drying racks will be purchased. • Finding 6: The fan in the dish room will be cleaned bi-weekly. 2. The monthly Food Safety Audit will be used to identify other potential residents who could be affected by the deficient practices. The same corrective actions listed in 1 above will be used to address any deficiencies found in these areas. 3. The following measures will be put in place to make sure that the deficient practices do not recur: • Finding 1: Inspection of floor surfaces will be included in the daily walk throughs, Food Safety Audit and monthly self inspections. • Finding 2: Inspection of shelf surfaces will be included in the daily walk throughs, Food Safety Audit and monthly self inspections. • Finding 3: The flat top grill will be inspected daily by the supervisor. • Finding 4: Inspection of compressor fan during weekly inspections. • Finding 5: Inspections of pots and pans during monthly Food Safety audit. The cooks will also inspect pots and pans regularly before using. • Finding 6: The fan will be inspected during the regular monthly food and safety inspection. 4. Performance will be monitored through regular inspections and review of checklists. Progress reports will be provided at the quarterly Quality Assurance committee meetings.	8/18/06 9/7/06 8/14/06 8/10/06 8/10/06 9/7/06

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F 371	Continued From page 7 operating in the dishwashing area. These findings were observed in the presence of the operations manager. The findings include: 1. Floor surfaces in the rear of equipment and along walls in the bake shop, bake shop refrigerator, ice machine and pot and pan wash area were soiled with debris in four (4) of four (4) observations between 8:50 AM and 9:00 AM on July 24, 2006. 2. The shelf surfaces of racks in the main kitchen were soiled with accumulated debris in the bake shop, salad preparation room, thaw box and storage room in four (4) of four (4) observations between 9:15 AM and 9:30 AM on July 24, 2006. 3. The top, side and rear surfaces of the flat grill were soiled with accumulated grease in one (1) of one (1) observation at 9:30 AM on July 24, 2006. 4. Compressor fan covers in the walk in refrigerator were soiled with accumulated dust and debris in four (4) of four (4) observations between 9:30 AM and 9:50 AM on July 24, 2006. 5. The inner surfaces of four (4) of nine (9) hotel pans (14 x 24 x 6 inches) and 14 of 19 hotel pans (8 x 12 x 8 inches) were soiled with leftover food and were not allowed to dry before placing on a rack for reuse at 2:30 PM on July 24, 2006. 6. A large fan with a soiled cover was operating on the clean side of the dish room in one (1) of one (1) observation at 1:50 PM on July 24, 2006.	F 371	also be cleaned if needed. • Finding 4: The compressor fan in the walk-in refrigerator will be vacuumed and dusted bi-weekly. • Finding 5: Each pot and pan will be inspected before they are stored. Additional drying racks will be purchased. • Finding 6: The fan will be removed from the dish room. 2. The monthly Food Safety Audit will be used to identify other potential residents who could be affected by the deficient practices. The same corrective actions listed in 1 above will be used to address any deficiencies found in these areas. 3. The following measures will be put in place to make sure that the deficient practices do not recur: • Finding 1: Inspection of floor surfaces will be included in the daily walk throughs, Food Safety Audit and monthly self inspections. • Finding 2: Inspection of shelf surfaces will be included in the daily walk throughs, Food Safety Audit and monthly self inspections. • Finding 3: The flat top grill will be inspected daily by the supervisor. • Finding 4: Inspection of compressor fan during weekly inspections. • Finding 5: Inspections of pots and pans during monthly Food Safety audit. The cooks will also inspect pots and pans regularly before using. • Finding 6: The fan will be removed from the dish room. 4. Performance will be monitored through regular inspections and review of checklists. Progress reports will be provided at the quarterly Quality Assurance committee meetings.	8/18/06 9/7/06 9/7/06 8/10/06 9/7/06 9/7/06

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	095030	A. BUILDING _____ B. WING _____	07/25/2006

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F 492 SS=D	483.75(b) ADMINISTRATION The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. This REQUIREMENT is not met as evidenced by : Based on staff interview and record review for one (1) supplemental resident, it was determined that the Physician's Assistant failed to comply with State and local laws by ordering Schedule II controlled substances for Resident S1. The findings include: A review of Resident S1's record revealed admission orders signed by the Physician's Assistant dated July 19, 2006 and directed, " OxyContin 20 mg po (by mouth) bid (twice per day) and Vicodin 5/500 mg 1 - 2 tabs po q 4 hours PRN pain (every 4 hours as needed for pain)." The physician cosigned the order, no date noted. An order signed by the Physician's Assistant dated July 24, 2006, directed, "OxyContin 10 mg orally twice daily." The order was not co-signed by the physician. According to District of Columbia Title 17, Chapter 49, "Prescribing and Dispensing Drugs", Section 4912.6, "A physician assistant shall not dispense or prescribe controlled substances..." A face-to-face interview was conducted with the	F 492	**F 492 – 483.75(b) ADMINISTRATION** Sibley Memorial Hospital's Renaissance Skilled Nursing Facility operates and provides services in compliance with all applicable federal state and local laws regulations and codes. During the survey, a problem area was identified that has been cited in this report. The following plan of correction addresses it. Finding for Resident S1 1. The resident was discharged on July 28, 2006 and no further corrective action is applicable. However, the surgeon who supervises the Physician Assistant (PA) was contacted and informed of the D.C. regulations governing the scope of a PA's practice regarding prescribing and dispensing controlled substances. The surgeon has agreed that his PA will not order or dispense controlled substances for SNF residents. 8/8/06 2. There are only seven Physicians with SNF privileges who utilize PA's. Any resident who is being cared for by one of these Physicians has the potential to be affected by the same deficient practice. The following corrective actions will be taken: 8/31/06 • The Medical Director will send a letter to these 7 Physicians and inform them about a PA's scope of practice under D.C. regulations. • All residents having the potential to be affected by the same deficient practice will be identified through the initial nursing assessment and 24-hour chart reviews of Physician orders. 3. The following systemic changes will be put in place to ensure the same deficient practice will not recur: 9/7/06 • Nursing staff will receive in-service training about the scope of PA practice under D.C. law and regulations and will be directed not to fill orders for controlled substances if written by a PA. • 24 hour chart checks of Physician orders will be done to monitor and ensure compliance. 4. 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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F 492	Continued From page 9 Physician's Assistant on July 25, 2006 at 7:45 AM . He/she was asked about the scope of his/her practice. He/she stated, "I can order anything, as long as [physician] co-signs. I use [physician] DEA and DC Control Substance license to order Schedule II drugs." The Physician's Assistant was acting outside of the scope of his/her practice by prescribing Schedule II drugs. The record was reviewed July 25, 2006.	F 492		
F 514 SS=D	483.75(I)(1) CLINICAL RECORDS 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. 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 staff interview and record review for two (2) of 11 sampled residents, facility staff failed to document the reason prescribed treatments and/ or medications were not administered. Residents #5 and 6. The findings include:	F 514	**F 514 – 483.75(I)(1) CLINICAL RECORDS** The Renaissance SNF maintains clinical records on each resident in accordance with accepted professional standards. During the survey, a number of problem areas were identified that have been cited in this report. The following plan of correction addresses them. Finding for Resident #5 1. It has been reinforced with the nursing staff that any resident who does not receive medications as prescribed by the Physician will have the appropriate documentation placed in the clinical record. 2. Other residents having the potential to be affected by the same deficient practice will be identified through daily clinical record reviews. The following corrective action will be taken. The charge nurse or her designee will instruct the nurse to complete the MAR by documenting the reason the medication was not given. There are four residents currently on the unit who were present during the licensure survey. Their charts have been reviewed and this same deficient practice was not found. 3. The following systemic changes will be put in place to ensure the deficient practice will not recur: • The DON implemented a policy on "missed medications." • The DON presented an in-service to the nursing staff on the "missed medication"	9/7/06 9/7/06 9/7/06

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F 514	Continued From page 10 1. Facility staff failed to document the reason that Resident #5's Toprol XL and OxyContin were not administered. A review of Resident #5's record revealed physicians's orders dated May 11, 2006 for " Toprol XL 25 mg po [by mouth] daily for HTN [hypertension] and June 28, 2006 for "OxyContin 20 mg po q [every] 12 hours for pain". According to the Medication Kardex, on July 16, 2006 OxyContin was initialed and circled, indicating the medication was not administered. On July 16, 17, 24 and 25, 2006 Toprol XL was initialed and circled, indicating that the medication was not administered. The area on the reverse side of the kardex entitled, "Nurse's Notes on medication" was blank, failing to note why the medications were not administered. A review of the nurses' notes for July 16 through 25, 2006, failed to explain why the medications were not administered. The record was reviewed 2. Facility staff failed to document the reason Resident #6's treatments were not administered. A review of Resident #6's record revealed a physician's order dated July 16, 2006, "Change R (right) axillary wound daily. Apply Neosporin." According to the Treatment Kardex, the treatment was administered July 16 and 17, 2006. On July 18, 19 and 20, 2006 the nurse signed and circled his/her initials, indicating that the treatment was not administered. The area on the reverse side of	F 514	policy. • The charge nurse will monitor the MAR's on a daily basis to ensure appropriate documentation of the clinical record and adherence to policy. She will instruct the nurse to compete the documentation at that time. • Nursing staff will update each other via intershift reports with the names of residents who have specific medications that are not being carried out and the reasons they have not been given. • The charge nurse will document the reason for holding medications and follow-up with the Physician. 4. The quality assurance process will be utilized to maintain and sustain compliance. The findings will be presented at the quarterly Quality Assurance Committee. <u>Finding for Resident #6</u> 1. It has been reinforced with the nursing staff that any resident who does not receive treatments and/or procedures as prescribed by the Physician, will have the appropriate documentation placed in the clinical record. 2. Other residents having the potential to be affected by the same deficient practice will be identified through daily clinical record reviews. The following corrective action will be taken. The charge nurse or her designee will instruct the nurse to complete the Treatment Administration Kardex by documenting the reason the treatment was not given. There are four residents currently on the unit who were present during the licensure survey. Their charts have been reviewed and this same deficient practice was not found. 3. The following systemic changes will be put in place to ensure the deficient practice will not recur: • The DON developed a policy on "missed treatments". • The DON presented an in-service to the nursing staff on the "missed treatments" policy. • The charge nurse will monitor the treatment administration Kardexes on a daily basis to ensure appropriate documentation on the clinical record and adherence to the policy. She will instruct	9/7/06 9/7/06 9/7/06

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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. 4. 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