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 _____	08/30/2007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An annual recertification survey was conducted on August 29 through 30, 2007. The following deficiencies were based on observations, record reviews and staff interviews. The sample included 11 residents based on a census of 42 on the first day of survey and five (5) supplemental residents.	F 000		
F 241 SS=D	483.15(a) DIGNITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations during the survey period and staff interviews, it was determined that facility staff failed to knock on resident's doors and introduce themselves prior to entering. The findings include: 1. During initial tour conducted on August 29, 2007 from 8: 50 AM to 9:25 AM, it was observed that Employee #7 failed to knock on residents' room doors and introduce himself/herself prior to entering rooms 303, 304 and 306. A face-to-face interview with Employee #7 was conducted on August 29, 2007 at 9:25 AM. He/She acknowledged that he/she did not knock or introduce himself/herself prior to entering the resident's rooms. 2. On August 30, 2007 at 12:55 PM, it was	F 241	**F241 483.15(a)** **DIGNITY** The Renaissance Skilled Nursing Facility (SNF) provides services that meet professional standards of quality and maintains each resident's dignity. During a recent survey, some problems were identified that have been cited in this report. The following plan of correction addresses it: Findings for residents #303, 304, 305 and 306: 1. There are no further corrections for the residents of rooms 303, 305 and 306 as these residents have been discharged from the facility. The resident in room 304 remains in the facility and staff have been instructed to always knock and wait for acknowledgment before entering the room. 2. All residents have the potential to be affected by the same deficient practice. An in-service training will be conducted to remind staff of the importance of knocking and waiting for an acknowledgement before entering. Compliance will be maintained through direct observation by the Director of Nursing (DON) and the charge nurse. 3. The following systemic changes will be put in place to ensure the same deficient practice will not recur: o The DON and/or his/her designee will monitor compliance daily on an ongoing basis. o The Department Heads for all areas providing service to the SNF will receive an email instructing them to notify their staff of the importance of knocking and waiting for a response before entering a residents' room. o The staff will be reminded of the residents' right to privacy.	10/12/07 10/12/07 10/12/07

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Barry Eisenberg	Vice President for Senior Services & Administrator of the Renaissance SNF	9/24/2007

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 241	Continued From page 1 observed that Employee #8 failed to knock on resident room door 305 and introduce himself/herself prior to entering. A face-to-face interview with Employee #8 was conducted on August 30, 2007 at 1:00 PM. He/She acknowledged that he/she did not knock or introduce himself/herself prior to entering resident's room.	F 241	4. The quality assurance process will be utilized to maintain and sustain compliance. The findings will be presented at the quarterly Quality Assurance meeting.	10/12/07
F 253 SS=D	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 initial kitchen and environmental tour, it was determined that facility staff failed to maintain the facility in a clean and sanitary manner as evidenced by: soiled floor surfaces behind equipment, supply vents in dry storage room, window sills and bathroom vents, and a missing threshold. The findings include: 1. Floor surfaces were soiled and stained behind equipment under cooking hoods and the ice machines in the main kitchen near the serving area in two (2) of two (2) observations of a soiled floors between 8:36 AM and 9:19 AM on August 29, 2007. These observations were made in the presence of Employees #12, 13 and 14 who acknowledged the above findings at the time of the observations. 2. The exterior surfaces of supply vents and duct	F 253	**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: Findings 1, 2 and 5: 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: o Finding 1: The floor surfaces behind the equipment, under cooking hoods and the ice machine have been cleaned daily or as needed. This will be monitored by our closing check list. — 8/29/07 o Finding 2: The exterior surfaces of the supply vents and duct in the dry storage room and kitchen have been cleaned. Ducts cleanings are scheduled every quarter which was the same day of the inspection. — 8/29/07 o Finding 5: The threshold located at the rear entrance door to the main kitchen has been requested to be fixed. Cleaning will be monitored for compliance. — 10/12/07 2. The following measures will be put in place to make sure that the deficient practices do not continue: — 10/12/07 o Monthly Sanitation audits (Physical Safety Audit) o Daily walk-through inspection of the floors, hoods, vents, and doors.	

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F 253	Continued From page 2 work in the dry storage room of the main kitchen were soiled with dust accumulation in six (6) of eight (8) supply vents observed on August 29, 2007 at 9:00 AM. These observations were made in the presence of Employees #12, 13 and 14 who acknowledged the above findings at the time of the observations. 3. Window sills were observed to be soiled with accumulated dust in the following rooms: 306, 310, 312, 315, and the South sitting room in six (6) of 12 window sills observed on August 29, 2007 between 8:50 AM and 10:30 AM. These observations were made in the presence of Employees # 1 and 2 who acknowledged the above findings at the time of the observations. 4. Vents in resident's bathrooms were observed to be soiled with accumulated dust in the following rooms: 308, 310 and 315 in three (3) of six (6) vents observed on August 29, 2007 between 8:50 AM and 10:30 AM. These observations were made in the presence of Employees #1 and 2 who acknowledged the above findings at the time of the observations. 5. The threshold located at the rear entrance door to the main kitchen was missing and floor surfaces were soiled with accumulated debris in one (1) of one (1) threshold observed at 8:50 AM on August 29, 2007. These observations were made in the presence of Employees #12, 13 and 14 who acknowledged the above findings at the time of the observations.	F 253	3. Performance will be monitored through regular inspections and review of the daily and monthly walk-through/Physical Safety Audits. 10/12/07 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. 10/12/07 Findings 3 & 4 1. The following corrective action has been taken in the identified rooms. The window sills and the bathroom vents have been cleaned. 08/29/07 2. Other residents having the potential to be affected by the same deficient practice will be identified through regular environmental rounds and inspection of window sills and bathroom vents. Rooms that are found to be dusty will be cleaned. 10/12/07 3. The following systemic changes will be put in place to ensure the same deficient practice will not recur: 10/12/07 o The DON will conduct regular environmental rounds with the Day Operations Manager of the Environmental Services Department to insure compliance. o Staff from Environmental Services will continue to retrain on the 7-step cleaning method to ensure high dusting is completed on a regular basis. o The day operations manger will conduct room inspections at the 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. 10/12/07	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS The resident has the right, unless adjudged incompetent or otherwise found to be	F 280	**F280 483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS** Comprehensive care plans are developed for all residents on the SNF. During the recent survey, a problem area was identified that has been cited in this report. The following plan of correction	

Revised 10/15/07
Revised 10/16/07

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F 280	Continued From page 3 incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. 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 facility staff failed to revise and/or amend a care plan with new approaches and goals for Resident #11 who sustained a fall with injury. The findings include: Resident #11 was admitted to the facility on June 28, 2007 post fall at home and status post left hip hemiarthroplasty. The resident's initial care plan dated June 28, 2007 included: "Problem High risk for falls- Goal: Will not sustain any injury from___, will not experience fall due to___, and safely will be	F 280	addresses it: Findings for resident #11: 1. There is no further corrective action for resident #11, who has been discharged from this facility. 2. The care plans for other residents having the potential to be affected by the same deficient practice were reviewed and revised accordingly. 3. The following systemic changes will be put in place to ensure the deficient practice will not recur: o The DON and/or his/her designee will continue to monitor all occurrence reports related to resident falls on an ongoing basis. o At the time of the occurrence, the charge nurse and the resident's nurse will immediately revise and/or amend the resident's care plan and update the appropriate documentation in the clinical record. o The MDS Coordinator will revise the current "high risk for falls" and the "potential for injury, related to history of falls" care plans. o The DON and MDS Coordinator will provide additional training for the nursing staff related to the process for activating/ revising and/or amending care plans for residents at risk for falling. This will also include teaching the importance of appropriate notification and documentation in the clinical record. o The interdisciplinary care planning team will discuss during their regular meetings any resident who has sustained a fall to ensure that proper revisions, amendments, and/or change in goals or approaches are reflected in the care plan. o The DON will develop a monitoring tool to track compliance with this plan of correction revising or amending the care plans for fall risk and potential for injury related to history of falls. o The fall risk assessment scoring has been updated to further identify higher risk residents. Residents with a fall risk score of 15-30	7/18/07 10/12/07 10/12/07

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F 280	Continued From page 4 maintained through ___." Responses to these areas were blank. The interventions included: "Reorient resident to environment and use of call light; Reinforce use of call light and treaded shoes for ambulation; schedule toileting/bowel or bladder management; 30 minute hourly checks if indicated; B/P[blood pressure] for postural hypotension, while sitting, standing, lying; Monitor for syncope agitation, seizures bowel/bladder urgency; Keep bed in lowest position; Assist/supervise with mobility or transfers; Pt (patient) consult if needed; Evaluate for proper use of appliance -attention to safety; Move resident closer to nurses' station and apply bed check alarm increase diversional activities; monitor labs as ordered; notify MD to modify treatment including appropriate medication intervention; educate and engage resident and family in all aspects of the fall protocol/safety maintenance; reassess fall risk score if occurs." According to a nurse's note dated July 5, 2007, "...At 1345 (1:45 PM) Pt [patient] was found on the floor lying on [his/her] back by [name] who came to nursing station and called for help. No bruising noted no skin tear. Pt assisted back to bed x [times] 2 persons..." The resident sustained no injury from the fall. A nurse's note dated July 16, 2007 0550 (5:50 AM), documented "...At 0055 (12:55 AM) Pt was found on floor near [his/her] closet by staff ..." According to an x-ray taken on July 16, 2007, " IMPRESSION: Right hip hemiarthroplasty in place. There is an acute fracture of the greater trochanter and subtrochanteric region of the right femur. This is new in comparison to the previous	F 280	will wear a blue fall risk bracelet designating them as high risk for falls. o The DON/charge nurse will monitor rooms to ensure that residents designated as high risk have their rooms flagged as high fall risk. 4. The quality assurance process will be utilized to maintain and sustain compliance. The findings will be presented at the quarterly Quality Assurance meeting.	10/12/07

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F 280	Continued From page 5 study." A fall risk assessment was completed on June 28, July 5 and July 16, 2007. According to the evaluation tool, "Total score of 4 or above represents HIGH RISK". The resident's total score on June 28, 2007 was 9. The total score for July 5, 2007 was 16 and the total score for July 16, 2007 was 14. Facility staff identified that the resident's risk for falls had significantly increased on July 5, 2007. There was no evidence that facility staff initiated additional approaches or actions as a result of this assessment. The Interdisciplinary care team (IDT) met on July 5, 2007 to discuss the resident's status. According to the IDT notes, "IDT reviewed problem list. Min A (minimum assist) bed mobility, CTA (contact guard assist) transfers. Ambulating 20 feet with CGA. Will re-eval (evaluate)." There was no time noted on the IDT notes, indicating if the team met prior to the fall. The IDT notes for July 9, 2007 indicated, "IDT reviewed. Progressing towards goals. IDT to re-eval." There was no evidence that at the resident's fall of July 5, 2007 was discussed at the IDT team meeting, or that additional approaches were initiated because of the resident's fall. The resident fell in his/her room on July 16, 2007 and sustained a fracture of the greater trochanter and subtrochanteric region of the right femur. After surgical intervention, the resident returned to the skilled nursing unit on July 25, 2007. The same plan of care that was initiated on June 28, 2007 was initiated on July 25, 2007 without additional/new interventions.	F 280		

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F 280	Continued From page 6 On August 30, 2007 at approximate y 9:00 AM a face-to-face interview was conducted with the Employees #3, 4 and 5. Employee #3 stated, "[Resident #11] was confused and non-compliant with calling for help. That's why the resident's room was close to the nurse's station." Additionally, he/she acknowledged that no additional interventions were implemented between the falls. The record was reviewed August 29, 2007.	F 280		
F 309 SS=D	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, record review and staff interviews for two (2) of 11 sampled residents and two (2) supplemental residents, it was determined that facility staff failed to provide the necessary care and services as evidenced by failing to: clarify the medication strength and/or transcribe medication orders for two (2) residents; follow up with the physician for observation of a vaginal discharge for one (1) resident; and obtain a physician's order to apply a treatment for one (1) resident. Resident's # 3, 9, JH3 and T1. The findings include: 1. Facility staff failed to clarify a medication	F 309	F309 483.25 QUALITY OF CARE The Renaissance SNF provides services that meet professional standards of quality. During the recent 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: 1. There are no further corrective actions for resident #3, who has been discharged from the facility. — 9/5/07 2. Other residents' medication orders and orders for Tylenol with Codeine were checked to ensure that the correct strength was specified by the physician and transcribed correctly. Other residents' physician orders and medication administration record have been checked and transcribed correctly. — 10/12/07 3. The following systemic changes have been put in place to ensure the deficient practice does not recur: — 10/12/07 o The nursing staff and secretarial associates will monitor the physician orders and medication administration records to ensure the medication strength has been identified and transcribed correctly. o The eight-hour chart review followed by the 24-hour chart review of the medication administration record will be utilized to monitor orders for accuracy and completeness. o The nursing staff will receive inservice training on the importance of the clarification of medication orders to	

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

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F 309	Continued From page 7 strength and transcribe two (2) PR N (as needed) medications for Resident #3. A. A review of Resident #3' s record revealed admission orders signed by the physician but undated, directing, " Acetaminophen (Tylenol)/Codeine 1 tab po (by mot th) PRN - every 4 hours for pain." The strength for the medication was not indicated. According to the manufacturer's description, Acetaminophen (Tylenol) with Codeine comes in the following strengths: Tylenol #1: 8 mg (milligrams) of codeine and 300 mg of Tylenol Tylenol #2: 15 mg of codeine and 300 mg of Tylenol Tylenol #3: 30 mg of codeine and 300 mg of Tylenol Tylenol #4: 60 mg codeine and 300 mg Tylenol A face-to-face interview was conducted with Employee #10 on august 30, 2007 at 11:30 AM. He/she stated, " The only one we use is Tylenol #3. That' s all the pharmacy every sends us." The record was reviewed on August 30, 2007. B. Facility staff failed to transcribe PRN (as needed) medication orders for Resident #3. A review of the admission orders for Resident #3, signed by the physician but undated, revealed, "Tylenol 650 mg po q 4 hours PRN for temp greater than 101 (degrees Fahrenheit) or mild pain" and " MOM (Milk of Magnesia) 30cc po daily - PRN constipation." The facility prints a Medication Administration	F 309	prevent a delay in treatment for the resident and to ensure appropriate dosing. 4. The quality assurance process will be utilized to monitor and sustain compliance. The findings will be presented at the quarterly Quality Assurance meeting.	10/12/07
			<u>Findings for resident #9</u>: 1. There are no further corrective actions for the resident #9, who as has been discharged from the facility.	9/8/07
			2. Other residents having the potential to be affected by the same deficient practice will be identified during routine care and nursing assesement of the resident. The nurse will ensure all abnormal findings are documented and reported to the physician for treatment.	10/12/07
			3. The following systemic changes will be put in place to ensure the deficient practice will not recur: o Provide additional inservice training to the staff on the importance of physician notification for any noted abnormal finding. o The nursing staff will ensure all calls made to physicians related to abnormal findings or changes in condition have been returned. o The charge nurse will continue to monitor inter-shift reports for concerns that may need physician intervention.	10/12/07
			4. The quality assurance process will be utilized to monitor and sustain compliance. The findings will be presented at the quarterly Quality Assurance meeting.	10/12/07
			<u>Findings for resident JH3</u>: 1. There are no further corrective actions for resident JH3, who has been discharged from the facility.	8/31/07
			2. Other residents having the potential to be affected by the same deficient practice will be identified by direct observation, monitoring and review of physician orders and the medication administration record.	10/12/07
			3. The following systemic changes have been put in place to ensure the deficient practice does not recur: o ~~The staff will monitor the medication~~	10/12/07

received 10/16/07

received 10/16/07

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F 309	Continued From page 8 Record (MAR) for each day. A review of the MARs from August 23 through August 28, 2007 revealed that the above cited orders for PRN Tylenol and Milk of Magnesia were not transcribed onto the daily MARs. A face-to-face interview with Employee #11 was conducted on August 30, 2007 at 2:15 PM. He/she acknowledged that the PRN orders for Tylenol and Milk of Magnesia were not transcribed onto the MARs. The record was reviewed August 30, 2007. 2. Facility staff failed to follow up with the physician for observation of a vaginal discharge for Resident #9. A record review revealed a nurse's note dated August 24, 2007 at 2:15 AM "...vaginal discharge observed during bath [with] strong odor. A call placed to Dr. [name] who wants me to give him/her a call back." The record lacked evidence of further evaluations regarding the vaginal discharge in the nursing notes from August 25, 2007 to August 30, 2007. A face-to-face interview with Employees #3 and #10 was conducted on August 30, 2007 at 2:20 PM. Both stated,"Aloe Vesta cream was being used as ordered. It may have been the cream." Additionally, Employee #3 acknowledged that there was no further investigation of the vaginal discharge. The record was reviewed on August 30, 2007. 3. On August 30, 2007 at 11:00 AM, during the reconciliation of the morning medication pass with the physician's orders and the MAR, it was	F 309	administration record and physician orders to ensure medications, strength and dosages are transcribed per physician orders. o The quality monitoring tool for eight-hour and 24-hour chart check compliance will continue to be utilized. o Provide additional inservice training to nursing staff and secretarial associates on the importance of accuracy of transcription of medications. It will be reinforced with the nurse on the importance of verifying transcription of orders by the secretarial associates. 4. The quality assurance process will be utilized to monitor and sustain compliance. The findings will be presented at the quarterly Quality Assurance meeting. Findings for resident T1: 1. There are no further corrective actions for this resident because the resident has been discharged from this facility. 2. All records were checked to ensure appropriate orders for wound care were obtained from the physician and utilized. 3. The following systemic changes will be put in place to ensure the deficient practice will not recur: o The nurse will cover the area with a dry, sterile gauze to prevent infection. o The nurse will call the attending physician to obtain wound care orders and subsequently carry those orders out for the resident. o The DON and/or the charge nurse will review skin care sheets and treatment records to ensure orders are accurate and complete. 4. The quality assurance process will be utilized to maintain and sustain compliance. The findings will be presented at the quarterly Quality Assurance meeting.	10/12/07 9/31/07 10/12/07 10/12/07 10/12/07

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 9 determined that facility staff incorrectly transcribed a medication order for Resident JH3. A review of the hospital discharge summary, faxed to the facility on August 28, 2007 at 11:26 AM, included, "K-Dur 40 meq (milliequivilents) po daily for 10 days." The medication was transcribed onto the facility's admission orders on August 28, 2007 at 3:00 PM as, "K-Dur 40 mg po daily x 10 days for supplement." The physician signed the admission orders on August 29, 2007, no time indicated. It was observed that the medication received from the facility's pharmacy was, "KCL 40 mEq/30 ml." A face-to-face interview was conducted with Nurse #3 on August 30, 2007 at 11:30 AM. He/she stated that the physician would be contacted to clarify the order. 4. Facility staff failed to obtain a physician's order to apply a treatment to Resident T1's right lower leg blisters. During an observation of Resident T1's right lower leg blisters on August 29, 2007 at 1:05 PM, it was observed that Employee #6 removed the dressing that covered the blisters. The dressing was inclusive of an ABD (abdominal) pad and several yellow pieces of cloth which covered the blistered areas. The dressing was soiled with blood and brown tinged drainage; the area under the dressing was then assessed. There were several open blisters and several fluid filled blisters that were draining on the right shin	F 309		