

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

PRINTED: 10/29/2007
FORM APPROVED
OMB NO. 0938-0391

Re survey
11/19/07

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 095030	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 10/19/2007
--	---	--	---

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	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	{F 000}		
F 164 SS=D	<p>A follow up survey was conducted on October 19, 2007 (to the recertification survey on August 29 through 30, 2007). The following deficiencies were based on record review observation and staff interview. The sample size was seven (7) residents based on 60% of the standard survey sample for 42 residents.</p> <p>483.10(e), 483.75(l)(4) PRIVACY AND CONFIDENTIALITY</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p>	F 164	<p>F164 483.10(e), 483.75(l)(4) PRIVACY AND CONFIDENTIALITY</p> <p>The Renaissance Skilled Nursing Facility (SNF) provides for the complete privacy and confidentiality of all residents. During a recent survey, some problems were identified that have been cited in this report. The following plan of correction addresses them:</p> <p><u>Findings for residents #306, 320 and 322:</u></p> <ol style="list-style-type: none"> No specific residents were identified as being adversely affected or related to deficient practices in the survey report. The following corrections have been put in place to address the deficient practices: <ul style="list-style-type: none"> The Venetian blinds on the side windows in rooms 306, 320 and 322 were measured and ordered. Installation of new side Venetian blinds will be completed within 30 days. Other residents having the potential to be affected by the same deficient practice will be identified during environmental rounds. Any room found without side windows will immediately be measured and ordered for installation. The following systemic changes will be put in place to ensure the same deficient practices do not recur: <ul style="list-style-type: none"> Environmental rounds will be conducted on the Unit every other Friday. During rounds, checks will be conducted to see that side windows for Venetian blinds are intact. If any are found missing, a work order will be sent in immediately to measure, order and have the identified side window Venetian blinds installed. The quality assurance process will be utilized to maintain and sustain compliance. The findings 	10/31/07 <i>no</i> <i>11/19/07</i> <i>11/04/07</i> 10/26/07 11/05/07

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Robert L. [Signature]</i>	TITLE <i>President/CEO</i>	(X6) DATE <i>11/20/07</i>
---	-----------------------------------	----------------------------------

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.

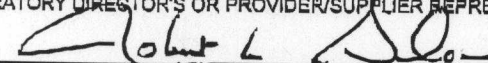
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/29/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 095030	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 10/19/2007
--	--	--	---

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	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	{F 000}		
F 164 SS=D	<p>A follow up survey was conducted on October 19, 2007 (to the recertification survey on August 29 through 30, 2007). The following deficiencies were based on record review observation and staff interview. The sample size was seven (7) residents based on 60% of the standard survey sample for 42 residents.</p> <p>483.10(e), 483.75(l)(4) PRIVACY AND CONFIDENTIALITY</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p>	F 164	<p>F164 483.10(e), 483.75(l)(4) PRIVACY AND CONFIDENTIALITY The Renaissance Skilled Nursing Facility (SNF) provides for the complete privacy and confidentiality of all residents. During a recent survey, some problems were identified that have been cited in this report. The following plan of correction addresses them:</p> <p><u>Findings for residents #306, 320 and 322:</u></p> <ol style="list-style-type: none"> No specific residents were identified as being adversely affected or related to deficient practices in the survey report. The following corrections have been put in place to address the deficient practices: <ul style="list-style-type: none"> The Venetian blinds on the side windows in rooms 306, 320 and 322 were measured and ordered. Installation of new side Venetian blinds will be completed within 30 days. Other residents having the potential to be affected by the same deficient practice will be identified during environmental rounds. Any room found without side windows will immediately be measured and ordered for installation. The following systemic changes will be put in place to ensure the same deficient practices do not recur: <ul style="list-style-type: none"> Environmental rounds will be conducted on the Unit every other Friday. During rounds, checks will be conducted to see that side windows for Venetian blinds are intact. If any are found missing, a work order will be sent in immediately to measure, order and have the identified side window Venetian blinds installed. The quality assurance process will be utilized to maintain and sustain compliance. The findings 	10/31/07 11/01/07 10/28/07 11/05/07

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE President/CEO	(X6) DATE 11-20-07
---	------------------------	-----------------------

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.

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

PRINTED: 10/29/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 095030	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 10/19/2007
--	---	--	--

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	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
--------------------	--	---------------	---	----------------------

<p>F 164</p> <p>{F 253} SS=D</p>	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations during the survey period, it was determined that venetian blinds were not installed on the side windows in residents' rooms to provide privacy. These findings were observed in the presence of Employee #1.</p> <p>The findings include:</p> <p>Venetian blinds were not installed on the side windows to provide complete privacy in rooms 306, 320 and 322 in three (3) of seven observations between 10:00 AM and 11:10 AM.</p> <p>Employee #1 acknowledged the above findings at the time of the observations.</p> <p>483.15(h)(2) HOUSEKEEPING/MAINTENANCE</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations during the survey, 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 soiled and/or damaged venetian blind slats. These findings were observed in the presence of Employee #1.</p> <p>The findings include:</p> <p>1. The slat surfaces of venetian blinds were soiled and stained in rooms 306, 308, 310 and 320 in</p>	<p>F 164</p> <p>{F 253}</p>	<p>will be presented at the quarterly Quality Assurance meeting.</p> <p>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:</p> <p><u>Finding 1 for Rooms 306, 308, 310 and 320:</u></p> <p>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:</p> <ul style="list-style-type: none"> o The Venetian blind slats in rooms 306, 308, 310 and 320 were immediately dusted and wiped clean by the Environmental Services staff to remove the soil and stains. o Other residents' Venetian blind slats were checked for soil and stains and cleaned if needed. <p>2. Other residents having the potential to be affected by the same deficient practice will be identified through regularly scheduled Environmental rounds that include inspection of</p>	<p>10/19/07</p> <p>11/05/07</p>
--------------------------------------	---	-----------------------------	---	---------------------------------

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

PRINTED: 10/29/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 095030	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 10/19/2007
--	---	--	---

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	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 253}		{F 253}	<p>window sills and Venetian blind slats for dust, soil and stains.</p> <ul style="list-style-type: none"> o Rooms that are found to have dusty, soiled stained Venetian slats will be cleaned. o Environmental rounds will occur every other Friday. <p>3. The following systemic changes have been put in place to ensure that deficient practice does not recur:</p> <ul style="list-style-type: none"> o The Administrator/Director of Nursing will continue to conduct scheduled environmental rounds every other Friday with the day operations manager of the Environmental Services Department to ensure that the deficient practice does not recur. Any Venetian blind slats found with dust, soil and stains will be cleaned immediately. o All staff from Environmental Services will continue to receive education on the seven-step cleaning method to ensure high dusting is completed every six months. This includes removal of any dust, soil and stains found on Venetian blind slats. o The day operations manager of Environmental Services will continue to inspect rooms upon discharge to ensure that Venetian blind slats are free of dust, soil and stains. <p>4. The quality assurance process will be utilized to maintain and sustain compliance. The findings will be presented at the quarterly Quality Assurance meeting.</p> <p><u>Finding 2 for Rooms 306, 308, 310, 315, 320, 322 and 329</u></p> <p>1. No specific residents were identified as being adversely affected related to deficient practices in the survey report. The following corrections have been put in place to address the deficient practices:</p> <ul style="list-style-type: none"> o The Venetian blinds on the side windows in rooms 306, 308, 310, 315, 320, 322 and 329 will be replaced. Blinds were measured and ordered. o Installation of new side Venetian blinds will be completed within 30 days. <p>2. Other residents having the potential to be affected by the same deficient practice will be identified during regularly scheduled</p>	<p>10/26/07</p> <p>11/05/07</p> <p>11/18/07</p> <p>11/18/07</p>

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

PRINTED: 10/29/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 095030	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 10/19/2007
--	---	--	---

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	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 253}	Continued From page 2 four (4) of seven (7) observations between 10:00 AM and 11:10 AM on October 19, 2007.	{F 253}	environmental rounds that include inspection of Venetian blind slats that may be damaged and bent. Rooms with Venetian blinds slat surfaces that are bent and damaged will be replaced.	10/26/07
{F 323} SS=D	2. The slat surfaces of venetian blinds were bent and damaged in rooms 306, 308, 310, 315, 320, 322 and 329 in seven (7) of nine (9) observations between 10:00 AM and 11:00 AM on October 19, 2007. Employee #1 acknowledged the above findings at the time of the observations.	{F 323}	3. The following systemic changes will be put in place to ensure the same deficient practice does not recur: o Environmental rounds will be conducted on the Unit every other Friday to include checks to see that blinds in windows of all rooms are not bent or damaged. If found to be bent or damaged, these affected blinds will be replaced.	11/05/07
	483.25(h) ACCIDENTS AND SUPERVISION The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.		4. The quality assurance process will be utilized to maintain and sustain compliance. The findings will be presented at the quarterly Quality Assurance meeting.	
	This REQUIREMENT is not met as evidenced by: Based on observations during medication pass, it was determined that facility staff failed to ensure a safe environment for residents by failing to lock the medication carts.		F323 483.25(h) ACCIDENTS AND SUPERVISION The Renaissance SNF provides services that meet the professional standards of quality and safety. During the recent survey, a problem was identified that has been cited in this report. The following plan of correction addresses them:	
	The findings include: 1. During a medication pass on 3 South at approximately 9:25 AM on October 19, 2007, Employee #2 was passing medications in room #328. She/he did not have all of the resident's Medication Administration Records (MARs). She/he went to the nurses' station to obtain the MARs and failed to lock the medication cart.		<u>Findings 1 & 2 for unlocked medication cart:</u> 1. No residents were affected by the unlocked medication carts found in the hallway of the Renaissance Unit. The medication carts utilized by the nursing staff for resident medication administration were immediately secured and locked to ensure the safety of other residents on the Renaissance. 2. The safety of any resident admitted to the Renaissance Unit receiving medications from the medication carts will be ensured by the locking and securing of medication carts at all times. 3. The following systemic changes have been put in place to ensure the deficient practice does not recur: o An inservice was provided to the nursing staff on the importance of ensuring medication carts are secured and locked at all times. o Medication carts utilized have been serviced and an automatic lock time has been set for 30 seconds after opening to lock the cart and secure all medication drawers.	10/19/07 10/19/07 11/01/07

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

PRINTED: 10/29/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 095030	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 10/19/2007
--	---	--	---

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	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 323}	Continued From page 3 2. A medication cart was observed on 3 North in front of room #308 at approximately 10:10 AM on October 19, 2007, unattended and unlocked. Employee #3 was in a resident's room.	{F 323}	<ul style="list-style-type: none"> o A quality assurance monitoring tool was developed to track compliance. o The Director of Nursing and/or his/her designee will monitor compliance on an ongoing basis. o The importance of keeping medication carts locked and secured will continue to be reinforced at staff meetings. 	
{F 371} SS=E	A face-to-face interview was conducted with Employee #1 at approximately 11:00 AM on October 19, 2007. She/he stated that the nurses were inserviced on locking the medication carts. 483.35(i)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE The facility must store, prepare, distribute, and serve food under sanitary conditions.	{F 371}	4. The quality assurance process will be utilized to maintain and sustain compliance. The findings will be presented at the quarterly Quality Assurance meeting. F371 483.35(i)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE Sibley Memorial Hospital stores, prepares, distributes and serves food under sanitary conditions. During the survey, several problem areas were identified that have been cited in this report. The following plan of correction addresses them:	11/05/07
	This REQUIREMENT is not met as evidenced by: Based on observations during the survey, it was determined that dietary services were not adequate to ensure that foods were served in a safe and sanitary manner as evidenced by soiled hotel pans and pans not allowed to dry before placing on racks for reuse. These findings were observed in the presence of Employee #6.		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 The hotel pans were thoroughly cleaned and allowed to dry before storing on the racks.	10/19/07
	The findings include: 1. Hotel pans washed in the pot and pan wash area were not thoroughly cleaned of food residue and pans were not allowed to dry before storing on racks for reuse as follows: Five (5) of six (6) (12 x 24 x 6) inch hotel pans, six (6) of eight (8) (12 x 14 x 6) inch hotel pans and four (4) of five (5) (8 x 12 x 6) inch hotel pans. The observations of hotel pans were made		2. The food preparation/service department will ensure other residents having the potential to be affected by the same deficient practice is addressed by the following plan of correction: o All hotel pans will be cleaned in the three-bay sinks and allowed to completely dry before storing.	11/16/07
			3. The following systemic changes have been put in place to ensure the deficient practice does not recur: o Additional drying racks have been purchased. Delivery is anticipated within 30 days. o After implementation of the new drying rack, staff will be inserviced and trained on the new system. o New hotel pans will be ordered to replace all damaged and stained hotel pans. o Nutrition Services will complete monthly audits on hotel pans to ensure the new	11/16/07

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

PRINTED: 10/29/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 095030	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 10/19/2007
--	--	--	---

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	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 371}	Continued From page 4 between 8:25 AM and 1:15 PM on October 19, 2007.	{F 371}	procedure is effective. 4. The quality assurance process will be utilized to maintain and sustain compliance. The findings will be presented at the quarterly Quality Assurance meeting.	11/29/07
{F 441} SS=D	<p>483.65(a) INFECTION CONTROL</p> <p>The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections.</p> <p>This REQUIREMENT is not met as evidenced by: Based on an observation and staff interviews for one (1) of two (2) wound treatments, it was determined that facility staff failed to establish a clean field on Resident #2's overbed table prior to the wound treatment.</p> <p>The findings include: On October 19, 2007 at 11:00 AM during a wound treatment, Employee #4 put the treatment supplies on Resident #2's overbed table. He/she did not clean the overbed table before setting the supplies on the table. Employee #4 proceeded to perform the wound treatment. He/she did not clean the overbed table after completion of the wound treatment.</p>	{F 441}	<p>F441 483.65(a) INFECTION CONTROL</p> <p>The Renaissance SNF provides infection control measures to maintain a sanitary environment to prevent the development and transmission of disease and infection. During a recent survey, several problems were identified that have been cited in this report. The following plan of correction addresses them:</p> <ol style="list-style-type: none"> 1. There are no further corrective actions for Resident #2, who has been discharged from the facility. Other residents remaining on the Unit receiving wound care will have all treatment provided with a prepared, clean field for infection control purposes, and upon completion of wound care will have the same field cleansed to prevent the development and transmission of disease/infection. 2. Other residents receiving wound care with the potential to be affected will be monitored and observed to ensure that a clean field is prepared prior to wound care performance and that the field is cleaned again upon completion of wound care. 3. The following systemic changes have been put in place to ensure the deficient practices will not recur: <ul style="list-style-type: none"> o The nursing staff member was inserviced and provided with the rationale for setting up a clean field before wound care and cleansing the field surface immediately following wound care. o The nurse involved (Enterostomal Therapist) in this citation was provided with a copy of the SNF wound care policy and competency sheet identifying procedural steps for performance of wound care which includes setting up a clean field and cleansing the field upon completion of the wound care. o The nurse (Enterostomal Therapist) in 	<p>10/19/07</p> <p>10/22/07</p> <p>10/26/07</p>

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

PRINTED: 10/29/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 095030	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 10/19/2007
--	--	--	---

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	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 441}	Continued From page 5 A face-to-face interview was conducted with Employees #1 and 5 at approximately 11:30 AM. They both said that Employee #4 was hospital staff and was not included in their nursing staff in-service training on wound care policy and procedure. They both acknowledged after speaking with Employee #4 that he/she failed to establish a clean field on Resident #2's overbed table prior to the wound treatment.	{F 441}	<p>this citation was monitored by the Nurse Educator for compliance with wound care policy. This nurse successfully completed the wound care competency. Ongoing monitoring will continue.</p> <ul style="list-style-type: none"> o The Enterostomal Therapist will be included in the annual clinical competencies for wound care. This includes setting up a clean field and cleansing of the field upon completion of wound care. o All nursing staff were given results of the survey to enhance their understanding of the importance of providing a clean field prior to performance of wound care and the cleansing of the field upon completion of wound care. <p>4. The quality assurance process will be utilized to maintain and sustain compliance. The findings will be presented at the quarterly Quality Assurance meeting.</p>	11/05/07
---------	---	---------	--	----------