STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095019	A. BUILDING _____ B. WING _____	R 05/16/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANT PARK CARE CENTER	5000 BURROUGHS AVE. NE WASHINGTON, DC 20019

(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 A follow-up survey was conducted on May 16, 2007 (to the April 5, 2007 recertification survey). The following deficiencies were based on record review, staff interviews and observations. The sample included 18 residents based on 60% of the standard survey.	{F 000}	**This Plan of Correction does not constitute an admission or agreement by the Provider of the truth of the facts alleged or conclusions set forth in this Statement of Deficiencies. This Plan of Correction is prepared solely because it is required by State and Federal law.**	
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 record review and staff interview for one (1) of 18 sampled residents, it was determined that facility staff failed to initiate care plans with appropriate goals and approaches for the management of seizures, the potential for	F 279	F279 Comprehensive Care Plan 1. Resident # 3's care plan has been developed and includes goals and approaches for seizures, potential adverse drug interaction from use of nine or more medications and pain management. 05/31/07 2. Care Plans of residents have been reviewed to ensure they are present and that they meet needs of residents medical, nursing, mental and psychosocial needs as identified in the comprehensive assessment. 06/02/07 3. The Care Plan Team and licensed nurses have been re educated on developing, reviewing and revising residents comprehensive plan of care using results of assessments. 06/02/07 4. Unit managers/DON will review care plans to ensure development of and that they have been reviewed and revised weekly x 4 then monthly. Results of review will be presented to RM/QI meeting monthly. 06/02/07	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Administrator 6-1-07

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.

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F 279	Continued From page 1 adverse drug interactions from the use of nine (9) or more medications and pain management for Resident #3. The findings include: A. Facility staff failed to initiate a care plan with goals and approaches for the management of seizures. The "History and Physical" signed and dated by the physician on April 24, 2007 included Seizure Disorder under diagnosis. A review of the IDT (Interdisciplinary Team) care plan did not include goals and approaches for the management of seizures. B. Facility staff failed to initiate a care plan with goals and approaches for the potential adverse drug interactions from the use of nine (9) or more medications in the IDT care plan. The "Physician's Order Form" signed and dated by the physician on May 3, 2007 included: Aricept, Furosemide, Gabapentin, Lipitor, Plavix, Warfarin, Keppra, Omeprazole, Remeron, Colace, Lactulose and Tylenol. A review of the IDT care plan did not include goals and approaches for the potential adverse drug interaction from the use of nine (9) or more medications. C. Facility staff failed to initiate a care plan with goals and approaches for pain management. The "History and Physical" signed and dated by	F 279		

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F 279	Continued From page 2 the physician on April 24, 2007 included DJD (Degenerative Joint Disorder) under diagnosis. The "Pain Flowsheet" revealed that the resident complained of generalized pain on May 1, 2, 8, and 16, 2007. A review of the IDT care plan did not include goals and approaches for pain management. A face-to-face interview was conducted on May 16, 2007 at 11:30 AM with Unit Manager #1. He/she acknowledged that there were no care plans initiated for Seizure Disorder, the potential for adverse drug interactions from the use of nine (9) or more medications or pain management. The record was reviewed on May 16, 2007.	F 279		
{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 record review and staff interview for one (1) of 18 sampled residents, it was determined that facility staff failed to follow up on an Occupational Therapy (OT) recommendation for a chair alarm. Resident #1. The findings include:	{F 309}	F 309 1. Resident # 1 had chair alarm placed 5-16-2007. Falls risk assessment and plan of care was updated 5-16-2007. 2. Residents with falls since May 1, 2007 have had medical record review and all recommended intervention are in place. Clinical record review of consults recommendation to ensure follow up has been completed. 3. Licensed Nurses and therapy staff have been re-educated on communication, implementation and documentation of all recommended interventions. Licensed Nurses have been re educated on follow up on consults recommendations. 4. DON & Adm. Or there designee will review medical records of all residents with falls at daily stand up meeting to ensure recommended interventions are implemented. UM/Designee will review consults reports weekly x 4 then monthly to ensure recommendations have been followed up on. Reports and trending of reviews will be presented monthly at RM/QI committee meeting.	05/16/07 06/02/07 06/01/07 06/11/07

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{F 309}	Continued From page 3 Resident #1 was admitted to the facility on April 27, 2007. During the review of the clinical record, a nurse's note dated April 30, 2007 indicated, "...Resident was observed in his room floor in sitting position 'Stated he was trying to move to the bed from the wheelchair' . No injury or pain verbalized ..." Further review of the clinical record revealed a consult for occupational therapy. The report/findings indicated, "Given to OT on 5/1/07. Completed eval (evaluation) on 5/2/07 for OT services with recommendation of applying PSA (Patient Safety Aid) or tab alarm secondary to recent fall. Educated pt. (Patient) with regard for need or assist with transfers." The report was signed by the occupational therapist (no date). On May 16, 2007 at approximately 11:00 AM a face-to-face interview was conducted with Unit Manager #2 who acknowledged that a safety device was not attached to the resident's wheelchair. The record was reviewed May 16, 2007.	{F 309}	F323 Accident Free Environment 1. The door from main dining room to kitchen has been repaired, screws have been replaced in top and bottom hinges on 5-16-2007. 2. 100% audit of all doors in facility has occurred to ensure no other doors are an accident hazard. 3. Maintenance and Dietary staff members were re-educated on appropriate notification of need for maintenance and use of maintenance repair log. 4. Maintenance will complete random audits on all doors in dietary and through facility weekly x 4 then monthly to ensure doors fit tightly in frame and hinges are securely attached to door. Results of audit will be reported monthly to RM/QI meeting.	05/16/07 06/02/07 06/01/07 06/11/07
F 323 SS=D	483.25(h)(1) ACCIDENTS The facility must ensure that the resident environment remains as free of accident hazards as is possible. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview during the tour of the main kitchen, it was determined that facility staff failed to ensure that the door leading from the kitchen to the dining room was secure in the frame.	F 323		

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F 323	Continued From page 4 The findings include: On May 16, 2007 at 7:50 AM, the door from the main kitchen to the dining room was observed hanging from the door frame with screws missing from the top and bottom hinges. The door failed to close and latch. This was observed in the presence of the Food Service Director. The Director of Maintenance was contacted by the Food Service Director at 7:55 AM with a request to repair the door. The Director of Maintenance stated that the screws to the hinges needed to be replaced and that a replacement door had been ordered in April, 2007. A re-inspection of the door was conducted at 8:10 AM with both Directors (Food Service and Maintenance). The door closed and latched when tested. The hinges were securely attached to the door. The door fit tightly into the frame.	F 323	F 333 1. Resident #5 is receiving her medications with direct observation by licensed nurse and they are administered within 60 minutes of scheduled time. Resident #5 had behavior data collection and monitoring record were completed 5-17-2007. Residents care plan was update to include agitated behavior related to medication administration with intervention of licensed nurse when administering medications will provide resident medication in med, cup and step back and stay within 3 feet to observe resident taking medication.	05/17/07
F 333 SS=D	483.25(m)(2) MEDICATION ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 18 sampled residents, it was determined that facility staff failed to observe Resident #5 swallowing his/her medication and administer the medication within 60 minutes of its scheduled time. The findings include: A. Facility staff failed to observe Resident #5	F 333	2. Licensed nursing staff have had medication pass observation to ensure no other residents medication have been left for residents to self administer unobserved and that medication are administered within 60 minutes of scheduled time. 3. Licensed nursing staff have been re-educated on medication administration policy and procedure. 4. Unit Managers & Nursing Supervisors will complete medication pass observation weekly X 4 and continue at least monthly. Results of medication pass observation to be given to DON for trending and reporting to monthly RM/QI committee meeting.	06/02/07 06/02/07 06/02/07

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F 333	Continued From page 5 swallowing the medication. Resident #5 was observed on May 16, 2007 at 11:48 AM holding a plastic medicine cup containing pills. The resident was sitting at a table in the common dining area. Four (4) residents were sitting at the same table. Charge Nurse #1 was observed approximately 13 feet away from the resident speaking with another staff member, back turned to Resident #5. A face-to-face interview with Charge Nurse #1 who administered the medications was conducted on May 16, 2007 at 11:50 AM. He/she stated, "[Resident #5] is my last resident. [He/she] doesn't want anyone to stand near [him/her] while taking the medicine. If [he/she] sees a nurse standing near, [Resident #5] will start to scream and yell and refuse to take the meds because of the Schizophrenia. We usually stand behind [him/her] and watch [Resident #5] take the meds. The phone rang and I had paged a doctor before and I was waiting for a call back. I went to the desk and asked the nurse practitioner, who was sitting at the desk, to handle the doctor's call. That's when you (the surveyor) walked up. I think I was gone less than a minute." Charge Nurse #1 acknowledged that he/she should have observed the resident swallowing the medications. B. Facility staff failed to administer medication within 60 minutes of its scheduled time. According to the Medication Administration Record (MAR) the medications were scheduled to be administered at 9:00 AM and 10:00 AM. The May 2007 Medication Administration Record	F 333		

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F 333	Continued From page 6 (MAR) revealed that facility staff had scheduled the medications as follows: Metoprolol 25 mg, scheduled for 9:00 AM and 5:00 PM Namenda 10 mg scheduled for 10:00 AM and 6:00 PM Oysco 500 + D scheduled for 10:00 AM, 2:00 PM and 6:00 PM. Reminyl 8 mg scheduled for 10:00 AM and 6:00 PM, to be taken with food Risperdal 1.5 mg scheduled for 10:00 AM and 6:00 PM A face-to-face interview with Charge Nurse #1 was conducted on May 16, 2007 at 11:50 AM. Charge Nurse #1 acknowledged that the medications were administered more than 60 minutes after the scheduled time. The record was reviewed May 16, 2007.	F 333		
{F 492} SS=E	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 a review of "Nursing Daily Staffing" sheets and staff interview for six (6) of 16 days reviewed, it was determined that facility staff failed to maintain nurse staffing at 3.5 nursing hours per resident per day. The findings include:	{F 492}	F492 Administration 1. Facility has contracted with three Agencies to ensure maintaining 3.5 nursing hours per resident per day. 2. Facility has advertise for prn certified nursing assistants for weekends at rate of $16.50 per hour. This rate is also being offered to facilities present certified nursing assistants for working weekends. Staffing will be reviewed daily to ensure maintaining 3.5 nursing hours per resident per day. 3. Staffing coordinator has been educated on appropriate use of agency, certified nursing assistants PRN pool, and facility staff to ensure maintaining 3.5 nursing hours per resident per day. 4. Administrator/Designee will review staffing daily to ensure 3.5 nursing hours per resident per day. Results of review will be reported monthly to RM/QI meeting.	06/01/07 06/01/07 06/01/07 06/15/07

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{F 492}	Continued From page 7 According to 22 DCMR 3211.3,"Beginning no later than January 1, 2005, each facility shall employ sufficient nursing staff to provide a minimum daily average of 3.5 nursing hours per resident per day. The "Nursing Daily Staffing" sheets were reviewed with the Director of Nursing May 13, 14, 15, 16, and 17, 2007 and revealed inadequate nurse staffing on the following days: Date — Nursing Hours May 13, 2007 — 2.7 May 14, 2007 — 3.2 Additional "Nursing Daily Staffing" was requested May 2 through May 12, 2007 and revealed inadequate staffing on the following days: May 5, 2007 — 3.0 May 6, 2007 — 3.2 May 11, 2007 — 3.1 May 12, 2007 — 3.2 A face-to-face interview was conducted with the Director of Nursing on May 16, 2007 at approximately 11:00 AM who acknowledged that the staffing was below 3.5 nursing hours per resident per day due to scheduled staff not reporting to work (called in). The facility is in the process of obtaining a contract with a nursing agency. This was a repeat deficiency from the recertification survey completed April 14, 2006, the follow-up-up survey completed June 29, 2006, and the annual recertification survey completed April 5, 2007.	{F 492}		