PRINTED: 06/23/2006
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095026	A. BUILDING ______ B. WING ______	06/13/2006

NAME OF PROVIDER OR SUPPLIER: KNOLLWOOD HSC

STREET ADDRESS, CITY, STATE, ZIP CODE: 6200 OREGON AVE NW, WASHINGTON, DC 20015

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 re-certification survey and incident (06-I-1284) investigation was conducted on June 12 and 13, 2006. An Immediate Jeopardy (IJ) in the areas of CFR 483.25(h)(1), F323 and CFR483.25 (h)(2), F324 (Quality of Care) and CFR 483.70(c)(2) (Space and Equipment) were identified on June 12, 2006 at 5:15 PM. The facility administrator was informed of the IJ and a plan of action to address the issue of resident safety was received. The IJ remained in effect at the conclusion of the survey. The following deficiencies were based on observations, record reviews and interviews with the facility staff and residents. The sample included 11 sampled residents based on a census of 44 residents on the first day of survey and six (6) supplemental residents.	F 000		
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 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 scarred and marred furnishings in residents' rooms and foot boards with holes and splintered edges. These findings were observed in the presence of the Administrator, Housekeeping and Maintenance Directors.	F 253	(1) A. The frontal surfaces of television stands, nightstands, and chair legs will be repaired in residents' rooms 8, 14A, 12, 19 and 27. (1) B. Foot boards on residents' beds in Rooms 19, 23, 26, 27 and 28 with drilled holes with splinters around the edges have been repaired. (2) The Environmental Services Supervisor for the HSC will conduct an audit of all residents' rooms to determine if any television stands, night stands, chair legs and foot boards are in need of repair. If any are found, a furniture contractor will be contacted to make all needed repairs. (3) The above will be monitored on a quarterly basis by the Administrator and the Environmental Services Supervisor for the HSC during grand rounds. (4) The result of these inspections will be incorporated in the Quality Assurance Program.	07/20/06

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Barbara D'Agostino, LNHA — TITLE: Administrator — (X6) DATE: 7/3/06

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 The findings include. 1. The frontal surfaces of television stands, night stands and chair legs were marred and scarred in residents' rooms 8, 14a, 12, 19 and 27 in five (5) of 13 observations between 11:20 AM and 12:20 PM on June 12, 2006. This is a repeat deficiency from the annual re-certification survey completed May 19, 2005. 2. Foot boards on residents' beds were observed to have drilled holes with splintered areas around the edges in rooms 19, 23, 26, 27 and 28 in five (5) of 13 observations between 11:20 AM and 12:20 PM on June 12, 2006.	F 253		

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F 278 SS=D	483.20(g) - (j) RESIDENT ASSESSMENT The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by : Based on observation, interview and record review for two (2) of 11 sampled residents, it was determined that facility staff failed to sign Section R2 (Signature of Registered Nurse (RN) coordinating the Minimum Data Set (MDS) assessment) for one (1) resident and accurately code wandering in Section E for one (1) resident.	F 278	(1) A. The MDS was signed on R2b for resident #2 by the RN Coordinator on 6/27/06. (1) B. Facility staff corrected the coding for Resident S1 for wandering in Section E of the MDS. (2) The MDS Coordinator will perform a chart review on the most recent assessments on all medical records to specifically note the coding of section R2a, R2b and E on the MDS. If any MDS's are found to be missing a signature, they will be signed, or if inaccurate, they will be resubmitted. In addition, the MDS Coordinator and Director of Social Services will review the MDS RAI User's Manual for instructions under proper coding of Section E. The MDS Coordinator and Director of Social Services will use these guidelines on all future residents identified with wandering behavior. (3) The MDS Coordinator will perform a quarterly quality assurance audit of random medical records to assure all MDS's are signed and certified that the assessment is complete in Items R2a and R2b as well as the accuracy of MDS Section E. (4) Results of this audit will be reported and reviewed at the Quarterly Quality Assurance meetings.	07/07/06

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F 278	Continued From page 3 Residents #2 and S1. The findings include: 1. The RN failed to sign R2b for Resident #2. According to the MDS 2.0 User ' s Manual, page 3-211, " These regulations also require the RN Assessment coordinator to sign and certify that the assessment is complete in Items R2a and R2 b." A review of Resident #2's record revealed a significant change MDS completed January 19, 2006. There was no RN coordinator signature at R2b. The record was reviewed June 6, 2006. 2. Facility staff inaccurately coded Resident S1 for wandering in Section E of the MDS. A review of Resident S1 ' s record revealed an annual MDS completed January 26, 2006, assessment reference date (ARD) January 26, 2006 and quarterly MDS assessments completed April 20, 2006, ARD April 20, 2006 and November 3, 2005, ARD November 3, 2006. The resident was coded on all the MDS assessments in Section E4a as wandering daily. According to the MDS 2.0 User ' s Manual, page 3-66, " To identify (A) frequency and (b) the alterability of behavioral symptoms in the last seven days [from the ARD] that cause distress to the resident, or are distressing or disruptive to facility resident or staff members. " A review of the nurses ' notes from August 20, 2005 through April 20, 2006 revealed no	F 278		

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F 278	Continued From page 4 reference to the resident wandering seven (7) days prior to the ARD for the above cited MDS assessments. A face-to-face interview with the MDS coordinator was conducted on June 13, 2006. He/she acknowledged that there was insufficient documentation to code the resident for wandering on all the above cited MDS assessments. The record was reviewed June 13, 2006.	F 278		
F 323 SS=L	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 observations during the survey, it was determined that the facility failed to ensure that five (5) of five (5) exit doors located in resident hallways had a system to notify staff when residents exited the doors. This was observed in the presence of the Director of Nursing and the Administrator. The findings include: It was observed on June 12, 2006 at 5:10 PM that the nursing unit had five (5) ingress/egress doors. None of the doors had a system to notify staff when residents exited the unit. Two (2) doors opened onto stairwells. One (1) door opened to an enclosed patio that was surrounded by a waist high wall. Beyond the wall, was an area of trees	F 323	(1) The five (5) ingress/egress doors on the nursing unit have had a system added to notify staff when residents exit the unit. The resident with Dementia that eloped through the ambulance entrance and fell on the driveway was brought back through the ambulance entrance by nursing staff and the minor scratches due to the fall were immediately treated. (2) The five (5) ingress/egress doors on the nursing unit now have a system to notify staff when any resident may exit from the unit. (3) The five (5) ingress/egress doors will be tested on a daily basis by the Security Officer or Engineer to assure the alarms are operating properly. A daily log will be maintained at the nurse's station and will be monitored by the Administrator. (4) Results of these findings will be incorporated into the Quality Assurance Program.	06/20/06

Revised 1/1/06

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F 323	Continued From page 5 and shrubs abutting the facility's driveway. One (1) door opened onto a long corridor, termed by facility staff as the "black and white" hallway. The hallway terminated with a door opening to the outside. One (1) door exited to the ambulance entrance; the ambulance entrance door automatically opens to the facility driveway. A resident with Dementia eloped through the ambulance entrance and fell on the driveway. Facility staff was unaware that the resident had exited through the corridor door which led to the ambulance entrance.	F 323		06/13/06
F 324 SS=J	483.25(h)(2) ACCIDENTS The facility must ensure that each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by : Based on observations, record review and staff interviews for one (1) of 11 sampled residents, it was determined that facility staff failed to adequately supervise and monitor one (1) resident with Dementia who eloped from the facility on June 5, 2006 and was found in the ambulance driveway. Resident #9. The findings include: The incident report dated June 5, 2006, sent to the State Agency included the following: "Resident observed in sitting position in ambulance entrance driveway. Resident was	F 324	(1) The five (5) ingress/egress doors on the nursing unit have had a system added to notify staff when residents exit the unit. The resident with Dementia that eloped through the ambulance entrance and fell on the driveway was brought back through the ambulance entrance by nursing staff and the minor scratches due to the fall were immediately treated. (2) Nursing staff will monitor and document that the bracelets worn by the residents on the wanderguard system are in place every shift and there will be a documented test of each ankle transmitter each day. The Security Officer or Engineer will monitor and document that the door exits are alarming when a wanderguard device/tester is passed by it on a daily basis. (3) Nursing, Security and Engineer staff has been inserviced and will comply with the requirements of this schedule and the Chief Engineer and Administrator will regularly monitor the documentation. (4) Documentation will be incorporated in the Quality Assurance Program.	

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F 324	Continued From page 6 observed at 2 AM by nursing. Resident sustained an abrasion to Left elbow approximately 3 cm long and an abrasion to Left knee approximately 1 cm long ... " The resident was admitted to the facility on January 25, 2006. The admission MDS (Minimum Data Set) dated February 2, 2006 included the following diagnoses in Section I: Other Cardiovascular Disease and Dementia other than Alzheimer ' s Disease. The admission MDS and the quarterly MDS dated April 27, 2006 in Section E4 coded the resident with the behavior of wandering daily. The June 2006 POS (Physician's Order Sheet) included the following order: "Wanderguard to prevent elopement " . The nurses' notes read as follows: June 5, 2006 at 7:30 AM, " At 1:30 AM OOB (out of bed) ambulating in hallway... Assisted to bed at 2AM, made comfortable. 2:30 AM resident found on ground in the ambulance driveway. Upon investigation, resident said that he/she was trying to find his/her friend ... Wanderguard not found on either ankle ... " June 5, 2006 at 7:30 AM, " Addendum - Wanderguard reapplied to right ankle. " A telephone interview was conducted on June 12, 2006 at 12:50 PM with the charge nurse on duty the morning of the elopement. He/She stated, " He/she got up and was walking as [resident] usually does ... One of the CNAs took [resident] back to his/her room and put him/her back to bed. [Resident] came back and was put back to bed. One of the engineers past by and said he/she	F 324		

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F 324	Continued From page 7 thought someone was outside; I think he/she heard something. We immediately went out there . [Resident] had fallen in the driveway. " A follow up telephone interview was conducted with the charge nurse on June 20, 2006 at 10:12 AM. He/she stated, " I had not checked it [wanderguard] that shift. It had been checked the previous shift. There is no set time to check it. Now, I check it the beginning and end of each shift. " A telephone interview was conducted with the facility engineer on June 12, 2006 at 1:15 PM. He /she stated, " Someone from upstairs [Independent Living area] called the front desk and they [front desk] called me. The front desk said a resident heard someone outside screaming. I went out there and saw the resident and went back and told the nurse and they went out. It was about 2:30 AM. I helped them put [resident] in the wheelchair. " The resident had a history of attempting to exit the facility. His/her room was adjacent to the corridor exit door that led to the ambulance entrance. The nurses' notes revealed the following: January 27, 2006 at 12 midnight, " ... wandering in hallway. Attempted to leave the unit via the ambulance door. " January 27, 2006 at 4:15 PM, " Resident attempted elopement from [facility] X3 after lunch today. " January 27, 2006 at 9:30 PM, " ...Continues to wander on unit, attempted to leave via ambulance door X2 ... " January 28, 2006 at 10:30 PM, " ...Wanders	F 324		