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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
	095019	A. BUILDING _____ B. WING _____	R 07/23/2009

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 second follow-up survey to the annual certification survey conducted on April 2 through 5, 2007, was conducted on July 23, 2009. The following deficiencies are based on observations, interviews and record review. The sample size was 18 residents.	{F 000}	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider with the statement of deficiencies. The plan of correction is prepared and/or executed because it is required by provision of Federal and State regulations.	
{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 observation during the environmental tour of the of the facility on July 23, 2009 from 9:15 AM through 3:00 PM, 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 the following observations: Damaged: cove base and corner guards in wheel chair storage areas in two (2) of eight (8) observed; cove base in rooms in seven (7) of 50 rooms observed; floor surfaces in two (2) of 50 rooms observed; walls in five (5) of 50 rooms observed; Sinks in six (6) of 50 resident rooms observed; and Wardrobes were observed to be missing one (1) of two (2) drawers and two (2) of two (2) closet doors in three (3) of 50 rooms observed. Marred and/or scarred: Walls in two (2) of 50 rooms observed; The bottom of training toilet doors were observed marred and scarred in two (2) of two (2) training doors observed on the 5th floor; and the bottom of resident room doors in three (3) of 50 rooms observed. Soiled: Ceiling tiles in two (2) of 50 ceiling tiles observed; privacy	{F 253}	F253 1. Wheelchair storage, cove base & corner guards on 3S & 5S have been repaired. 8/13/09 Cove basing in rooms 404, 415, 420, 421, 508, 513 and 517 has been replaced. 8/13/09 Floor surfaces have been repaired in rooms 326 & 506. 8/14/09 Damaged walls in 311, 404, 411 and 436 are repaired. 8/13/09 Sink in rooms 322, 326,408, 411, 421, and 426 have been caulked and cleaned. 8/13/09 Wardrobe drawers have been replaced in room 417. 8/13/09 The wardrobes in 201 & 421 have working doors. 8/13/09 Walls in 311 & 420 have been painted. 8/13/09 The bottom of the door to training toilet (2) on 5th floor have been repaired. 8/15/09	

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Sandra E Dunham | TITLE: Executive Director | (X6) DATE: 8/14/09

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other afeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of urvey 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 ocuments 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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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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{F 253}	Continued From page 1 curtains in resident rooms in nine (9) of 39 privacy curtains observed; the seat surfaces of straight back chairs in two (2) of six (6) chairs observed. These observations were made in the presence of Employees # 4, 6 and 7. These findings were acknowledged at the time of these observations. The findings include: A. The following were observed damaged: 1. The wheel chair storage areas on 3 South and 5 South were observed to have damaged cove base and corner guards in two (2) of eight (8) observed. 2. Damaged cove base was observed in rooms 404, 415, 420, 421, 508, 513 and 517 in seven (7) of 50 rooms observed. 3. Damaged floor surfaces were observed in room 326 and 506 in two (2) of 50 rooms observed. 4. Damaged walls were observed in rooms 311, 404, 411 Bed C, 436 Bed B in five (5) of 50 rooms observed. 5. Sinks were observed to have rust and in need of caulking in rooms 322, 326, 408, 411, 421 and 426 in six (6) of 50 resident rooms observed. 6. Wardrobes were observed to be missing one (1) of two (2) drawers in room 417 and two (2) of two (2) closet doors in room 201 and 421 in three (3) of 50 rooms observed. B. The following were marred and/or scarred:	{F 253}	Bottom of Resident room doors in 334, 425 and 534 have been repaired. Soiled ceiling tiles in 303 & 311 have been Replaced. Privacy curtains have been replaced and/ or cleaned and hooks replaced in rooms 322, 335, 401, 402, 411, 414, 419, 420 and 508. Straight back chairs in day rooms have been cleaned. 2. Focused facility rounds completed. Plan for correction & improvement Implemented. 3. Re-educated maintenance & Housekeeping on rounds & timely completion of work orders. Resident room & corridor painting schedule initiated. Two Resident rooms will have wall patched, painted, cove base replaced, sinks & toilets re-caulked daily. Quality improvement data collection tool for 4 rooms per floor will be completed 5 days/wk with environmental work order initiated for identified areas needing attention. Guardian angel daily worksheet has been updated to include privacy curtains & common area furniture. Guardian Angel rounds are completed daily by department manager & reported to assistant administrator. Vice President Of construction will validate progress on bi-monthly visit X 3 months then monthly thereafter.	8/15/09 8/12/09 8/13/09 8/13/09 7/28/09. 8/14/09

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{F 253}	Continued From page 2 1. Walls in resident rooms were observed marred and scarred in rooms 311 and 420 in two (2) of 50 rooms observed. 2. The bottom of the training toilet door was observed marred and scarred in two (2) of two (2) training doors observed on the 5th floor. 3. The bottom of resident room doors were marred and scarred, rooms 334, 425, 534 in three (3) of 50 rooms observed. C. The following items were observed soiled: 1. Ceiling tiles in resident rooms were soiled and/or stained in rooms 303 and 311 in two (2) of 50 ceiling tiles observed. 2. Privacy curtains in resident rooms were soiled with grease and hooks were detached in rooms 322, 335, 401, 402, 411, 414, 419, 420, and 508 in nine (9) of 39 privacy curtains observed. 3. The seat surfaces of straight back chairs in Day Rooms were soiled in two (2) of six (6) chairs	{F 253}	4. Results of Quality Improvement collection tool will be presented to risk management Quality Improvement committee monthly. Completion of work orders will also be reviewed for timely completion Guardian Angel rounds results will be reported monthly by assist administrator for any trending identified.	
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	F 279		

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F 279	Continued From page 3 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 one (1) of 18 sampled residents, it was determined that facility staff failed to initiate a care plan for the potential adverse interaction for nine (9) or more medications. Resident #1. The findings include: According to the July 2009 Medication Administration Record, the resident was receiving the following medications: Amlodipine Besylate 5 mg daily Arimidex 1 mg daily Docusate Sodium 100 mg twice daily Isosorbide Mononitrate 60 mg daily Lisinopril 40 mg daily Mirtazepine 7.5 mg daily Omeprazole 20 mg daily Singulair 10 mg daily Vitamin D3 1,000 units daily Spiriva 30 caps with handihaler 18 mcg cap with device daily A review of the resident's care plan, last updated	F 279	F279 1. Resident #1 care plan has been updated to include potential adverse interaction for 9 or more meds. 2. Current Residents care plans have been reviewed and updated as appropriate for use of 9 or meds. 3. MDS staff re-educated on care planning accuracy and process. Review of 5 random care plans completed by Registered Nurse. Assessment Coordinator daily X 5 days/wk X 2 wks then weekly for accuracy. 4. Results of reviews will be submitted to the Risk Management/Quality Improvement committee monthly by DON/Designee.	7/23/09 7/25/09 8/08/09

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F 279	Continued From page 4 May 11, 2009, revealed that there was no care plan initiated for the potential adverse interaction for nine (9) or more medications. A face-to-face interview was conducted on July 23, 2009 at 1:00 PM with Employee #2. He/she acknowledged that there was no care plan for the potential adverse interaction for the use of nine (9) or more medications. The record was reviewed July 23, 2009.	F 279		
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 observations during the medication pass conducted on July 24, 209 between 955 AM and 10:30 AM, it was determined that facility staff failed to use the proper size blood pressure cuff to obtain residents ' blood pressure. Residents #17 and 18. The findings include: An observation during medication pass conducted on July 24, 2009 at 9:55 AM on unit 4S, revealed that the nurse took Resident #17's blood pressure with a large adult cuff. An observation during medication pass conducted on July 24, 2009 at 10:20 AM, revealed that the nurse took Resident #18's blood pressure with a large adult cuff. The cuff was placed around the resident ' s left arm. The range for use was identified on the cuff with white markings. The cuff wrapped around Resident 17's arm was secured at the very	F 281		

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F 281	Continued From page 5 beginning of the manufacturer ' s identified range for use. The cuff was wrapped around Resident 18 ' s left arm was secured approximately 1 " (one inch) past the white markings of the manufacturer ' s identified range for use. A face-to-face interview was conducted with Employee #1 at the time of the observation. He/she was asked if a large adult cuff was the correct size cuff to use for an accurate reading for the above two residents. He/she stated that neither of the two above identified residents was obese but there was no other size cuff on the unit. Observations on units 4N, 5N and 5S revealed that each unit had a large adult cuff. There was no average adult cuff on either unit. Employees #2 and 3 acknowledged that there was no other size cuff available on the above identified units. According to the guidelines from the National Clearing House, web site <http://www.guideline.gov/>, "Use only a blood pressure cuff that is designed for your size arm. Your arm size measured around the middle of the upper arm should fall in the middle 75% of the cuff ' s range. When your size falls close to the upper and lower end of the cuff ' s range you can see error begin to occur. At this point you might need to step up to the next size. Obviously being near the lower end of the range requires stepping down but this is not as critical. "	F 281	F281 1. The blood pressure for Resident #17 and #18 are being obtained using proper sized blood pressure cuffs. 2. Current residents are at risk for alleged deficient practice. 3. New Blood Pressure Cuffs have been obtained (Reg & Lg) for each medication cart. Nursing staff Re-educated on procedure of obtaining blood pressures. Competency testing on procedure of obtaining blood pressures on going & as part of orientation. Unit managers will validate that blood pressure cuffs are available on cart daily 5 X's a week for 2 weeks then weekly thereafter. 4. Don/designee will report results of QI review monthly to Risk Management/ Quality Improvement committee monthly.	7/26/09 8/17/09 8/2/09
{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,	{F 309}		

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{F 309}	Continued From page 6 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 interview for one (1) of 18 sampled residents, it was determined that facility staff failed to administer milk with medication as ordered by the physician for Resident #1. The findings include: Facility staff failed to administer milk with medications in accordance with physician ' s orders for Resident #1. On July 23, 2009 at 8:39 AM Employee #5 was observed administering medications to Resident #1. He/she administered the 9:00 AM medications that were directed to be given with an 8 ounce cup of water. According to the July 2009 Physician ' s order sheet signed and dated June 29, 2009 Resident #1 is directed to receive the following medications daily and they are scheduled to be given at 9:00 AM: Norvasc 1 tab by mouth, Arimidex 1 tab by mouth, Aspirin 81 mg 1 tab by mouth, Colace 1 cap by mouth, Imdur 1 tab by mouth, Prinivil 1 tab by mouth, Remeron 1 tab by mouth, Prilosec 1 tab by mouth, and Singular 1 tab by mouth ... Drink non-fat/low fat milk with medications. " A review of the July 2009 Medication Administration Record " Drink non-fat/low fat milk	{F 309}	F 309 1. Physician order obtained to discontinue use of milk with medications Resident #1. 2. Review of current Residents physician orders completed for order to administer milk with medications. No other order identified. 3. Licensed nurses re-educated on following physician orders. Quality Improvement tool completed daily X 5 days/wk X2 wks, then weekly to review random sample of following physician orders. 4. DON/designee will report findings of Quality improvement review monthly @ RM/QI committee meeting.	8/6/09 8/17/09 7/29/09

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{F 309}	Continued From page 7 with medications " was not initialed as being given from July 15, 2009 to July 23, 2009. The record lacked evidence that milk was given with the medication in accordance with the physician ' s order. A face-to-face interview was conducted on July 23, 2009 at 9:10 AM with Employee #5. He/she stated, " I did not give milk, I gave water [with the medications]. " The record was reviewed on July 23, 2009.	{F 309}	F454 1. Doors to room 201 and 414 are not Propped open. 2. Facility round completed to removed any item propping doors open. 3. Maintenance and Housekeeping staff re-educated to not prop doors open. Guardian Angel daily worksheet updated to Include monitoring of doors being propped and to be corrected at time of discovery. 4. Results of Guardian Angel tracking/ trending will be reported monthly to the Risk Management/Quality Improvement committee by Assistant Administrator or designee.	7/23/09 7/28/09 8/17/09
F 454 SS=D	483.70 PHYSICAL ENVIRONMENT The facility must be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel and the public. This REQUIREMENT is not met as evidenced by: Based on observation during the environmental tour of the facility on July 23, 2009 from 9:15 AM through 3:00 PM, it was determined that facility staff failed to maintained and protect the health and safety of residents, personnel and the public as evidenced by entry way and resident room doors observed propped open with wooden and/or brown paper. These observations were made in the presence of Employees #4, 6 and 7. These findings were acknowledged at the time of these observations. The findings include: 1. Resident room entry doors were observed propped open with a wood wedge and or brown paper prevented the door from closing in room	F 454		

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F 454	Continued From page 8 201 and 414 in two(2) of 50 resident room doors observed. 2. On July 23, 2009 at 11:20 AM the 4 North right entry way door to the unit was observed propped open with brown paper and the "closure" was detached from the door preventing the door from closing in one (1) of eight (8) entry way doors observed.	F 454	F456 1. HVAC Unit has been repaired on the 5th floor HVAC repaired in room 429. Shower hose replace in 3 N male bath Room. 2. Facility HVAC system evaluated by contractor with repairs completed. 3. Maintenance Director re-educated on HVAC maintenance requirements. Maintenance Director or designee will review temps in random Resident areas weekly and discuss result and corrective actions at weekly safety meeting. 4. Results of weekly temperatures and preventative maintenance completion will be presented to Risk Management/Quality Improvement Committee monthly by Maintenance Director.	7/28/09 7/28/09 8/4/09 8/4/09 8/17/09 8/13/09
F 456 SS=D	483.70(c)(2) SPACE AND EQUIPMENT The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation during the environmental tour of the facility on July 23, 2009 from 9:15 AM through 3:00 PM, it was determined that the facility failed to maintain all essential mechanical, electrical, and patient care equipment in safe operating condition as evidenced by non-operating HVAC [Heating Ventilating and Air Conditioner] Units and a leaking shower hose. These observations were made in the presence of Employees #4, 6 and 7. These findings were acknowledged at the time of these observations. The findings include: 1. HVAC unit in the 5th floor green room was not operating and in need of repair in one (1) of one (1) HVAC unit observed. Air temperature was record at 83 degrees Fahrenheit. 2. HVAC not working in room 429 in one (1) of 50 resident rooms observed	F 456		

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F 456	Continued From page 9 3. A leaking shower hose was observed in the 3 North male bathroom shower stall in one (1) of eight (8) shower stalls observed.	F 456		