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FORM APPROVED
OMB NO. 0938-0391

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

Revised 6/27/07 as

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 _____	05/25/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KNOLLWOOD HSC	6200 OREGON AVE NW WASHINGTON, DC 20015

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F 000	INITIAL COMMENTS An annual recertification survey was conducted May 24 through 25, 2007. The following deficiencies were based on record review, observations and interviews with facility staff. The sample included 13 residents based on a census of 44 the first day of survey and five (5) supplemental residents			
F 332 SS=D	483.25(m)(1) MEDICATION ERRORS The facility must ensure that it is free of medication error rates of five percent or greater This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview for three (3) of eleven residents observed during medication pass, it was determined that licensed staff failed to ensure that residents were free from medication errors. The medication error rate was 10.5%. Residents JH3, JH5 and JH6 The findings include Five (5) errors occurred during the morning medication pass. The medication pass was observed on Thursday, May 24, 2007 at approximately 9.00 AM and 4:00 PM on Friday May 25, 2007 at approximately 8:30 AM Fifty-seven opportunities were observed during the medication pass. Three (3) medication nurses were observed during the medication pass. After the medication pass, the observed medications were reconciled with the physician's orders.	F 332	(1) A. The multivitamin tablet for resident JH3 was administered after staff became aware of the omission. In addition, medication nurse #1 was counseled on the proper procedure for documenting when a medication is omitted during the medication pass by encircling her initials on the front of the MAR, indicating that the medication was not given and entering the reason for the omission of the medication on the back side of the MAR (1) B. The second drop of Artificial Tears ophthalmic solution was instilled in Resident JH5's eyes (right and left) after staff became aware. Medication nurse #1 was counseled to carefully read the physician's orders regarding the number of drops of Artificial Tears ophthalmic solution. (1) C. Acular eye drop 0.5%, Aspirin 325 mg and Docusate Sodium Liquid 50 mg/5 ml were administered after staff became aware of the omission. Medication nurse #2 was immediately relieved of the responsibility of medication administration and replaced by another licensed nurse. (2) Medication nurse #2 is no longer employed at this facility. An audit was done on all MAR's to assure that all ordered medications were on the medication cart.	6/26/07

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Barbara O'Gwaltney, LNHA | TITLE: Administrator | (X6) DATE: 06/14/07

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 332	Continued From page 1 1. On May 24, 2007 at approximately 9:45 AM, medication nurse #1 administered eight (8) medications to Resident JH3. The multivitamin tablet for resident JH3 was omitted during the medication pass. The physician's order dated May 14, 2007 read, "Multivitamin one (1) tablet every day for supplement". The multivitamin tablet was documented as being administered on the MAR (Medication Administration Record), but was not observed being given to the resident during the medication pass. The record was reviewed on May 24, 2007. 2. On May 24, 2007, at approximately 10:00 AM, medication nurse #1 instilled one (1) drop of Artificial Tears ophthalmic solution into Resident JH5's eyes (right and left). The physician's order dated May 9, 2007 read, "Artificial Tears 1.4% drops. Instill 2 drops to each eye 3 times a day for dry eyes." The record was reviewed on May 24, 2007 3. On May 25, 2007, at approximately 8:30 AM, medication nurse #2 was observed administering five (5) medications to Resident JH6 The medication nurse omitted the following medications: Acular eye drop 0 5%, Aspirin 325mg and Docusate Sodium Liquid 50mg/ 5ml. The physician's orders dated May 2, 2007 read, "Acular Eye drops, Instill on (1) drop to right eye 4 times a day for pressure in eye, Aspirin 325mg one (1) tablet every day for clot prevention; and Docusate Sodium Liquid 50mg/5ml Ten (10) mls (100mg) po every day for constipation." A face-to-face interview was conducted with medication nurse #2 on May 25, 2007 at approximately 9:15 AM. He/She stated that the	F 332	**(3) The Director of Nurses/designee will monitor medication pass with various medication nurses on a weekly basis for the next thirty days, and monthly thereafter. Additionally, The RN Account Manager with our Pharmacy will monitor the medication pass on 6/13/07 and 6/26/07 with all medication nurses and immediately inservice them on the proper procedure for medication pass and documentation. This review will continue on a quarterly basis.** **(4) The results of the medication pass will be incorporated into the Quality Assurance Program.**	

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F 332	Continued From page 2 errors were due to the surveyors making him/her nervous. The record was reviewed on May 25, 2007.	F 332		
F 371 SS=D	483.35(i)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by: Based on observations during the tour of the main kitchen, it was determined that dietary services failed to ensure that foods were served and prepared in a safe and sanitary manner as evidenced by soiled hotel and sheet pans, floor surfaces, gas lines and shelves These findings were observed in the presence of the Director of Dietary Services on May 24, 2007 at 8:50 AM The findings include: 1 Nine (9) of 17 hotel pans were soiled with leftover food and a greasy residue after being washed and ready for reuse 2. Eight (8) of 22 sheet pans were soiled with leftover food and a greasy residue after being washed and ready for reuse 3 The floor behind the grill and deep fryer and in the rear of the steamer and convection ovens was soiled with dirt, debris and a greasy residue in one (1) of one (1) floor observation. 4. The gas lines to the grill were soiled with debris	F 371	(1) A. The nine hotel pans were rewashed and all leftover food and greasy residue was removed. (1) B. The eight sheet pans were rewashed and all leftover food and greasy residue were removed. (1) C. The floor behind the grill and deep fryer and the rear of the steamer and convection ovens were cleaned of any dirt, debris or greasy residue. (1) D. The gas lines to the grill were cleaned to remove any debris or greasy residue. (1) E. The two shelves that stored hotel and sheet pans were cleaned to remove rust and debris. (2) Management will continue to monitor and spot-check the hotel pans, sheet pans, floors, gas lines and shelves on a daily basis. Food service staff has been inserviced on 6/12/07 and 6/13/07 regarding the cleaning schedule and proper procedure for cleaning the hotel pans, sheet pans, floors, gas lines and shelves. (3) Food Service Management will monitor the above on a daily basis. The Director of Dining Services or designee will monitor this on a daily basis and the Registered Dietitian and Administrator will monitor this during quarterly grand rounds. (4) The results of management's findings will be incorporated into the Quality Assurance Program.	6/13/07

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F 371	Continued From page 3 and a greasy residue in one (1) of one (1) observation of the gas lines. 5. Two (2) of two (2) shelves that stored hotel and sheet pans were rusty and soiled with debris. The Director of Dietary Services acknowledged the above cited soiled items and areas at the time of the observations.	F 371		
F 425 SS=D	483.60(a),(b) PHARMACY SERVICES The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483 75(h) of this part The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by Based on observations, record review and staff interview for two (2) of eleven residents observed during medication pass, it was determined that facility staff failed to ensure that Clonazepam, an	F 425	1) A. Resident JH7 was administered the proper medication as ordered. Clonazepam 0.25mg tablets were immediately ordered from the pharmacy. Medication nurse #2 was counseled about the proper ordering of medications in a timely manner to avoid running out of any medication. (1) B. Resident #9 was administered the proper medication as ordered. Clonazepam 0.25mg tablets were immediately ordered from the pharmacy. Medication nurse #2 was counseled about the proper ordering of medications in a timely manner to avoid running out of any medication. (2) Medication nurse #2 is no longer employed at this facility. An audit was done on all medication carts to assure that all medications were available. (3) The Director of Nurses/designee will monitor the medication cart on a weekly basis for the next thirty days, and monthly thereafter to assure that all medication orders have been received. Additionally, the RN Account Manager with our Pharmacy will monitor the medication pass on 6/13/07 and 6/26/07 with all medication nurses and immediately inservice them on the proper procedure for ordering medication in a timely manner. This review will continue on a quarterly basis. (4) The results of this audit will be incorporated into the Quality Assurance Program	6/26/07

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F 425	Continued From page 4 anticonvulsant, was available for Residents #9 and JH7. The findings include: 1 On May 25, 2007, at approximately 9:50 AM, medication nurse #2 administered three (3) medications to Resident JH7. Medication nurse #3 administered Clonazepam 0.25mg tablet to Resident JH7 from the medication blister pack of another resident In a face-to-face interview at the time of the observation medication nurse #2 stated that he/she gave the resident someone else ' s medication because Resident JH7 did not have any of his/her own medication The record was reviewed on May 25, 2007 2. On May 25, 2007, at approximately 10:00 AM, medication nurse #2 administered six (6) medications to Resident #9. Medication nurse #3 administered Clonazepam 0 25mg tablet to Resident #9 from the medication blister pack of another resident. In a face-to-face interview at the time of the observation, medication nurse #2 stated that he/she gave the resident someone else ' s medication because Resident #9 did not have any more Clonazepam 0.25 mg tablets in his/her medication blister pack. The record was reviewed on May 25, 2007	F 425		
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	F 456		

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F 456	Continued From page 5 This REQUIREMENT is not met as evidenced by. Based on review of the generator log book and staff interview during the environmental tour, it was determined that facility staff failed to exercise the generator at least once monthly for a minimum of thirty minutes. This observation was made in the presence of the Director of Maintenance at 4:00 PM on May 24, 2007. The findings include: According to NFPA (National Fire Protection Association) 110, 1999 Edition, generators set in Level I shall be exercised at least once monthly for a minimum of thirty minutes. According to the facility's generator log book, the generator odometer readings were as follows: November 24, 2006 276.0 to 276.2 December 6, 2006 276.2 to 276.3 December 13, 2006 276.3 to 276.4 December 20, 2006 276.4 to 276.5 December 27, 2006 276.5 to 276.6 January 3, 2007 276.6 to 276.8 The generator was operated 0.1 to 0.2 hours (6 minutes to 12 minutes) weekly. There was no evidence that the generator was exercised at least once for a minimum of thirty minutes during the months of November and December 2006 or January 2007. The Director of Maintenance acknowledged that the generator should be exercised for 30 minutes at least once a month at the time of the observation.	F 456	**(1) Instructions have been posted on the generator and placed in the generator log book, detailing that the generator is to be exercised at least once monthly for a minimum of thirty minutes.** **(2) The engineering staff was educated on 5/30/07 regarding the proper operation and frequency when testing the generator.** **(3) The Chief Engineer will monitor the generator log to assure that it is exercised at least once a month for a minimum of thirty minutes.** **(4) The results of this audit will be incorporated into the Quality Assurance Program.**	5/30/07

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F 514 SS=D	483.75(l)(1) CLINICAL RECORDS The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes This REQUIREMENT is not met as evidenced by Based on observation and record review for one (1) supplemental resident, it was determined that facility staff failed to document the resident's refusal of a medication on the Medication Administration Record (MAR). Resident JH1. The findings include: On May 25, 2007, at approximately 9:30 AM, during the medication pass, Resident JH1 refused the Miralax powder The physician's order dated May 2, 2007 read, "Polyethylene Glycol Powder 100% (Miralax), one teaspoon in juice and drink every day for constipation". A face-to-face interview was conducted with medication nurse #2 at the time of the observation, he/she stated that Resident JH1 did not want to take his/her medication. Medication nurse #2 failed to encircle his/her initials on the front of the MAR, indicating that the	F 514	**(1) Medication nurse #1 corrected the MAR and was counseled on the proper procedure for documenting when a resident refuses a medication during the medication pass by encircling her initials on the front of the MAR, indicating that the medication was not given and entering the reason for the omission of the medication on the back side of the MAR.** **(2) An audit was done on all the MAR's to assure proper documentation if any residents refused medication.** **(3) The Director of Nurses/designee will monitor the MAR's on a weekly basis for the next thirty days, and monthly thereafter. Additionally, the RN Account Manager with our Pharmacy will monitor the medication pass on 6/13/07 and 6/26/07 with all medication nurses and immediately inservice them on the proper procedure for documenting a resident's refusal of a medication. This review will continue on a quarterly basis.** **(4) The results of the medication pass will be incorporated into the Quality Assurance Program.**	6/26/07

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F 514	Continued From page 7 Miralax was not given and enter the reason for omission of the medication on the back side of the MAR. The record was reviewed on May 25, 2007.	F 514		