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	t of deficiencies of correction	(X1) PROVIDER/SUPPLI IDENTIFICATION NU 095026		(X2) MULT A. BUILDI B, WING		(X3) DATE SU COMPLE - 06/13	
AME OF P	ROVIDER OR SUPPLIER		STREET AD	STREET ADDRESS, CITY, STATE, ZIP CODE			
KNOLLM	100d HSC			EGON AVE STON, DC			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEEDED B LSC IDENTIFYING INFORM	YFULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION S REFERENCED TO THE APPROF	HOULD BE CROSS-	(X5) COMPLET DATE
L 000	Initial Comments			L 000			
,	1284) investigation and 13, 2006. The based on observat interviews with the The sample includ based on a census	facility staff and resided 11 sampled resides of 44 residents on the state of the s	June 12 as were and dents. ents he first				
L 016	 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. 2016 3203.6 Nursing Facilities A qualified employee shall be assigned the responsibility for ensuring that records are maintained, completed, and preserved. This Statute is not met as evidenced by: Based on observation, interview and record review for nine (9) of 11 sampled residents and six (6) of six (6) supplemental residents, it was determined that facility staff failed to write a complete description of an elopement incident for one (1) resident and consistently document on percentage of food intake on the " Resident Care Flow Record " for 15 residents. Residents #1, 2, 3, 4, 5, 7, 8, 9, 10, W1, W2, W3, W4, S1, and S2 The findings include: 1. Facility failed to include a complete description of an elopement incident in Resident #9's record. The incident report sent to the State Agency on June 6, 2006, included the following: "Resident observed in sitting position in ambulance entrance driveway. Resident was observed at 2 AM by nursing. Resident sustained an abrasion to Left elbow approximately 3 cm 		are y: cord ents and s, it was ite a ncident for nent on ident Care ents #1, 2, 1, and S2. escription y's record. ency on ht was t sustained	L 016	 (1) A. The Director of Nursi medical record of Resident # staff and educate them appropriately document a elopement in the medical record (1) B. Facility staff has beg document the percentage of "Resident Care Flow Record" 2, 3, 4, 5, 7, 8, 9, 10, W1, and S2. None of the experienced weight loss durin (2) A. Nursing staff will be eccomplete a more thorough documentation on elopemer record and on the incident re 2) B. The Certified Nursing inserviced on the importar documentation of the food resident on the flow sheet. (3) The Director of Nursing v the records on a monthly ba all documentation is complete and the percentage. (4) The results of the Dir findings will be incorporate Assurance Program. 	9 with the nursing n on how to nd describe an ord. un to consistently food intake on the for Residents #1, W2, W3, W4, S1 above residents ing this timeframe. Jucated on how to investigation and nt in the medical port. Assistants will be ice of consistent intake of each will randomly audit sis to assure that ete for attempted ige of food intake.	7/10/06

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM		A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SU COMPLE	
			STREET ADD	RESS, CITY,	STATE, ZIP CODE		12000
	VOOD HSC		6200 ORE	GON AVE	NW		
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEEDED BY		FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTION REFERENCED TO THE APPRO	SHOULD BE CROSS-	(X5) COMPLETI DATE
L 016	The nurses' notes in June 5, 2006 at 7:3 of bed) ambulating at 2AM, made com found on ground in Upon investigation, trying to find his/he found on either ank June 5, 2006 at 7:3 Wanderguard reap A telephone intervit 2006 at 12:50 PM v the morning of the One of the engine thought someone v heard something. there. [Resident] h A telephone intervit facility engineer on She stated, " Som Independent Living and they [front desi said a resident hea screaming. I went and went back and out. It was about 2 resident] in the whe The nurse's note w circumstances surr resident in the amb was reviewed June	read as follows: 30 AM, " At 1:30 AM O in hallway Assisted fortable. 2:30 AM res the ambulance drivew, resident said that he/ r friend Wandergua de" 30 AM, " Addendum - plied to right ankle." ew was conducted on with the charge nurse elopement. He/She s eers past by and said vas outside; I think he/ We immediately went ad fallen in the drivew ew was conducted wit June 5, 2006 at 1:15 eone from upstairs [area] called the front k] called me. The front rd someone outside out there and saw the told the nurse and the :30 AM. I helped then elchair." ras not inclusive of the ounding the discovery pulance driveway. The 12, 2006. ed to consistently docu	to bed ident vay. she was ard not June 5, on duty tated, " he /she out ray. " h the PM. He/ desk nt desk resident ey went n put [/ of the record	L 016			

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PRINTED: 06/23/2006 FORM APPROVED

	t of deficiencies of correction	(X1) PROVIDER/SUPPLIER/CI IDENTIFICATION NUMBE 095026			(X3) DATE SU COMPLE	
AME OF P		ST	REET ADDRESS, CITY	, STATE, ZIP CODE	· · · · · · · · · · · · · · · · · · ·	
NOLLW	OOD HSC		200 OREGON AVE ASHINGTON, DC			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FUL SC IDENTIFYING INFORMATIO		PROVIDER'S PLAN OF (EACH CORRECTIVE ACTION REFERENCED TO THE APPR	N SHOULD BE CROSS-	(X5) COMPLET DATE
L 016	number indicated, i following areas are as stated on the flo	age 2 to effective date or policy under "Procedure - The to be checked or docum w sheetFood intake - entages - i.e. 50% "	e nented			
A face-to-face interview was conducted with the charge nurse on June 13, 2006 at approximate 10:30 AM. He/she acknowledged that documentation for the percentage of food intak for the following residents was inconsistent on "Resident Care Flow Record."		nately ntake				
	for June 2006 for R was no percentage following days: Bre and 9, 2006. The re	" Resident Care Flow Sh Resident #1 revealed that of intake recorded for the akfast and lunch: June 7 esident did not experience this timeframe. The reco	t there ne 7, 8, ce			
B. for wa fol thi . T du	for June 2006 for R was no percentage following days: Bre through 9, 2006; D The resident did r	"Resident Care Flow Sh Resident #2 revealed that of intake recorded for the akfast and lunch : June 2 inner: June 1 through 10 not experience weight los ne. The record was revie	t there ne 2, 5 9, 2006 3 5			
	for June 2006 for R was no percentage following days: Bre through 12, 2006; I 9, 2006. The reside	" Resident Care Flow Sh Resident #3 revealed that of intake recorded for th akfast and lunch: June 1 Dinner: June 2 through 5 ent did not experience we eframe. The record was 2006.	t there ne , 3 , and			
	D. A review of the	" Resident Care Flow St	heet "			

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SI COMPLE	TED
		095026	ATDOCT ADDD			06/1	3/2006
AME OF P					STATE, ZIP CODE	ż	
KNOLLW	OOD HSC		6200 OREG				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S REFERENCED TO THE APPROP	HOULD BE CROSS-	(X5) COMPLET DATE
L 016	Continued From pa	age 3	· 1	016			· · · ·
		Resident #4 revealed t					
	following days: Bre 8 through 11, 2006	akfast and lunch: Jun ; Dinner: June 1 throu	e 1, 2, 4, { gh 4, 8			į	
	weight loss during	resident did not exper this timeframe. The re					
	was reviewed June	•					
	for June 2006 for F	" Resident Care Flow Resident #5 revealed to of intake recorded for	hat there				
	following days: Bre through 7, 10 and through 11, 2006.	e 1					
		loss during this timefra /iewed June 12, 2006.					
	for June 2006 for F	"Resident Care Flow S Resident #7 revealed to of intake recorded for	hat there				
	following days: Bre 1, 2, 4, 8 through 1	akfast and lunch: June 2 , 2006; Dinner June 1, 2006. The resident	e 1				
1	experience weight	loss during this timefra viewed June 13, 2006.	ame.				
	for June 2006 for R	" Resident Care Flow Resident #8 revealed the	hat there		、	İ	
	following days: Bre through 13, 2006; I	of intake recorded for akfast and lunch: June Dinner: June 3, 4, 5, 9, resident did not expe	e 1 and 3 , 10, 11				
ĺ		this timeframe. The re				.	
	for June 2006 for R was no percentage following days: Brea	" Resident Care Flow lesident #9 revealed th of intake recorded for akfast: June 1 through unch: June 1 through	nat there the 13, 5				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MULTI A. BUILDIN B. WING _	PLE CONSTRUCTION	(X3) DATE SU COMPLE	TED	
		095026		DDRESS, CITY, STATE, ZIP CODE				
	Rovider or Supplier 1000 HSC		6200 ORE	GON AVE N TON, DC 2	W			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIE MUST BE PRECEEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION S REFERENCED TO THE APPROP	HOULD BE CROSS-	(X5) COMPLETE DATE	
L 016	2006; Dinner: June 2006. The resident during this timefran June 13, 2006. I. A review of the "F June 2006 for Resi was no percentage following days: Brea 8 through 11, 2006 and 11, 2006. The	1 through 4, 5 through did not experience when the record was re- Resident Care Flow S dent #10 revealed the of intake recorded for akfast and lunch: Jur ; Dinner: June 1 through resident did not expen- this timeframe. The re-	veight loss eviewed Sheet" for at there or the ne 1, 2, 4, ugh 4, 8, prience	L 016				
	for June 2006 Residuation was no percentage following days: Breat through 12, 2006; E and 9, 2006. The residuation of the second	" Resident Care Flow dent W1 revealed tha of intake recorded for akfast and lunch: Jur Dinner: June 1 throug esident did not experi his timeframe. The re 13, 2006.	at there or the ne 1, 2, 5 nh 4, 8, ience					
	for June 2006 for R there was no perce the following days: and 12 2006; Lunch Dinner: June 1, 3, resident did not exp	Resident Care Flow esident W2 revealed ntage of intake recor Breakfast: June 4 thr 1: June 4 through 12, 4, 8, 9 and 11, 2006 erience weight loss record was reviewed	I that ded for rough 9, , 2006; The during					
	for June 2006 for R there was no perce the following days: through 12, 2006; E 2006. The resident	Resident Care Flow esident W3 revealed ntage of intake recor Breakfast and lunch: Dinner: June 1 throug did not experience w ne. The record was n	I that ded for June 3, 7 h 12, veight loss		3 			

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	t of deficiencies of correction	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU 095026		(X2) MULT A. BUILDIN B. WING _	IPLE CONSTRUCTION	(X3) DATE SI COMPLE 06/1 1		
AME OF P	ROVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·	STREET AD	TREET ADDRESS, CITY, STATE, ZIP CODE				
NOLLW	IOLLWOOD HSC 6200 OF WASHIN							
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEEDED B		r FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION SH REFERENCED TO THE APPROPR	OULD BE CROSS-	(X5) COMPLET DATE	
L 016	 D16 Continued From page 5 June 13, 2006. M. A review of the "Resident Care Flow Sheet" for June 2006 for W4 revealed that there was no percentage of intake recorded for the following days: Breakfast and lunch: June 1 through 7, 10 		L 016					
	and 11 2006; Dinne The resident did no	d lunch: June 1 through 11 er: June 1 through 11 ot experience weight ne. The record was r	, 2006. loss					
	for June 2006 for R was no percentage following days: Breathrough 12, 2006; I 2006. The resident	"Resident Care Flor tesident S1 revealed of intake recorded for akfast and lunch: Jur Dinner: June 1 throug did not experience w ne. The record was m	that there or the ne 7 jh 12, /eight loss					
	for June 2006 for R was no percentage following days: Brea 8 through 13, 2006 and 11, 2006. The	" Resident Care Flow Resident S2 revealed of intake recorded for akfast and lunch: Jur Dinner: June 1 throu resident did not expen- this timeframe. The re- 13, 2006.	that there or the ne 1, 2, 4, ugh 4, 8, prience					
L 052	3211.1 Nursing Fac Sufficient nursing ti resident to ensure 1 receives the followi	me shall be given to hat the resident	each	L 052				
	(a)Treatment, medi	cations, diet and nut uids as prescribed, a					·	
İ	(b)Proper care to m	inimize pressure ulc	ers and			ļ		

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(X5)

COMPLETE

DATE

06/13/06

Health Regulation Administration (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A BUILDING B WING 095026 06/13/2006 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 6200 OREGON AVE NW KNOLLWOOD HSC WASHINGTON, DC 20015 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PROVIDER'S PLAN OF CORRECTION ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE CROSS-PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG TAG L 052 L 052 Continued From page 6 (1) It has been witnessed by staff that the wanderguard system was working contractures and to promote the healing of ulcers: appropriately on 6/10/06 and had alarmed. This system has a battery back-up in the event (c)Assistants in daily personal grooming so that of power failures. Therefore, it appears that the resident is comfortable, clean, and neat as the alarm failed between the dates of 6/10/06 evidenced by freedom from body odor, cleaned and 6/12/06. When this was discovered, a and trimmed nails, and clean, neat and wellstaff member was immediately placed at the corridor exit door, which leads to the ambulance entrance. Additionally, a back-up groomed hair: system was installed on this door. Staff (d) Protection from accident, injury, and infection; monitored the door and kept a log until 6/13/06 when both the wanderguard and the back-up (e)Encouragement, assistance, and training in alarm were operational. self-care and group activities; (2) Nursing staff will monitor and document (f)Encouragement and assistance to: that the bracelets worn by the residents on the wanderquard system are in place every shift (1)Get out of the bed and dress or be dressed in and there will be a documented test of each ankle transmitter each day. The Security his or her own clothing; and shoes or slippers, Officer or Engineer will monitor and document which shall be clean and in good repair; that the door exits are alarming when a wanderguard device/tester is passed by it on a (2)Use the dining room if he or she is able; and daily basis. (3)Participate in meaningful social and (3) Nursing, Security and Engineer staff will recreational activities; with eating; comply with the requirements of this schedule and the Chief Engineer and Administrator will (g)Prompt, unhurried assistance if he or she regularly monitor the documentation. requires or request help with eating; (4) Documentation will be incorporated in the Quality Assurance Program. (h)Prescribed adaptive self-help devices to assist him or her in eating independently; (i)Assistance, if needed, with daily hygiene, including oral acre; and i)Prompt response to an activated call bell or call for help. This Statute is not met as evidenced by: Based on observations, record review and staff interviews for one (1) of 11 sampled residents, it Health Regulation Administration STATE FORM 5899 D4QG11 tricontinuation sheet 7 of 18

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	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU 095026		(X2) MULT A. BUILDIN B. WING _	IPLE CONSTRUCTION NG	(X3) DATE SI COMPLE	
NAME OF P	ROVIDER OR SUPPLIER		STREET AD	DRESS, CITY,	STATE, ZIP CODE		
KNOLLW				EGON AVE STON, DC 2			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEEDED BY LSC IDENTIFYING INFORM/	YFULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION SH REFERENCED TO THE APPROPR	HOULD BE CROSS-	(X5) COMPLETE DATE
L 052	adequately monitor Dementia who elop 2006 and was four Resident #9. The findings includ The incident report the State Agency in "Resident observed ambulance entrance observed at 2 AM I an abrasion to Left long and an abrasi 1 cm long " The resident was a January 25, 2006. Minimum Data Set included the follow Other Cardiovascu other than Alzheim MDS and the quart in Section E4 code behavior of wander The June 2006 PO included the follow "Wanderguard to p The nurses' notes June 5, 2006 at 7:3 of bed) ambulating at 2AM, made com found on ground in Upon investigation, trying to find his/he found on either and	at facility staff failed t r one (1) resident with bed from the facility on in the ambulance of the atting position in the driveway. Resident the admission approximately on to Left knee appro- admitted to the facility The admission MDS (atted February 2, 2 ing diagnoses in Sec- the admission MDS atted February 2, 2 ing diagnoses in Sec- the admission MDS (atted April d the resident with the ring daily. (S (Physician's Order ing order: orevent elopement " attent as follows: 30 AM, "At 1:30 AM in hallway Assiste afortable. 2:30 AM re the ambulance drive resident said that he or friend Wandergu	sent to sent to sustained y 3 cm oximately y on 6 (2006 tion I: nentia admission 1 27, 2006 ne Sheet) OOB (out d to bed sident eway. a/she was uard not	L 052			

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MULT A. BUILDIN B. WING	IPLE CONSTRUCTION	(X3) DATE SU COMPLE			
		095026		06/13/2006					
	PROVIDER OR SUPPLIER		6200 ORE	TREET ADDRESS, CITY, STATE, ZIP CODE 5200 OREGON AVE NW NASHINGTON, DC 20015					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		S 'FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTION REFERENCED TO THE APPR	N SHOULD BE CROSS-	(X5) COMPLETE DATE		
L 052	Wanderguard reap A telephone intervi 2006 at 12:50 PM the morning of the He/she got up and usually does On back to his/her roo . [Resident] came One of the engineer thought someone in heard something. there. [Resident] h A follow up telephone with the charge nu AM. He/she stated wanderguard] that previous shift. The Now, I check it the shift. " A telephone intervit facility engineer on He/she stated, " S Independent Living and they [front des said a resident heat screaming. I went and went back and out. It was about 2 resident] in the who The resident had a the facility. His/heat corridor doors that	oplied to right ankle. " iew was conducted or with the charge nurse elopement. He/She was walking as [resid e of the CNAs took [r m and put him/her ba back and was put ba- ers past by and said h was outside; I think he We immediately wen had fallen in the driver one interview was con- rse on June 20, 2006 d, "I had not checked shift. It had been che ere is no set time to cl beginning and end of ew was conducted wi June 12, 2006 at 1:1 omeone from upstains area] called the from k} called me. The fro- out there and saw the told the nurse and the :30 AM. I helped the eelchair. "	a on duty stated, " dent] esident] ick to bed ck to bed ck to bed ck to bed ck to bed ducted at 10:12 ducted at 10:12 dit [ecked the neck it. f each th the 5 PM. s [t desk nt desk e resident rey went m put [to exit o the entrance ng:	L 052					

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	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM 095026		(X2) MULT A. BUILDIN B. WING _		(X3) DATE SURVEY COMPLETED 			
NAME OF P	ME OF PROVIDER OR SUPPLIER		STREET ADDR	ESS, CITY,	STATE, ZIP CODE				
	IOOD HSC		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)		FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION S REFERENCED TO THE APPROP	HOULD BE CROSS-	(X5) COMPLE DATE		
L 052	January 27, 2006 a attempted elopem today. " January 27, 2006 a wander on unit, att door X2 " January 28, 2006 a about unit, attempt wanderguard effect February 5, 2006 a wandered X2 this s February 5, 2006 a confused and diso opened the exit do February 6, 2006 a wandering on unit home. " February 8, 2006 a attempts made to entrance at the hal February 10, 2006 always attempting room door " February 11, 2006 wander in hallway ambulance door February 12, 2006 looking for a door s February 12, 2006 leave unit via ambu February 16, 2006 wandering a hallwat through ambulance February 18, 2006	at 4:15 PM, "Resident ent from [facility] X3 aff at 9:30 PM, "Contine tempted to leave via an at 10:30 PM, "Wand ted X3 to leave unit, stive" at 6:50 AM, "Resident shift and tried the exit of at 1:25 PM, "Resident riented. Wandered on or X3." at 6:50 AM, "started trying the exit doors to at 7:00 AM, "Severa go through the ambular I door" at 7:00 AM, "Contin Attempt to go out the " at 3:00 PM, "Always so he/she can go upsta at 10:00 PM, "Atter ulance entrance" at 7:00 AM, "OOB ay. Attempted twice to e door" at 6:45 AM, "wande	t ter lunch ues to nbulance ders door " remains unit go l nce is rgency nue to rough s sirs " mpt to go	. 052					
	through ambulance February 18, 2006 the ambulance doo February 19, 2006 leave the unit thru March 1, 2006 at 6 most of the night	a door " at 6:45 AM, "wande or " at 6 " 55 AM, "Atter doors and elevators :00 AM, "OOB amb	ared to npted to " ulating						

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU 095026		(X2) MULT A. BUILDIN B. WING _		(X3) DATE SI COMPLE 06/12		
NAME OF P	ROVIDER OR SUPPLIER		STREET AD	DDRESS, CITY, STATE, ZIP CODE				
KNOLLW	IOOD HSC			GON AVE I STON, DC 2				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEEDED BI LSC IDENTIFYING INFORM	/ FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTION REFERENCED TO THE APPR	N SHOULD BE CROSS-	(X5) COMPLETE DATE	
L 052	Continued From page 10 unable to locate where he/she is " The care plan dated February 2, 2006 included the following: "Problem - Resident experiences wandering. Approach - Equip resident with a device that alarms when he/she wanders (Wanderguard). Check for proper functioning of device on a regular basis. 1st quarter review - 4/ 27/06 - The resident likes to walk about, sometimes aimlessly Sometimes in search of his/her longtime friend who has remained in Assisted Living. [Resident] does not realize where he/she is actually going because of severe Dementia and wears a wanderguard anklet because he/she may elope 6/5/06 - Resident attempted to exit through ambulance entrance. Had cut off or taken off wanderguard. Has since			L 052				
	June 2006 include Elopement "The that the wandergua 2006 for the evenin However, the TAR for the night shift [ministration Record (d "Wanderguard To TAR was initialed [in ard was checked] for ng shift [3PM-11PM]. lacked initials for Jur 11PM-7AM], the time ecord was reviewed J	Prevent dicating June 4, ne 5, 2006 of the					
	after the elopement that the wandergue	new wanderguard a nt. Facility staff failed ard device elicited an or door leading to the ce.	to ensure audible					
	during medication Prevacid 30 mg ca proceeded to chew	06, at approximately 9 pass, a nurse admini- psule to S1. The res v the capsule. The nu xes to chew his/her m	stered ident rse stated					

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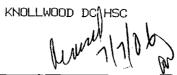
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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE		A. BUILDI	IPLE CONSTRUCTION NG	(X3) DATE SU COMPLE	TED
	IAME OF PROVIDER OR SUPPLIER					06/13	3/2006
NAME OF P					STATE, ZIP CODE		
KNOLLW				GON AVE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEEDED B' LSC IDENTIFYING INFORM	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION S REFERENCED TO THE APPROP	HOULD BE CROSS-	(X5) COMPLET DATE
L 052	Continued From pa	age 11		L 052		 	
	manufacturer's sp	ved release medicatic pecifications stipulate not be crushed or ch	that this				
L 099	from spoilage, safe served in accordar forth in Title 23, Su Regulations (DCM This Statute is not Based on observat it was determined f adequate to ensure served under sanit : soiled sheet pans over the mixing bo spillage on the plat water and chemica silverware, chinawa non-dietary staff we covering, elevated dining room and co degrees Fahrenhei observed in the pre- director. The findings includ 1. The inner and on were soiled with lef washing in the pot	all be clean, wholeson e for human consump- nce with the requirem ubtitle B, D. C. Munici R), Chapter 24 throug timet as evidenced by tions during the surve that dietary services we that foods were pre- cary conditions as evid and grate surfaces, wi on a mechanical n te warmer on the tray al stains on chinaward are soiled with leftove orking in kitchen with ambient air temperational food foods served it (F). These findings esence of the food se	t pans t pans	L 099	 A. The inner and outer sheet pans were rewashed in wash area on 6/13/06. Sheet not be adequately cleaned we B. The grate surfaces of g cook's preparation area w 6/13/06 C. The leak from a fitting over the mixing bowl area mixer in the cook's prepared on 6/15/06. Note: the observation was made 6 the survey team was here 6/1 so the observation was made 6 dates. D. The inner and outer sur warmer on the tray line v 6/12/06. E. The dishwasher was resurvey and the final rins replaced. The plates, glass and silverware were rewash dishwasher. F. The top and bottic chinaware plates were rewash (1) G. The non-dietary indivithe main kitchen repairing 	the pot and pan et pans that could are discarded. rills located in the are cleaned on g directly located on a mechanical ration area was CMS 2567 stated 5/24/06, however, 12/06 and 6/13/06 e on one of these faces of the plate were cleaned on apaired during the e solenoid was ses, bowls, cups vashed in the com surfaces of hed on 6/12/06.	06/30/0

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AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MULT A. BUILDII 8, WING _	IPLE CONSTRUCTION NG	(X3) DATE S COMPLE	TED
		095026	STREET AD		STATE, ZIP CODE	06/1	3/2006
NAME OF P	ROVIDER OR SUPPLIER			GON AVE			
KNOLLV	OOD HSC			TON, DC			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHOUL REFERENCED TO THE APPROPRIAT	D BE CROSS-	(X5) COMPLETE : DATE
L 099	 observations at 8:1 3. Oil was observed located over the mi mechanical mixer in in one (1) of one (1 June 24, 2006. 4. The inner and ou on the tray line were 	ildup in two (2) of two 5 AM on June 13, 20 d leaking from a fitting xing bowl area on a n the cook's preparat) observation at 9:24 tter surfaces of a plate e soiled with accumu	06. g directly ion area AM on te warmer lated	L 099	 (2) A, B, D, E and F. Food Sembleen re-educated on the protechniques and proper use of chemicals. Management will monitor and spot check dishes on as they come out of the dishwar and pan area. (2) C. The Food Service Manage a review of all equipment to as proper working order. If any found to be in need of repair, thi will be relayed to the Chief immediate repair. 	ber washing dishwashing continue to a daily basis sher and pot r will conduct ssure it is in equipment is s information	
	 approximately 9:50 5. Hard water and opresent on chinawa bowls, cups and silv dishwasher in five (between 1:45 PM at 6. The top and bottop lates were soiled with particles in 17 of 33 June 12, 2006. 7. Non-dietary staff main kitchen without (3) of three (3) obset 	(1) of one (1) observ AM on June 12, 200 chemical stains were re such as plates, glaverware after washing 5) of five (5) observa nd 2:30 PM on June om surfaces of china with leftover food and observations at 12:5 were observed working revations between 1:0 ne 12, 2006 and in fo	6. visibly asses, g in the tions 12, 2006. ware dark i0 PM on ing in the g in three 00 PM		 (2) G. The Food Service Managall contractors who enter the kitcl must wear proper hair covering. (3) A. B. C. D. F. G. F. Management will monitor the abobasis. The Director of Dining S Administrator will monitor this crounds. (3) E. Engineering will monitor the solution of the water softener spotting. (4) The results of management's be incorporated into the Qualit Program. 	tor the salt to reduce findings will	
L 108	four (4) observation PM on June 13, 200 3220.2 Nursing Fac The temperature for forty-five degrees (4 foods shall be above	s between 11:00 AM 06. ilities r cold foods shall not 15°F) Fahrenheit, and e one hundred and fo hrenheit at the point of	and 2:00 exceed I for hot orty	L 108	 (1) A. The ambient air temperative alth care kitchen has been at range of 71-81 degrees Fahrenhei (1) B. The temperatures of cold from the health care kitchen to readining room were affected by the temperature. The air temperature adjusted and decreased to help temperature of cold foods. 	djusted to a t (F). sidents in the ambient air re has been	6/30/06

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MULI A. BUILDII B. WING	IPLE CONSTRUCTION	(X3) DATE S COMPLE	TED
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NAME OF F	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
KNOLLV	NOOD HSC			GON AVE			
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L 108	This Statute is not Based on observati the kitchen, it was o were served above	met as evidenced by ions during the inspe determined that cold 45 degrees Fahrenh	ction of foods	L 108	(2) A. and B. The ambient a the health care kitchen will engineering staff on a daily proper temperature. In additi temperatures will be taken di by food service staff and rec temperature.	be recorded by basis to assure on, the cold food uring every meal	
	health care kitchen room were above 4 degrees F, tuna sa cheese 52 degrees	of cold foods served to to residents in the di 5 degrees F: chicker ad 60 degrees F, col F and pudding 50 de) observations at 12:	ning n salad 60 itage egrees F		 (3) A. Food Service Manager the above on a daily basis. Dining Services and Administr this quarterly during grand rou (3) B. Engineering will n solution of the water soft spotting. 	The Director of rator will monitor nds. nonitor the salt	
L 157	3227.8 Nursing Fac	cilities		L 157	(4) The results of manageme be incorporated into the Qu Program.	ent's findings will Dality Assurance	
	medication shall op between thirty-six d 46°F) Fahrenheit; e equipped with a the	at is used for storage erate at a temperatu legrees (36°F) and for each refrigerator shall ermometer that is eas and in proper workin	re hty-six (l be sily		 (1) The thermostat on containing drugs and biolog increased to reflect temperatubetween thirty-six (36) and degrees Fahrenheit (F). (2) A new refrigerator has the store all drugs and biological temperature controls. 	picals has been pres in the range of forty-six (46) been ordered to	
	Based on observati interview, it was det to store all drugs ar temperature contro The findings include		d staff ility failed proper		(3) The "Medication Refrigera Log" will be monitored on a nursing staff, a weekly basi Manager, and a monthly Consultant Pharmacist to temperature controls are in p has been inserviced on	a daily basis by s by the Office basis by the assure proper lace. The staff the appropriate the medication	
	Have refrigeration f storage of drugs re- temperature control keep it maintained l	acilities exclusively for quiring cold storage v lling the interior temp between thirty-six (36	or the vith a erature to		(4) The results of the "Medica Temperature Log" will be inco Quality Assurance Program.		
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6200 OREG		IDENTIFICATION NUM		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SU COMPLE	
		STREET AD	TREET ADDRESS, CITY, STATE, ZIP CODE				
		DRESS, CITY, STATE, ZIP CODE EGON AVE NW GTON, DC 20015					
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L 157			L 157				
	Fahrenheit (F) on A were recorded as 3 and 31, 2006; Febr 25, 2006; April 12 a were recorded as 3	e recorded as 30 deg April 1, 2006. Temper 32 degrees F on Janu uary 3, 7 and 10, 200 and 22, 2006. Tempe 34 degrees F on Febr 6; March 1, 3, 8 and 2 2006.	atures ary 30 06; March eratures uary 2, 4,				
	13, 2006 at 10:30 A . He/she stated the	view was conducted AM with the Director c at he/she was not awa igerator temperatures	of Nursing are that				
L 214	3234.1 Nursing Fac	cilities		L 214			
	located, equipped, functional, healthfu	e designed, construc and maintained to pro I, safe, comfortable, a nent for each residen visiting public.	ovide a and				

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	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		A. BUILDI	TIPLE CONSTRUCTION NG	(X3) DATE S COMPLE	TED	
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L 214	Continued From page 15 This Statute 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:			L 214 (1) The five (5) ingress/egress doors on nursing unit have had a system added to staff when residents exit the unit. The resident with Dementia that end through the ambulance entrance and five the driveway was brought back throug ambulance entrance by nursing staff and minor scratches due to the fail immediately treated. (2) The five (5) ingress/egress doors on nursing unit now have a system to notify when any variable for the unit form t				
	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 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.			 when any resident may exit from the unit. (3) The five (5) ingress/egress doors we tested on a daily basis by the Security C or Engineer to assure the alarms are open properly. A daily log will be maintained a nurse's station and will be monitored b Administrator. (4) Results of these findings will incorporated into the Quality Assur Program. 				
	ambulance entrance Facility staff was un exited through the c ambulance entrance	at with Dementia eloped through the ce entrance and fell on the driveway. aff was unaware that the resident had ough the corridor door which led to the ce entrance.			 (1) The ambient air temper care kitchen as been adjus to an appropriate temperatu (2) The ambient air temper care kitchen will be record staff on a daily basis temperature. 	red and decreased re. ature in the health	6/30/06	
	3238.1 Nursing Facilities Each piece of heating and air conditioning equipment and its installation shall comply with the 1996 BOCA International Mechanical Code (Heating, Air Conditioning and Refrigeration), and all applicable District laws and regulations. This Statute is not met as evidenced by: tion Administration			L 245	 3) Food Service Manageme above on a daily basis. The Services and Administrator during grand rounds. (4) The results of managem be incorporated into the G Program. 	will monitor this		

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L 245	Continued From pa	-		L 245			
	the kitchen, it was o	ons during the insped letermined that air nealth care kitchen w					1
	The findings include):					
	kitchen were elevat	atures in the health c ed and reached 90 d ne (1) of one (1) obse 12, 2006.	egrees				
L 410	3256.1 Nursing Fac	cilities		L 410	(1) A. The frontal surfaces of nightstands, and chair legs w residents' rooms 8, 14A, 12, 1	ill be repaired in	07/20/06
	maintenance servic exterior and the inte sanitary, orderly, co manner. This Statute is not Based on observati it was determined th maintenance servic ensure that the faci and sanitary manner and marred furnishi foot boards with hol	rovide housekeeping es necessary to main arior of the facility in a imfortable and attract met as evidenced by ons during the survey hat housekeeping and es were not adequate lity was maintained in a s evidenced by sc ngs in residents' roor es and splintered edge observed in the pre- lousekeeping and	ntain the a safe, tive y period, d e to a safe arred ms and ges.		 (1) B. Foot boards on res Rooms 19, 23, 26, 27 and 28 with splinters around the ed repaired. (2) The Environmental Servic the HSC will conduct an audi rooms to determine if any tr night stands, chair legs and for need of repair. If any are for will be contacted to make the result (3) The above will be monitored basis by the Administrator and Environmental Services during 	sidents' beds in with drilled holes dges have been es Supervisor for t of all residents' elevision stands, bot boards are in und, a contractor needed repairs. ed on a quarterly d the Director of	
	Maintenance Direct	ors.			(4) The result of these inspirincorporated in the Qua Program.	ections will be	
	stands and chair leg residents' rooms 8, of 13 observations t PM on June 12, 200	es of television stand s were marred and s 14a, 12, 19 and 27 in setween 11:20 AM ar 6. This is a repeat de certification survey co	carred in five (5) id 12:20 eficiency				
	tion Administration						<u> </u>

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AND PLAN OF CORRECTION IDE		(X1) PROVIDER/SUPPLIER	ICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		JRVEY TED
095026					STATE, ZIP CODE	06/1	3/2006
iame of f	ROVIDER OR SUPPLIER			GON AVE			
KNOLLV	OOD HSC			TON, DC			
(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) COMPLE DATE
L 410	Continued From p	age 17		L 410			
	to have drilled hole the edges in room 5) of 13 observation	ons between 11:20 AM	s around I in five (
L 442	 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. 3258.13 Nursing Facilities The facility shall maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This Statute is not met as evidenced by: Based on observations during the survey, it was determined that the facility failed to ensure that the wanderguard system on the corridor exit door which leads to the ambulance entrance was operational. This was observed in the presence of the Director of Nursing. The findings include: On June 12, 2006 at 5:05 PM it was observed that the wanderguard system located on the corridor exit door which leads to the ambulance entrance failed to elicit an alarm when a wanderguard device passed by it. The ambulance entrance door automatically opens to the facility driveway. Facility staff passed two (2) wanderguard devices across the alarm box located at the base of the corridor exit door. Neither device caused the system to elicit an audible alarm. The Director of Nursing accompanied a resident wearing a wanderguard device through the corridor exit door. The system failed to elicit an audible alarm. 		, it was re that exit door vas esence arved the ulance facility devices of the the rector of a exit	L 442	 (1) It has been witnessed I wanderguard system appropriately on 6/10/06 an This system has a battery bac of power failures. Therefore the alarm failed between the and 6/12/06. When this was staff member was immediate corridor exit door, which ambulance entrance. Additional system was installed on the monitored the door and kept a when both the wanderguard alarm were operational. (2) Nursing staff will monito that the bracelets worn by the wanderguard system are in p and there will be a document ankle transmitter each day. Officer or Engineer will monito that the door exits are alawanderguard device/tester is p daily basis. (3) Nursing, Security and Encomply with the requirements and the Chief Engineer and A regularly monitor the document. (4) Documentation will be inc. Quality Assurance Program. 	was working ind had alarmed. k-up in the event is appears that dates of 6/10/06 as discovered, a aly placed at the leads to the bonally, a back-up his door. Staff log until 6/13/06 and the back-up r and document residents on the blace every shift ted test of each The Security or and document arming when a bassed by it on a his schedule administrator will tation,	06/13/0

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