STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER			(X2) MUL		(X3) DATE SURVEY COMPLETED			
		095026				05/2	5/2007	
	ROVIDER OR SUPPLIER		STREET ADD 6200 ORE WASHING	GON AVE				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PHOVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENCY	TON SHOULD BE COMPLET THE APPROPRIATE DATE		
	D Initial Comments An annual licensure 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.			L 000	DEFICIENCY)			
interviews with facility staff The sample included 13 residents based on a census of 44 the first		L 052	<ul> <li>(1) B. The second drop ophthalmic solution was insufficient ophthalmic solution was insufficient ophthalmic solution nurse #1 carefully read the physician's the number of drops of ophthalmic solution.</li> <li>(1) C. Acular eye drop 0.5% and Docusate Sodium Liquid administered after staff becard omission. Medication immediately relieved of the medication administration a another licensed nurse.</li> <li>(2) Medication nurse #2 is not at this facility. Additionally Nurses/designee will monitor with various medication nurbasis for the next thirty dathereafter.</li> <li>(3) The RN Account Manager Pharmacy will monitor the medication. This review of quarterly basis.</li> <li>(4) The results of the medication into the Quarter.</li> </ul>	atilied in Resident after staff became was counseled to a orders regarding Artificial Tears and ang/5 ml were ame aware of the nurse #2 was responsibility of and replaced by b longer employed t, the Director off medication pass ses on a weekly hys, and monthly with Woodhaven edication pass on nedication pass and will continue on a				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 095026		(X2) MULTI A BUILDIN B WING		COMPL	(X3) DATE SURVEY COMPLETED 05/25/2007		
	ROVIDER OR SUPPLIER	· · ·	6200 OR				
(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 OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	(X5) Complete Date	
	recreational activiti (g)Prompt, unhurrie requires or request (h)Prescribed adap him or her in eating independently; (i)Assistance, if new including oral acre; j)Prompt response for help This Statute is not Based on observati interview for three ( observed during me determined that lice that residents were The medication error JH3, JH5 and JH6 The findings includ Five (5) errors occu medication pass. T observed on Thurso approximately 9:00 May 25, 2007 at app Fifty-seven opportu- the medication pass nurses were observ pass. After the med medications were re	eaningful social and es, with eating; ed assistance if he of thelp with eating, otive self-help device eded, with daily hygi and to an activated call met as evidenced to ion, record review a (3) of eleven resider edication pass, it was ensed staff failed to free from medication or rate was 10 5% le: urred during the mo he medication pass day, May 24, 2007 a AM and 4 00 PM o proximately 8:30 AM nities were observe s. Three (3) medication ication pass, the ob	or she es to assist iene, bell or call by nd staff nts ensure on errors. Residents in Friday A. d during ation cation eserved	L 052			
	orders. 1   On May 24, 2007	7 ot opprovimetaly (					

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## P.13

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	AENT OF DEFICIENCIES AN OF CORRECTION (X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER 095026		(X2) MULTIPLE CONSTRUCTION A BUILDING B WING		COMPL	(X3) DATE SURVEY COMPLETED 05/25/2007	
NAME OF P	ROVIDER OR SUPPLIER	•	STREET ADD	DRESS CITY, S	TATE, ZIP CODE		
KNOLLV	VOOD HSC			GON AVE NUTON, DC 20			
(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 C (EACH CORRECTIVE A) CROSS REFERENCED TO DEFICIEN	CTION SHOULD BE	(X5) COMPLET DATE
L 052	medication nurse # medications to Res tablet for resident J medication pass. T May 14, 2007 read every day for suppl tablet was docume the MAR (Medications) was not observed to during the medications)	administered eight ident JH3. The multi H3 was omitted durir he physician 's order "Multivitamin one ( ement "The multivi nted as being administration Reco being given to the resi	ivitamin ng the r dated 1) tablet itamin stered on cord), but ident	L 052			
	medication nurse # Artificial Tears opht JH5 's eyes (right a order dated May 9, 1.4% drops Instill 2 day for dry eyes. " The record was rev 3. On May 25, 200 medication nurse # medications to Res #2 did not sign the 1 (5) medications wer	7, at approximately 1 1 instilled one (1) dro halmic solution into F and left). The physici 2007 read, "Artificia drops to each eye 3 iewed on May 24, 20 7, at approximately 8. 2 administered five (5 dent JH6. Medicatio MAR, indicating that t e administered to the	p of Resident an ' s il Tears times a 07 .30 AM, 5) n nurse the five	•			
	medications. Acular 325mg and Docusa The physician 's ord "Acular Eye drops, 4 times a day for pro one (1) tablet every Docusate Sodium Li (100mg) po every day A face-to-face interv	se omitted the followi eye drop 0 5%, Aspi te Sodium Liquid 50n ders dated May 2, 20 Instill on (1) drop to ri assure in eye, Aspirin day for clot preventio iquid 50mg/5ml Ten ( ay for constipation " new was conducted w	rin ng/ 5ml 07 read, ight eye a 325mg a 325mg an; and (10) mls		·		

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## P,14

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUME 095026		ER A BUILD		TE SURVEY MPLETED <b>5/25/2007</b>		
NAME OF PROVIDER OR SUPPL		TREET ADDRESS, CITY				
6200 ORE			EGON AVE NW GTON, DC 20015			
PREFIX (EACH DEFICI	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FUI OR LSC IDENTIFYING INFORMATIC		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	SHOULD BE COMPLE		
errors were due nervous	0.15 AM He/She stated that to the surveyors making hi	im/her				
Food and drink from spoilage, s served in accord forth in Title 23, Regulations (D0 This Statute is Based on obser- main kitchen, it services failed t and prepared in evidenced by so surfaces, gas lin were observed is Dietary Services The findings inc 1. Nine (9) of 17 leftover food and washed and rea 2. Eight (8) of 22 leftover food and washed and rea 3. The floor behi the rear of the st was soiled with o	<ul> <li>approximately 9.15 AM He/She stated that the errors were due to the surveyors making him/her nervous.</li> <li>The record was reviewed on May 25, 2007.</li> <li>3219 1 Nursing Facilities</li> <li>Food and drink shall be clean, wholesome, free from spoilage, safe for human consumption, and served in accordance with the requirements set forth in Title 23, Subtitle B, D. C. Municipal Regulations (DCMR), Chapter 24 through 40. This Statute 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</li> <li>The findings include.</li> <li>1. Nine (9) of 17 hotel pans were soiled with leftover food and a greasy residue after being washed and ready for reuse.</li> <li>2. Eight (8) of 22 sheet pans were soiled with leftover food and a greasy residue after being washed and ready for reuse.</li> <li>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</li> </ul>		<ul> <li>(1) A. The nine hotel pans were rewashed a all leftover food and greasy residue weremoved.</li> <li>(1) B. The eight sheet pans were rewash and all leftover food and greasy residue weremoved.</li> <li>(1) C. The floor behind the grill and deep fry and the rear of the steamer and convection ovens were cleaned of any dirt, debris greasy residue.</li> <li>(1) D. The gas lines to the grill were cleaned remove any debris or greasy residue.</li> <li>(1) E. The two shelves that stored hotel a sheet pans were cleaned to remove rust a debris.</li> <li>(2) Management will continue to monitor a spot-check the hotel pans, sheet pans, floor gas lines and shelves on a daily basis. For service staff has been inserviced on 6/12/and 6/13/07 regarding the cleaning schedu and proper procedure for cleaning the hopans, sheet pans, floors, gas lines a shelves.</li> <li>(3) Food Service Management will monitor this on daily basis and the Registered Dietitian er Adminiatrator will monitor this during quarter grand rounds.</li> <li>(4) The results of management's findings w be incorporated into the Quality Assurance Program.</li> </ul>	ras ed sre rer on or to nd nd rs, od 07 ile tel nd set site ile tel nd		

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	NT OF DEFICIENCIES NOF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 095026		(X2) MULTIPLE CONSTRUCTION A BUILDING B WING			(X3) DATE SURVEY COMPLETED - 05/25/2007		
				DDRESS, CITY, STATE, ZIP CODE				
	OOD HSC			EGON AVE NV STON, DC 200				
(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) COMPLET( DATE	
L 099	Continued From pa	age 4		L 099	· ·			
	5 Two (2) of two (2 sheet pans were ru	<ol> <li>shelves that store sty and soiled with</li> </ol>	ed hotel and debris			· .		
	The Director of Die the above cited soil of the observations	led items and areas	owledged at the time					
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