PRINTED: 10/14/2016 FORM APPROVED OMB NO. 0938-0391

F 000  INITIAL COMMENTS  An unannounced Quality Indicator Survey was conducted at Sibley Memorial Hospital Renaissance from September 12, 2016 through September 14, 2016. Survey activities consisted of a review of 20 sampled residents during Stage 1, and review of 20 sampled residents during Stage 1. The following deficiencies are based on observation, record review and staff interviews. After analysis of the findings, it was determined that the facility is not in compilance with the requirements of 42 CFR Part 483, Subpart B, and Requirements of 42 CFR Part 483, Subpart B, and Requirements of 42 CFR Part 483, Subpart B, and Requirements of 42 CFR Part 486. The following is a directory of abbreviations and/or acronyms that may be utilized in the report:  Abbreviations  AMS - Altered Mental Status  ARD - assessment reference date BID - Twice-a-day B/P - Blood Pressure cm - Centimeters  CMS - Centers for Medicare and Medicaid Services  CNA- Certified Nurse Aide CRF - Community Residential Facility D.C District of Columbia Municipal Regulations  D/C Discontinue D.L - deciliter  DMH - Department of Mental Health  Triand Commental Hospital		AND PLAN OF CORRECTION IDENTIFICATION NUMBER			MULTIPLE CONSTRUCTION UILDING			SURVEY MPLETED
SIBLEY MEM HOSP RENAISSANCE    CAGID   PREFIX   CACH DEPICIENCY MUST REPRECEDED BY PLLI REQULATORY OR TAGE   TAGE			095030	B. WING	B. WING			14/2016
FROM INITIAL COMMENTS  An unannounced Quality Indicator Survey was conducted at Sibley Memorial Hospital Renalissance is filing the completion of correction for purposes of regulator compliance, in response to the Quality Indicator and Ilcensure survey conducted on September 12, 2016 through September 14, 2016. Survey activities consisted of a review of 20 sampled residents during Stage 2. The following deficiencies are based on observation, record review and staff interviews. After analysis of the findings, it was determined that the facility is not in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities.  The following is a directory of abbreviations and/or acronyms that may be utilized in the report:  Abbreviations  AMS - Altered Mental Status  APD - assessment reference date BID - Twice-a-day  BFP - Blood Pressure cm - Centimeters  CMS - Centers for Medicare and Medicaid Services  CNA- Certified Nurse Aide  CRF - Community Residential Facility D.C District of Columbia DOMR- Regulations  D/C Discontinue DI - deciliter  DMH - Department of Mental Health  F 000  INITIAL COMMENTS  F 000  Sibley Memorial Hospital Renalissance is filing the Correction of reputposes of regulator compliance, in response to the Quality Indicator and Ilcensure survey conducted on September 12, 2016 through September 14, 2016. The facility is submitting this plan of correction to comply the applicable aw and not as an admission or statemen of agreement with respect to the alleged deficiencies therein.  The following plan of correction to composition of an animal properties of the findings, it was determined that the facility is not in compliance with the requirements of 2.0 FR Part 4.83, Subpart B, and Requirements for Long Term Care Facilities.  The following plan of correction of Denterial of being affected by the same deficient provincement Care (EOC) Committee semi-annually will include attention to solide Abaust vents. Vork orders should be submitted to Plant O&M for an			NCE		52	255 LOUGHBORO ROAD NW		
An unannounced Quality Indicator Survey was conducted at Sibley Memorial Hospital Renaissance from September 12, 2016 through September 14, 2016. Survey activities consisted of a review of 30 residents' clinical records during Stage 1; and review of 20 sampled residents during Stage 2. The following deficiencies are based on observation, record review and staff interviews. After analysis of the findings, it was determined that the facility is not in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities.  The following is a directory of abbreviations and/or acronyms that may be utilized in the report:  Abbreviations  AMS - Altered Mental Status  ARD - assessment reference date BID - Twice- a-day B/P - Blood Pressure cm - Centimeters CMS - Centers for Medicare and Medicald Services  CNA - Certified Nurse Aide  CRF - Community Residential Facility D.C District of Columbia DCMR- District of Columbia Municipal Regulations  DIC Discontinue DI - deciliter  DMH - Department of Mental Health	PREFIX	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR				(EACH CORRECTIVE ACTION SHOUL	D BE	(X5) COMPLETION DATE
completion and satisfaction rates on an annual basis by the EOC committee.  5. Date Corrective Action Completed: by 10/27/18	F 000	An unannounced Conducted at Sibley from September 12, 2016. Survey activ residents' clinical rec of 20 sampled reside following deficiencie record review and st the findings, it was c in compliance with the 483, Subpart B, and Care Facilities.  The following is a diacronyms that may be assessed as a see so that the findings is a diacronyms that may be assessed as a see so the following is a diacronyms that may be assessed as a see so that the findings is a diacronyms that may be assessed as a see so that the following is a diacronyms that may be assessed as a see so that the following is a diacronyms that may be assessed as a see so that the following is a diacronyms that may be assessed as a see so that the following is a diacronyms that may be assessed as a see so that the following is a diacronyms that may be assessed as a see so that the following is a diacronyms that may be assessed as a see so that the following is a diacronyms that may be assessed as a see so that the following is a diacronyms that may be assessed as a see so that the following is a diacronyms that may be assessed as a see so that the following is a diacronyms that may be assessed as a see see see see see see see see se	Memorial Hospital Renaissance 2016 through September 14, ities consisted of a review of 30 cords during Stage 1; and review ents during Stage 2. The sare based on observation, taff interviews. After analysis of determined that the facility is not he requirements of 42 CFR Part Requirements for Long Term  Trectory of abbreviations and/or be utilized in the report:  Mental Status ment reference date a-day Pressure neters is for Medicare and Medicaid and Nurse Aide munity Residential Facility of Columbia of Columbia Municipal	F	0000	following plan of correction for put compliance, in response to the Clicensure survey conducted on Sthrough September 14, 2016. The submitting this plan of correction applicable law and not as an admof agreement with respect to the herein.  The following comments are in #1: Exhaust Vents  1. Corrective Action for Identific known direct impact to patie exhaust vents.  2. Identification of Other Patien Potential to be affected: Oth potential of being affected by practice will be addressed by correction: Environmental Rounds performental Round	irposes of cuality Indiceptember of the facility in to comply hission or salleged de a response of Patients from so the facility in the same of the following with the following the Envirolment of Plant Os in the Quality chaust ventate of Plant Os in the Grand satisfation of the Envirolment of Plant Os in the Grand satisfation of the Envirolment of Plant Os in the Grand satisfation of the Envirolment of Plant Os in the Grand satisfation of the Envirolment of the Env	regulatory cator and 12, 2016 is with statement efficiencies e to F 253 is: No biled in the with the edeficient ing plan of attention ence: the Director Plant conment of will its. Work a M for any ity the Process gated and enterly elemented work eaction ed into the quarterly in annual

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Idministrator 10/24/16

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.

PRINTED: 10/14/2016 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		095030	B. WING		09/14/2016	
	RÖVIDER OR SUPPLIER  JEM HOSP RENAISSA	NGE		STREET ADDRESS, CITY, STATE, ZIP CODE 5255 LOUGHBORO ROAD NW WASHINGTON, DC 20016		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST B	ATEMENT OF DEFICIENCIES SE PRECEDED BY FULL REGULATORY OR TIFYING INFORMATION)	ID PREFI) TAG		BE COMPLÉTION	
F 253	EKG - 12 lead EMS - Emerg G-tube Gastro HSC Healti HVAC - Heating ID - Intelle IDT - interdis L - Liter Lbs - Pound MAR - Medicat MD - Medicat MD - Milligra mL - milligra mL - milligra mMHg - milligra mm/Hg - milligra milligra milligra mm/Hg - milligra	d Electrocardiogram lency Medical Services (911) lestomy tube h Service Center ventilation/Air conditioning lectual disability leciplinary team  ds (unit of mass) leion Administration Record leal Doctor le Data Set lems (metric system unit of mass) lers (metric system measure of leams per deciliter lers of mercury light legical legi	F 0	<ol> <li>Corrective Action for Identified direct impact to patients from curtains/curtains.</li> <li>Identification of Other Patients Potential to be Affected: No dipatients from curtains loose.</li> <li>Systemic Changes to Prevent Environmental Services mana Environmental rounds perforn Environment of Care Committed the replacement of all curtains rooms and showers.</li> <li>Monitoring and Incorporation Assurance / Performance Impations are implemented as Environmental services monitored for deficient trends measures are implemented as Environmental services monitored for curtains on an ones.</li> <li>Date Corrective Action Complemental Stained Privacy Curtains</li> <li>Corrective Action for Identified direct impact to patients from curtains</li> <li>Identification of Other Patients Potential to be Affected: No dipatients from curtains stained markings.</li> <li>Systemic Changes to Prevent Environmental Services mana Environmental Services mana Environmental Founds perforn Environmen</li></ol>	I Patients: No loose shower  I Having the rect impact to other  Recurrence: gement team and led by the lee with attention to swhen needed for into Quality rovement Process re aggregated and lead to and correction is necessary. I patients: No letter impact to other leet impact to other with black  Recurrence: gement team and led by the lee with attention to	
SS=D	SERVICES	vide housekeeping and		rooms and showers.	When heeded for	
	momy mast pro					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		095030	B. WING			09/14/2016
	ROVIDER OR SUPPLIER	NCE		52	REET ADDRESS, CITY, STATE, ZIP CODE 155 LOUGHBORO ROAD NW (ASHINGTON, DC 20016	VVI THEO IV
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST B	ATEMENT OF DEFICIENCIES SE PRECEDED BY FULL REGULATORY OR TIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIATE DE	
F 253	maintenance services sanitary, orderly, and sanitary, orderly, and This REQUIREMEN  Based on observati 2016 at approximate that the facility failed services necessary tenvironment as evided 10 of 15 residents' refive (5) of 16 residents' refive (5) of 17 residents' refive (5) of 18 residents' refive (5) of 18 residents' refive (5) of 18 residents' refive (5) of 19	es necessary to maintain a d comfortable interior.  T is not met as evidenced by:  ions made on September 13, ely 2:00 PM, it was determined it to provide housekeeping to maintain a sanitary enced by soiled exhaust vents in coms, loose privacy curtains in ints' rooms, stained privacy of 15 residents' rooms and low in two (2) of 15 residents' rooms.  :  vere soiled in 10 of 15 residents' rooms #301, 302, 303, 305, 318 and #320.  were hanging loose and off the 5 residents' rooms. (#301B, 310A, 311).  were stained with black of 15 residents' rooms including, and 310B.  ures were measured at less than eit in two (2) of 15 residents'	F	253	<ol> <li>The following comments are in residuals: Stained Privacy Curtains (confidentials).</li> <li>Monitoring and Incorporation into Assurance / Performance Improve Plan: Environmental rounds are monitored for deficient trends an measures are implemented as nenvironmental services monitors replacing of curtains on an ongo 5. Date Corrective Action Complete The following comments are in residuals.</li> <li>Corrective Action for Identified Path Known direct impact to patients of temperatures less than 95 degree Plant Operations and Maintenan manually adjusted the water tembrought the temperatures to mear requirements for hot water on 9/ the survey.</li> <li>Identification of Other Patients Health Potential to be Affected: Although mixing valve appears to be work Po&amp;M will continue to monitor a adjust the temperature as needed compliance with the required tends.</li> <li>Systemic Changes to Prevent Repriremental Rounds performed of Plant Operations and Mainten O&amp;M) on a monthly basis and the Care (EOC) Committee semi-an attention to hot water temperature work orders should be submitted any repairs needed.</li> </ol>	co Quality verment Process aggregated and ad correction ecessary. s and inspects for ing basis. ed: 10/24/2016  sponse to F 253  ratients: No from hot water es at faucets. ace (PO&M) aperatures and et the 13/2016 during  laving the h the hot water ing at this time, and manually ed to stay in aperature. ecurrence: d by the Director ance (Plant e Environment of anually will include ares at faucets.
F 279	483.20(d), 483.20(k)	(1) DEVELOP	F 2	279		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095030	B. WING		09/14/2016
NAME OF PROVIDER OR SUPPLIER SIBLEY MEM HOSP RENAISSA	NCE		STREET ADDRESS, CITY, STATE, ZIP CODE 5255 LOUGHBORO ROAD NW WASHINGTON, DC 20016	
PREFIX (EACH DEFICIENCY MUST E	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY OR TIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIATE DE	
develop, review and comprehensive plan. The facility must der for each resident the objectives and timet medical, nursing, an needs that are ident assessment.  The care plan must be furnished to attain highest practicable psychosocial well-be and any services the under §483.25 but a resident's exercise of the right to refuse the right to refuse the right to refuse the control of 20 Stage 2 sand determined that facing plan with goals and adverse reactions from medications for Resident's included.  A review of the Physical Comprehensive plan with goals and adverse reactions for Resident's included.	care Plans  The results of the assessment to be revise the resident's and care.  The recipient of care includes measurable ables to meet a resident's and mental and psychosocial ified in the comprehensive in or maintain the resident's object of the services that are to nor maintain the services that are to nor maintain the resident's object of	F 279	The following comments are in re #4: Water Temp (continued)  4. Monitoring and Incorporation in Assurance / Performance Improperation Plan: Environmental rounds are monitored for deficient trends of basis and corrective measures as necessary. Plant O&M mon order system for completion are rates. This plan of correction is quality assurance system throus report of deficient trends and recompletion and review of compastisfaction rates on an annual Committee.  5. Date Corrective Action Completed The following comments are in recommendated as a comment of the resident found to have this deficient practice as the been discharged.  b. Care plans for all residents medications will be initiated the admitting RN  c. The Director of Nursing windividual identified as resideficiency  2. Identification of Other Patients Potential to be Affected: Qualities RN will perform chart audits on within 24 hours  3. Systemic Changes to Prevent a. Nurses will identify patient medications every Monday and report to the charge not be the charge nurse will reviewed and update the respective c. Provide care plan educations every findividual staff within 30 days	ato Quality ovement Process e aggregated and on a quarterly are implemented itors the work ad satisfaction integrated into the ugh the quarterly eview of oletion and basis by the EOC eted: 9/13/16 esponse to F re Plans Patients: ctive actions for been affected by the resident has es with 9 or more d on admission by will counsel the consible for the Having the y and Compliance a new admissions Recurrence: s with 9 or more y and Thursday urse ew the information care plan

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		095030	B. WING_			09/14/2016		
	ROVIDER OR SUPPLIER  MEM HOSP RENAISSA		STREET ADDRESS, CITY, STATE, ZIP CODE  5255 LOUGHBORO ROAD NW  WASHINGTON, DC 20016					
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F 279	Lanoxin, Colace, Flodigestion), Lidoderm Miralax, and Gas-X.  There was no evided with goals and approadverse drug interaction of the use the second of the second o	drin, Dulcolax, Wellbutrin, onase, Lactinex (probiotic-aiding n 5% patch, Mycostatin, Protonix, nce that a care plan was initiated paches to address the potential ctions associated with the use of dications found in Resident's riew was conducted with roximately 2:00 PM on a character and that the record lacked plan for the potential adverse of nine (9) or more ecord was reviewed on	F 2	The following comments ar 279: Develop Comprehensi  4. Monitoring and Incorpora Assurance / Performance Plan: The Quality and Coperform 5 random chart a results will be reported at Renaissance Compliance Committee Meeting.  5. Date Corrective Action Comments ar 323: Free of Accidents / Hamber 1 dentified to deficient practices of star the dish-machine.  2. Identification of Other Pare Potential to be Affected: preventive maintenance conducted by managements.	tion into Improve Improve Improve Improve Impliance audits et the quite and Que Implication Implicatio	e Plans (cont.)  o Quality vement Process ce RN will very week. Audit arterly uality Assurance ed: 10/17/16  sponse to F Supervision / atients: No s from the ater located by aving the onitoring and u of area will be		
F 323 SS=D	HAZARDS/SUPER\ The facility must ensenvironment remain is possible; and each supervision and assaccidents.  This REQUIREMEN  Based on observations	VISION/DEVICES sure that the resident s as free of accident hazards as h resident receives adequate istance devices to prevent  T is not met as evidenced by: ions made on September 13, ely 2:00 PM, it was determined	F3	<ol> <li>Systemic Changes to Prevent Rehave placed a slip resistant mat in the standing water is settling. The Nutrition Services Management To Service Team will meet with all tediscuss this new practice to ensuremployees.</li> <li>Monitoring and Incorporation into Assurance / Performance Improving Plan: The Food and Nutrition Teathis safety risk area daily until a crenovation of the floor is completed /closing manager will log any haz found daily.</li> <li>Date Corrective Action Complete</li> </ol>		ecurrence: We in the area where ie Food and Team and Food eam members to ure safety to all o Quality vement Process am will monitor complete ed. The opening zards that are		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED
		095030	B. WING			09/14/2016
NAME OF PROVIDER OR SUPPLIER  SIBLEY MEM HOSP RENAISSANCE  (X4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFI TAG	52 W	FREET ADDRESS, CITY, STATE, ZIP CODE  255 LOUGHBORO ROAD NW  /ASHINGTON, DC 20016  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRIATE DE	
F 325 SS=D	environment free of evidenced by a wet froom.  The findings include  2. The floor in the machine is located vapproximately an include approximately and approximately	potential accident hazards as loor in the dishwashing machine area where the dishwashing was constantly covered with the of water and presented a laff.  For made in the presence of exhowledged the findings.  NUTRITION STATUS UNLESS as comprehensive assessment, are that a resident—able parameters of nutritional weight and protein levels, clinical condition demonstrates ole; and peutic diet when there is a live and staff interview for one inpled residents, it was lity staff failed to re-weigh		323	The following comments are in re 325: Maintain Nutrition Status uni Unavoidable  1. Corrective Action for Identified Fa. The resident found to have the deficient practice of not re-weigh had no adverse oub. The Quality and Compliance staff education regarding the weight policy  c. The Director of Nursing Sent the staff involved in the deficient protection of Other Patients Factorial to be Affected:  a. Weekly chart audits perform and Compliance RN  b. Weekly review of weight disfollow-up with the staff assigned resident to ensure accuracy documentation  3. Systemic Changes to Prevent Redentify residents with Length of days during weekly Care plan medians during weekly Care plan medians and Incorporation into Assurance / Performance Improoplant: Continue weekly chart audial residents by the Quality and a Audit results will be reported at the Renaissance Compliance and Committee Meeting.  5. Date Corrective Action Complete	Patients: been affected by having a stcome. e RN will provide e Renaissance vices will counsel ciency laving the ed by the Quality crepancies with gned to the of ecurrence: Stay (LOS) of 30 eetings o Quality vement Process lits performed for Compliance RN. he quarterly uality Assurance

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NAME OF PROVIDER OR SUPPLIER  SIBLEY MEM HOSP RENAISSANCE  SIBLEY MEM HOSP RENAISSANCE  STREET ADDRESS, CITY, STATE, ZIP CODE  5255 LOUGHBORO ROAD NW  WASHINGTON, DC 20016  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5 PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETED ACTION SHOULD S		FATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
SIBLEY MEM HOSP RENAISSANCE  (C4) ID SUMMARY STATEMENT OF DEFICIENCIES TAGE  (C4) ID EACH DEFICIENCY MUST BE PRECEDED BY FULL RESULATORY OR LSC IDENTIFYING INFORMATION)  F 325  Continued From page 6  A review of Resident #61's weight history for the period of April 2016 through September 2016 revealed the following:  "April, 2016-171.3 lbs.  May 5, 2016-181.4 lbs.  September 8, 2016-171.98 lbs.  August, 2016-181.2 lbs.  September 8, 2016-170.9 lbs/IT/lbs "  A comparison of the August and September weights revealed that the resident sustained a loss of 10 pounds which was indicative of a 5% weight loss within 30 days. According to the Centers for Medicare & Medicard Services 'MDS' (Minimum Data See), San Seessenent. "  According to the documentation in the clinical record the resident was weighed on September 8, 2016 and the weight was recorded as 171/lbs. This weight when compared with the previous month" is (August) weight of 181 lbs indicated a significant weight loss of 5%/10lbs.  A dictician 's note dated September 8, 2016 in the clinical record revealed unitentinal/significant weight loss of 5%. Suspect measurement error. Reweight		-	095030	B. WING		09/14/2016	09/14/2016	
FREER TAG  FOR CONSTRUCTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  F 325  Continued From page 6  A review of Resident #61's weight history for the period of April 2016 through September 2016 revealed the following:  "April, 2016-179.9 lbs. (pounds) May 5, 2016-171.3 lbs. May 5, 2016-179.8 lbs. July, 2016-179.8 lbs. August, 2016-181.2 lbs. September 8, 2016-170.9 lbs/171 lbs "  A comparison of the August and September weights revealed that the resident sustained a loss of 10 pounds which was indicative of a 5% weight loss within 30 days. According to the Centers for Medicare & Medicaid Services' MDS (Minimum Data Set) 3.0 User 's Manual: October 2013 the Resident Assessment Instrument (RAI) Section K, Page K-4, "Weight loss should be assessed and care planned at the time of detection and not delayed until the next MDS assessment."  According to the documentation in the clinical record the resident was weighed on September 8, 2016 and the weight was recorded as 171lbs. This weight when compared with the previous month's (August) weight of 181lbs indicated a significant weight loss of 5%/10lbs.  A dietician 's note dated September 8, 2016 in the clinical record revealed the following: "Resident experienced unintentional/significant weight loss of 5%. Suspect measurement error. Reweight					5255 LOUGHBORO ROAD NW			
A review of Resident #61's weight history for the period of April 2016 through September 2016 revealed the following:  "April, 2016- 179.9 lbs. (pounds) May 5, 2016- 171.3 lbs. May 5, 2016- 181.4 lbs. (re-weigh) June, 2016- 184.5 lbs. July, 2016- 181.2 lbs. September 8, 2016- 181.2 lbs. September 8, 2016- 170.9 lbs/171 lbs."  A comparison of the August and September weights revealed that the resident sustained a loss of 10 pounds which was indicative of a 5% weight loss within 30 days. According to the Centers for Medicare & Medicaid Services' MDS (Minimum Data Set) 3.0 User 's Manual: October 2013 the Resident Assessment Instrument (RAI) Section K, Page K-4, "Weight loss should be assessed and care planned at the time of detection and not delayed until the next MDS assessment."  According to the documentation in the clinical record the resident was weighed on September 8, 2016 and the weight was recorded as 171 lbs. This weight when compared with the previous month 's (August) weight of 181 lbs indicated a significant weight loss of 5%/10 lbs.  A dietician 's note dated September 8, 2016 in the clinical record revealed the following: "Resident experienced unintentional/significant weight loss of 5%. Suspect measurement error. Reweight	PREFIX	(EACH DEFICIENCY MUST B	E PRECEDED BY FULL REGULATORY OR	PREFIX	(EACH CORRECTIVE ACTION SHOULD E		ОИ	
Further review of the resident 's documented	F 325	A review of Residen period of April 2016 revealed the followir "April, 2016- 179.9 II May 5, 2016- 171.3 May 5, 2016- 183.4 June, 2016- 184.5 Ib July, 2016- 179.8 Ib August, 2016- 181.2 September 8, 2016- A comparison of the revealed that the respounds which was ir within 30 days. Acc Medicare & Medicaic Set) 3.0 User 's Mar Assessment Instrume K-4, "Weight loss of planned at the time of the next MDS assess According to the doc the resident was weight everythe weight was reconvened with weight of 181lbs indiff 5%/10lbs.  A dietician 's note doclinical record reveal experienced unintensis. Suspect meas requested."	t #61's weight history for the through September 2016 ng:  os. (pounds) lbs. d lbs. (re-weigh) os. s. lbs. 170.9lbs/171lbs "  August and September weights sident sustained a loss of 10 ndicative of a 5% weight loss cording to the Centers for d Services' MDS (Minimum Data nual: October 2013 the Resident ent (RAI) Section K, Page should be assessed and care of detection and not delayed until sment. "  cumentation in the clinical record ghed on September 8, 2016 and red as 171lbs. This weight in the previous month's (August) cated a significant weight loss of urement error. Reweight	F 3	25			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION .	(X3) DATE SURVEY COMPLETED
		095030	B. WING		09/14/2016
	NAME OF PROVIDER OR SUPPLIER  SIBLEY MEM HOSP RENAISSANCE			STREET ADDRESS, CITY, STATE, ZIP CODE 1255 LOUGHBORO ROAD NW NASHINGTON, DC 20016	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST B	ATEMENT OF DEFICIENCIES IE PRECEDED BY FULL REGULATORY OR TIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIATE DE	
F 329 SS=D	staff reweighed their the 5%/10 lb weight A face-to-face interv September 12, 2016 Employee #3. A qui resident was reweight.  A face-to-face interv Employee #2 at app September 13, 2016 the finding during the reviewed on Septem 483.25(l) DRUG REGUNNECESSARY DEEach resident's drug unnecessary drugs. drug when used in eduplicate therapy); o without adequate modern indications for its used consequences which reduced or discontining reasons above.  Based on a comprehension and comprehension and comprehensions above and documented in twho use antipsychotems.	eal any evidence that the facility resident to determine whether loss was accurate.  iew was conducted on at approximately 11:30 AM with very was made whether the hed. He/she responded, "No.  iew was conducted with roximately 10:30 AM on The employee acknowledged interview. The record was aber 12, 2016.  GIMEN IS FREE FROM	F 329	1. Corrective Action for Identified P are no further corrective actions found to have been affected by the practice as the resident has bee 2. Identification of Other Patients Potential to be Affected: Other returned the potential to be affected by the practice will be identified through The corrective action will include Chief Medical Officer (CMO) to the cited for this deficiency with physical reducation on the completeness.  3. Systemic Changes to Prevent Refollowing systemic changes will be ensure the deficient practice will be presure the deficient practice.	Patients: There for the resident this deficient in discharged. It is a letter from the he physician is so forders. It is a letter from the he physician is so forders. It is equipped to not recur: It is medication in the etc. It is a letter from the he physician is so forders. It is a letter from the he physician is a letter from the he physician is a letter from the he physician is a letter from the physician in the physician in the physician in the letter from

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	ı			_			
		095030	B. WING	_		09/14/2016	
NAME OF P	PROVIDER OR SUPPLIER	•			TREET ADDRESS, CITY, STATE, ZIP CODE	,	
SIBLEY	MEM HOSP RENAISSA	NCE	1	i	255 LOUGHBORO ROAD NW		
		W. W	<del>,</del>	N	VASHINGTON, DC 20016		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST B	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY OR ITIFYING INFORMATION)	ID PREF TAG	IX.	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRIATE DE	BE (X5) COMPLETION DATE	
F 329	contraindicated, in a drugs.	an effort to discontinue these	F	329	The following comments are in rea 329: Drug Regimen is Free from U Drugs (continued)  4. Monitoring and Incorporation into Assurance / Performance Impro Plan: In order to monitor perform ongoing basis, weekly audits will by the MDS Coordinator and four	o Quality vement Process nance on an Il be performed nd discrepancies	
	This REQUIREMENT is not met as evidenced by:  Based on record review and staff interview for one (1) of 20 Stage 2 sampled residents, it was determined that the physician failed to include an indication for the use of Resident #224 's medications.				of medication indications will be Director of Nursing, Administrate Medical Director in order to iden physicians who are non-complia 90% or above compliance. The correction will be integrated into assurance system.  5. Date Corrective Action Complete 10/24/16.	provided to the or and the or and the tify and counsel ont, with a goal of the quality	
	The findings include: The electronic Physic	ician ' s Order Sheet dated					
	August 31, 2016 dire tablet 100mg, daily,   (Vitamin B-12) tablet Duloxetine (Cymbalta 30 mg [by mouth] da mg - Iron-125mg pe Enoxaparin (Lovenox [Subcutaneous] daily (Advair) 500-50mcg/times daily; Folic Acimouth] daily; Gabape 300mg [by mouth] tw (Neurontin) capsule (Hydrocodone-acetan tablet [by mouth] as i Megestrol (Megace) [by mouth] daily; Oncodone-acetan tablet [by mouth]	ected: "Allopurinol (Zyloprim) [by mouth]; Cyanocobalamin t 1,000 mcg [by mouth] daily; ta) DR [delayed release] capsule aily; Vitron C 65 er tablet 1 tablet [by mouth] daily; ix) syringe 40 mg y; Fluticasone-salmeterol /dose diskus inhaler 1 puff two id (Folvite) tablet 800mcg [by entin (Neurontin) capsule vo times daily; Gabapentin 600mg [by mouth] nightly, minophen (Vicodin) 5-300mg per needed every 6 hours; 40 mg/mL suspension 400mg dansetron (Zofran ODT) 4 mg [by mouth every six hours		11.			

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE COM	SURVEY MPLETED	
		095030	B. WING			09/ <sup>.</sup>	14/2016	
NAME OF PROVIDER OR SUPPLIER  SIBLEY MEM HOSP RENAISSANCE  (X4) ID  PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			STREET ADDRESS, CITY, STATE, ZIP CODE  5255 LOUGHBORO ROAD NW  WASHINGTON, DC 20016  ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMP					
		, , , , , , , , , , , , , , , , , , , ,	TAG		The following comments are in re	1		
F 329 F 371 SS=E	A review of the residence September 2016 Medications were documedications.  A face-to-face interved september 14, 2016 approximately 1:00 pthe physician's order no reason was indications.	aily] and Polyethylene glycol g [by mouth] daily. "  Ident 's August 2016 and edication Administration Records the resident was receiving the ons as ordered. However, no cumented for the use of the mich Employee #2 at om. The employee reviewed is sheet and acknowledged that ated for the use of the nical record was reviewed on it.  OCURE,	F:	371	<ol> <li>The following comments are in response to F 371: Food Procure, Store / Prepare / Serve - Sanitary</li> <li>Corrective Action for Identified Patients: No direct impact identified to patients from the deficient practice of five of seven convection ovens that were soiled with burnt food deposed identification of Other Patients Having the Potential to be Affected: Daily monitoring by management will identify other patients having the potential to be affected by the same deficience.</li> <li>Systemic Changes to Prevent Recurrence: The Food and Nutrition Services Management Teand Sanitation Team will meet with all sanitate employees and have compressor fan cleaning added to master cleaning assignments.</li> <li>Monitoring and Incorporation into Quality Assurance / Performance Improvement Proceptan: The sanitation manager and supervisor monitor regular cleaning of the convection ov The sanitation cleaning assignment log will become part of the quality assurance system the Food and Nutrition Services Department will be reviewed at the monthly managers</li> </ol>			
	(1) Procure food from considered satisfaction authorities; and (2) Store, prepare, disanitary conditions  This REQUIREMENT	m sources approved or ory by Federal, State or local istribute and serve food under  T is not met as evidenced by: ons made on September 13,			5. Date Corrective Action Comple	.ea: 10/2	·4/16	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED
		095030	B. WING	B. WING		09/14/2016
NAME OF PROVIDER OR SUPPLIER  SIBLEY MEM HOSP RENAISSANCE  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFI TAG	52 W X	REET ADDRESS, CITY, STATE, ZIP CODE  255 LOUGHBORO ROAD NW  /ASHINGTON, DC 20016  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIATE DE	
F 456 SS=D	that the facility failed conditions as evider convection ovens the deposits.  The findings include  Five (5) of seven (7) with burnt food deposits.  These observations Employee #8 who are 483.70(c)(2) ESSEN OPERATING COND  The facility must man electrical, and patier operating condition.  This REQUIREMEN  Based on observations 2016 at approximate that the facility failed in good working conform of seven (7) fire contitude gas stove.  The findings include  Three (3) of seven (7) stove were missing.	ely 9:45 AM, it was determined to prepare food under sanitary need by five (5) of seven (7) eat were soiled with burnt food sits.  convection ovens were soiled sits.  were made in the presence of eknowledged the findings.  ITIAL EQUIPMENT, SAFE electron all essential mechanical, at care equipment in safe  T is not met as evidenced by:  ons made on September 13, ally 9:45 AM, it was determined to maintain essential equipment dition as evidenced by three (3) rol knobs that were missing from		371 456	The following comments are in read56: Essential Equipment, Safe Condition  1. Corrective Action for Identified direct impact identified to patient deficient practices of three of seknobs from gas stove were mis  2. Identification of Other Patients: Potential to be Affected: Daily repreventive maintenance walk the verification by management where any other potential mechanical, equipment.  3. Systemic Changes to Prevent Food and Nutrition Services Market and Sanitation Team will meet team members to reinforce promaintenance of carts, warmers other equipment to include stow.  4. Monitoring and Incorporation in Assurance / Performance Improper Plan: The Operations Chef Market all equipment in kitchen to ensufunctional. The opening manage part of the quality assurance sy and Nutrition Services Department reviewed at the monthly manage.  5. Date Corrective Action Comples.	Patients: No onts from the even fire control sing Having the monitoring and or on equipment ich will identify electrical, and Recurrence: The enagement Team with sanitation oper cleaning and pots, pans and es. It is safe and er log will become stem for the Food ent and will be ers meeting.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI		(X3) DATE SURVEY - COMPLETED			
	į						
		095030	B. WING 09/14/20 <sup>2</sup>				
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE	•	
SIBLEY	MEM HOSP RENAISSA	NCE		l	55 LOUGHBORO ROAD NW		
				W	ASHINGTON, DC 20016		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST B	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY OR ITIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIATE DE		
F 456 F 463 SS=D	of Employee #8 who 483.70(f) RESIDENT SYSTEM - ROOMS/ The nurses' station resident calls throug resident rooms; and This REQUIREMENT  Based on observati 2016 at approximate that the facility failed in good working conductioning call is room.  The findings include: The call bell in reside alarm when tested. This observation was	o acknowledged the findings. T CALL /TOILET/BATH  must be equipped to receive ph a communication system from i toilet and bathing facilities.  IT is not met as evidenced by:  ions made on September 13, ely 2:00 PM, it was determined if to maintain the call bell system idition as evidenced by a bell in one (1) of 15 resident 's		456	The following comments are in re 463: Resident Call System – Roor  1. Corrective Action for Identified I known direct impact to patients nonfunctioning call bell. Plant C Maintenance staff repaired the c survey.  2. Identification of Other Patients I Potential to be Affected: Enviror with attention to nonfunctioning 3. Systemic Changes to Prevent F Environmental Rounds performe of Plant Operations and Mainter O&M) on a monthly basis and the Care (EOC) Committee semi-ar include attention nonfunctioning orders should be submitted to P repairs needed  4. Monitoring and Incorporation in Assurance / Performance Improperation Plan: Environmental rounds are monitored for deficient trends or basis and corrective measures as necessary. Plant O&M monitorder system for completion and rates. This plan of correction is in quality assurance system throug report of deficient trends and recompletion and satisfaction rate basis by the EOC Committee.  5. Date Corrective Action Completed	Patients: No from Operations and call bell during the Having the Immental Rounds I call bells Recurrence: ed by the Director mance (Plant The Environment of Innually will I goall bells. Work Plant O&M for any I to Quality Ovement Process of aggregated and In a quarterly are implemented tors the work of satisfaction integrated into the I go the quarterly oview of I se on an annual	
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