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SIBLEY MEM HOSP RENAISSANCE	5255 LOUGHBORO ROAD NW WASHINGTON, DC 20016

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F 000	INITIAL COMMENTS An unannounced Long Term Care Survey was conducted at Sibly Renaissance Skilled Nursing Facility from September 9, 2019 through September 13, 2019. Survey activities consisted of a review of 26 sampled residents. The following deficiencies are based on observation, record review, resident, 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 resident census during the survey was 27. 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 AV- Arteriovenous 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 DCMR- District of Columbia Municipal Regulations D/C Discontinue Dl - deciliter DMH - Department of Mental Health EKG - 12 lead Electrocardiogram	F 000	**Sibley Memorial Hospital Renaissance is filing the following plan of correction for purposes of regulatory compliance, in response to the Quality Indicator and licensure survey conducted on September 9, 2019 through September 13, 2019. The facility is submitting this plan of correction to comply with applicable law and not as an admission or statement of agreement with respect to the alleged deficiencies herein.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Deborah Elise Miller — TITLE: Administrator — (X6) DATE: 11/11/19

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 EMS - Emergency Medical Services (911) G-tube Gastrostomy tube HR- Hour HSC - Health Service Center HVAC - Heating ventilation/Air conditioning ID - Intellectual disability IDT - interdisciplinary team L - Liter Lbs - Pounds (unit of mass) MAR - Medication Administration Record MD- Medical Doctor MDS - Minimum Data Set Mg - milligrams (metric system unit of mass) mL - milliliters (metric system measure of volume) mg/dl - milligrams per deciliter mm/Hg - millimeters of mercury MN midnight Neuro - Neurological NP - Nurse Practitioner O2- Oxygen PASRR - Preadmission screen and Resident Review Peg tube - Percutaneous Endoscopic Gastrostomy PO- by mouth POS - physician ' s order sheet Prn - As needed Pt - Patient Q- Every QIS - Quality Indicator Survey ROM Range of Motion Rp, R/P - Responsible party SCC Special Care Center Sol- Solution TAR - Treatment Administration Record	F 000	**The following comments are in response to F558 – Failure to respond with timeliness to resident call lights when they request assistance (4 of 26 sampled).** 1. **Corrective Action for Identified residents:** No direct impact identified to the residents from the deficient practice. The deficiency was acknowledged and addressed by stressing the importance of timely response to the residents' call lights in Daily Safety huddles after the survey was done and also addressed during staff meeting by the Director of Nursing on September 18, 20, and 24, 2019. 2. **Identification of Other residents having the Potential of be Affected:** All resident have the potential of being affected by the deficient practice. 3. **Systemic Changes to Prevent Recurrence:** The following systemic changes will be put in place to ensure the deficient practice will not recur: a. Nursing staff will be re-educated the importance of timely call light response. This will be a standing topic on the daily safety huddle. b. Nursing staff will be re-educated to sign-in to their assigned residents in the EHR for call light notification and escalation. c. Administrative Service Representative (ASR) will respond to all resident calls that are automatically forwarded to team station, the ASR will notify the care team assign to the resident and escalate if necessary to the charge nurse or the facility manager. A follow up call will be done by the ASR to the resident within 5 minutes of notifying the care team to see if their needs have been attended. A log book of all resident calls that was forwarded will be kept in the team station for auditing purposes. 4. **Monitoring and Incorporation into Quality Assurance / Performance Improvement Process:** System will be monitored to ensure that there are improvements in nursing staff call light response. a. A log book of all resident calls that was forwarded will be kept in the team station for auditing purposes.	
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3)	F 558		

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F 558	Continued From page 2 §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on an resident interviews during the group meeting, record review and staff interview for four (4) of 26 sampled residents, it was determined that facility staff failed to respond with timeliness to resident call lights when they request assistance. Residents' #1, 5, 29 and T1. Findings include ... A review of the May 10, 2019 Resident Council meeting minutes showed residents had concerns which included " ...would like there to be more consistency with staff here ...they need more staff here on the weekend, not enough help to go around for everyone ...they need more staff so the wait time is less ... " The meeting minutes also included the facility's response to the resident's previously identified concerns included, "Resident's thoughts, comments and concerns immediately addressed. All patients were provided with Shining Star forms." The July 26, 2019 Resident Council meeting minutes showed residents had the following concerns, which included " ...There is a lot of confusion about the medicine I am taking and what they are for. Nurse cannot seem to give me	F 558	b. Bi-monthly report from the Nursing Call System will be collected to monitor the call light response to ensure improvements in nursing staff call light response. The data will be collected , analyzed , and reported quarterly to the Quality Assurance and Performance Improvement (QAPI) Committee Meeting 5. **Dates when corrective action will be completed:** Corrective action completed by November 1, 2019.	

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F 558	Continued From page 3 a straight answer..." "Resident's thoughts, comments and concerns immediately addressed. All patients were provided with Shining Star forms." There was no evidence that resident concerns from the May 10, 2019 and July 26, 2019 Resident Council meetings were addressed by the Administrator or designee. On September 11, 2019 at approximately 11:45 AM, the Group meeting was held with four (4) residents of the facility. During this time, one Resident stated, "When you ring the call bell, it's not enough people ....the call bell is a concern, the nurses do not answer them timely when you have to go to the bathroom ..." Based on the resident's comments/concerns a review of the facility's "Callpoint Activation Summary Report" (the facility's call light/bell activation system) was conducted and showed the following: Resident call - waited 16:45 minutes before the call light was answered Resident call - waited 12:40 minutes before the call light was answered Resident call - waited 15:27 minutes before the call light was answered Resident call - waited 8:36 minutes before the call light was answered Resident call - five total activations, 44.42 duration, duration average 8:56 before the call light was answered. Review of the facility's call light activation system report, supported resident concerns related to	F 558		

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F 558	Continued From page 4 staff answering the call light in a timely manner. There were five (5) occasions when facility staff failed to respond to the residents' call for assistance to accommodate their needs in a timely manner. During a face-to-face interview with Employee # 2 on September 13, 2019 at 11:00 AM, she acknowledged the findings.	F 558	**The following comments are in response to F565 – Failure to act promptly upon the grievances of the Resident Council concerning issues related to resident care and life in the facility.** 1. **Corrective Action for Identified residents:** No direct impact identified to residents from the deficient practice of not providing written documentation of follow-up to the concerns raised during the Resident Council meetings. Remaining residents from May and July and current residents were and are informed regarding the indications and known/reported side effects of their medications. Residents were and are also informed that it is our facility's goal to check on residents frequently and respond timely to their call lights. 2. **Identification of Other residents having the Potential of be affected:** Other residents who attended Resident Council meetings. 3. **Systemic Changes to Prevent Recurrence:** The following systemic changes will be put into place to ensure the deficient practice will not recur: a. The staff will be re-educated on policy REN051: REN-Grievance/Complaint Procedures and documenting the follow up actions and resolution. b. A log has been created to capture the residents' concerns from the Resident Council meetings. The staff will document the prompt follow-up and resolution of each concern in the log. The staff will be educated on the log. c. The Administrator or designee will review the log on a weekly basis to ensure that each concern raised by residents or the resident representative have been followed up and resolved. 4. **Monitoring and Incorporation into Quality Assurance / Performance Improvement Process:** In order to monitor performance on an ongoing basis, the documentation of concerns will be reviewed for follow up and resolutions. Grievance trends will also be reported at the quarterly QAPI Committee. 5. **Dates when corrective action will be completed:** The corrective action will be completed by November 11, 2019.	
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group.	F 565		

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F 565	Continued From page 5 §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, facility staff failed to act promptly upon the May and July 2019, grievances of the Resident Council concerning issues related to resident care and life in the facility. The resident census was 27 on the first day of the survey. Findings included ... The Facility's Grievance Policy last revised 08/12/2019 "Stipulated: ...2)A grievance and/or complaint may be submitted orally or in writing by the resident or the person filing the grievance and/or complaint to the appropriate area of responsibility ...6) the resident, or person filing the grievance and/or complaint on behalf of the resident, will be informed of the findings of the investigation and the actions that will be taken to correct any identified problems. Such report will be made orally by the Administrator or his or her designee within five (5) working days of the filing of the written report of the findings. A written summary of the report will also be provided to the resident." A review of the May 10, 2019 Resident Council meeting minutes showed residents had concerns which included "...would like there to be more	F 565		

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F 565	Continued From page 6 consistency with staff here ...they need more staff here on the weekend, not enough help to go around for everyone ...they need more staff so the wait time is less ... " The meeting minutes also included the facility's response to the resident's previously identified concerns included, "Resident's thoughts, comments and concerns immediately addressed. All patients were provided with Shining Star forms." The July 26, 2019 Resident Council meeting minutes showed residents had the following concerns, which included " ...There is a lot of confusion about the medicine I am taking and what they are for. Nurse cannot seem to give me a straight answer..." "Resident's thoughts, comments and concerns immediately addressed. All patients were provided with Shining Star forms." There was no evidence that residents concerns from the May 10, 2019 and July 26, 2019 Resident Council meetings were addressed or acted upon by the facility staff. During a face-to-face interview on 9/13/19, at 12:31 PM with Employee #2, she stated, we address the issues but it is not in writing.	F 565	**The following comments are in response to F657 – Failure to ensure Care Plans were patient-centered (3 of 26 sampled).** 1. **Corrective Action for Identified residents:** No direct impact identified to residents from the deficient practices of not individualizing residents care plans. The importance of patient-centered individualized care plans was acknowledged and addressed in Daily Safety Huddles by the Nurse Manager, Quality Compliance Coordinator Nurse and the Charge Nurse after the survey was completed and also addressed during staff meeting by the Director of Nursing. The three identified residents' care plans were reviewed and each resident's care plan was modified to the individual. 2. **Identification of Other residents having the Potential of be Affected:** Other residents having potential to be affected by the same deficient practice will be identified on admission, during the review of the Quality Compliance Nurse during the first 3 days of resident in the facility, and on an ongoing basis as indicated. 3. **Systemic Changes to Prevent Recurrence:** The following systemic changes will be put in place to ensure that the deficient practice will not occur: a. Nursing staff will be re-educated on the importance of providing appropriate resident-centered care with goals and approaches to address that are specific to resident needs while staying in the facility. The re-education will include care planning for nephrostomy tubes, wound care, and accurate documentation. b. The Quality Compliance Coordinator Nurse will provide in-service to re-educate the nursing staff in making a resident centered care plan with the existing template in the EHR 4. **Monitoring and Incorporation into Quality Assurance / Performance Improvement Process:** The Quality Compliance Coordinator Nurse will perform a monthly audit for appropriateness of the Care Plan created on admission for 3 months for a compliance of 90 %. The result of the chart audit will be reported to the monthly Renaissance	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be-	F 657		

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F 657	Continued From page 7 (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, record reviews, and interviews, the facility's staff failed to ensure that three (3) of 26 sampled residents' Care Plans were patient-centered (Residents' #5, #18, and #90) Findings include... 1. Review of Resident #5 current medical record on 09/13/19 at 11:45 AM showed that the resident was admitted on 04/18/19 with multiple diagnoses including Chronic Pain.	F 657	Sub-Committee Meeting and to quarterly Quality Compliance and Performance Improvement (QAPI) Committee Meeting. 5. **Dates when corrective action will be completed:** Corrective action completed by November 8, 2019.	

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F 657	Continued From page 8 Further review of the record revealed a Care Plan dated 04/18/19 that document Resident #5 used a non-pharmacological cold therapy device for pain management. Observation of the resident's room on 09/11/19 at 10: 15 AM, however, failed to evidence a cold therapy device. During a face-to-face interview on 09/13/19 at 1:00 PM, with the Unit Manager, she stated that the resident never used a cold therapy device, and that type of therapy was a general intervention used for pain management. The Unit Manager also said that she would update and remove the cold therapy device from Resident #5's Care Plan dated 04/13/19. 2. Review of Resident #18's current medical record starting on 09/11/19 at 9:45 AM showed that the resident was admitted on 07/11/19 with several diagnoses including: Nephrostomy Status, Flank Pain, Perinephric Fluid Collection, Immobility, Bilateral Nephrostomy tubes and a Deep Tissue Injury to the Left Buttocks. Continued review of the record revealed that the resident had a Fluoroscopy procedure done at the facility's hospital on 07/10/19 to replace the right-side nephrostomy tube due to hydronephrosis and displacement of the previous tube. Review of the current medical record revealed a Care Plan dated 07/11/19 failed to document that Resident #18 had bilateral nephrostomy tubes or a deep tissue injury to the left buttocks. The Care Plan also lacked documented evidence of the staffs' responsibility for monitoring and managing	F 657		

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F 657	Continued From page 9 the nephrostomy tubes or the left buttocks wound. During an interview the Unit Manager on 09/11/19 at 3:15 PM, she stated that the licensed nursing staff is responsible for monitoring and measuring the resident's urinary output from the nephrostomy tubes and monitoring the left buttock wound. The Unit Manager also said that she would update Resident #18's 07/11/19 Care Plan to include: the nephrostomy tubes, the left buttock wound, and the staffs' responsibility for monitoring and managing bilateral nephrostomy tubes and left buttocks wound. 3. Observation of the Resident #90's room on 09/10/19 at 10:40 AM showed the resident sitting in a chair applying ice to his right thigh, which had a white, dry, and intact dressing in place. Review of Resident #90's current medical record starting on 09/10/19 at 1:30 PM showed that the resident was admitted on 09/06/19 with multiple diagnoses including Femoral Shaft Fracture/Displacement [of] Right Femoral Rod Revision on 09/02/19. Further review of the record revealed a nursing note dated 09/06/19 at 7:51 PM that documented two nurses assessed the resident's skin and noted the following: "Surgical incision to right thigh covered with aqua cell dressing, gauze and Tegaderm at JP (Jackson-Pratt) drain removal site, RLE (right lower extremity) covered with ace wrap and knee immobilizer." Further review of the current medical record revealed a Care Plan dated 09/06/19 that lacked documented evidence the resident had a surgical	F 657		

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F 657	Continued From page 10 wound and the staffs' responsibility with wound care. During an interview on 09/10/19, at 3:20 PM, the Unit Manager, stated that she would update Resident #90's Care Plan dated 09/06/19, to include his right femoral surgical wound site and outline the staff's responsibility with monitoring and managing the wound.	F 657	**The following comments are in response to F686 – Failure to appropriately and accurately assess a significant change of deep tissue wound (1 of 26 sampled).**	
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility's nursing staff failed to appropriately and accurately assess a significant change of deep tissue wound for one (1) of 26 sampled residents (Resident #18). Findings include ... Centers for Medicaid and Medicare Services, State Operation Manual Appendix PP-Guidance	F 686	**1. Corrective Action for Identified residents:** No direct impact identified to the residents from the deficient practice of not appropriately and accurately documenting resident's wound change. The importance of appropriately and accurately assessing changes in wounds and deep tissue wounds was addressed in Daily Safety huddles after the survey was done and also addressed during staff meeting by the Director of Nursing on September 18, 20, and 23, 2019. During the survey, the resident's wound care nurse was also made aware of the importance of appropriately and accurately assessing changes in wounds and deep tissue wounds and the resident's wound was reassessed. **2. Identification of Other residents having the Potential of be Affected:** All residents with wound have the potential of being affected. **3. Systemic Changes to Prevent Recurrence:** a. Nursing staff will be re-educated on proper documentation of wound assessment, changes of wound condition, treatment and appropriate care plan done for the resident's wound. b. Revisiting the Four-Eyes Skin Assessment Process on admission. , with both nurses documenting on residents' EHR. c. Best practice on wound documentation was included on the Tip of the Week during daily safety huddle. d. Identified non-compliant nurses will have one on one counselling provided by the RN Quality Compliance Coordinator and the Nurse Manager.	

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F 686	Continued From page 11 to Surveyors for Long Term Care Deep Tissue Pressure Injury...once a deep tissue injury opens to an ulcer, reclassify the ulcer into the appropriate stage... Pressure Ulcer/Injury Characterizes...With each dressing change or at least weekly (and more often when indicated by wound complications or changes in wound characteristics), an evaluation of the PU/PI should be documented. At a minimum, documentation should include the date observed and: - Location and staging; - Size (perpendicular measurements of the greatest extent of length and width of the PU/PI), depth; and the presence, location and extent of any undermining or tunneling/sinus tract; - Exudate, if present: type (such as purulent/serous), color, odor and approximate amount; - Pain, if present: nature and frequency (e.g., whether episodic or continuous); - Wound bed: Color and type of tissue/character including evidence of healing (e.g., granulation tissue), or necrosis (slough or eschar); and - Description of wound edges and surrounding tissue (e.g., rolled edges, redness, hardness/induration, maceration) as appropriate... https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Appendix-PP-State-Operations-Manual.pdf Review of Resident #18's current medical record	F 686	**4. Monitoring and Incorporation into Quality Assurance / Performance Improvement Process:** a. The RN Quality Compliance Coordinator will perform monthly chart audits on residents identify with pressure injuries for accurate wound documentation. The audit will continue for three months with the compliance rate of 100%. The result will be reported during monthly Renaissance Sub-Committee Meeting and the quarterly Quality Compliance and Performance Improvement Meeting (QAPI) b. The RN Quality Compliance Coordinator will audit ten random chart every month on skin assessment and documentation done by both RN's during admission. The result will be reported during monthly Renaissance Sub-committee Meeting and quarterly Quality Compliance and Performance Improvement Meeting (QAPI). **5. Dates when corrective action will be completed:** Corrective Action completed by September 30, 2019.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095030	A. BUILDING _____ B. WING _____	09/13/2019

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F 686	Continued From page 12	F 686		

starting on 09/11/19 at 9:45 AM showed that the resident was admitted on 07/11/19 with several diagnoses including Immobility and Nephrostomy Status.

Further review of the record revealed a nursing admission note dated 07/11/19 that documented the resident was assessed by two nurses and noted to have bilateral nephrostomy tubes and a deep tissue injury to the left buttocks.

Continued review of the record showed a note from the Wound Ostomy and Continence nurse dated 07/11/19 that documented under the assessment section, "There is a localized purple and red area on left buttock, skin is intact. It [was] caused by [the] nephrostomy tube and plastic hub. Skin is intact around it." The nurse also described Resident #18's wound and the dressing status, as listed below:
Wound Bed Assessment: Purple
Description: Purple Intact Skin
Peri-Wound Assessment: Clean, Dry, Intact
Drainage Amount: None
Length: 5 centimeters
Width: 2.5 centimeters
Dressing Status: Open to air

Further review of Resident #18's current medical record revealed a nursing note dated 07/14/19 that documented, "Wound to left buttock noted with small break and cover [sp] with Mepliex." The nurse, however, failed to record the characteristics change(s) of the wound to include: the size of the open area, description of the wound bed, description of the tissue surrounding the wound, if the wound had exudate, if the wound had a smell, or if there was any pain associated with the wound.

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F 686	Continued From page 13 During a face-to-face interview on 09/13/19 at 1:00 PM, the Unit Manager stated, "The nurse should have documented the characteristic changes of [resident's name] wound." Continued review of the current medical record revealed a note from the Wound Ostomy and Continence nurse dated 07/16/19. The nurse documented, "The DTI (deep tissue injury) is less purple, old dressing has small amount of serosanguineous drainage, most of skin in place ...Pt (patient) couldn't stand long, so didn't measure the wound. Will check pt (patient) later this week." During a face-to-face interview on 09/13/19 at 2:00 PM, the Wound Ostomy and Continence nurse stated, "I did not measure the wound because the patient could not stand for long time." When asked, if it was the facility's practice to have residents stand while measuring their wounds? The Wound Ostomy and Continence nurse stated, "No, but she [resident's name] was sitting in a chair eating dinner and didn't want to go back to bed." The nurse was then asked, did you go back that week to measure the new open area of the resident's wound? The nurse stated, "No." There was no evidence that facility staff provided care to Resident' #18's wound that is consistent with professional standards of practice. During a face-to-face interview on 09/13/19 at 2:10 PM, the Unit Manager acknowledged the findings.	F 686		
F 756	Drug Regimen Review, Report Irregular, Act On	F 756		

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F 756 SS=D	Continued From page 14 CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that	F 756	**The following comments are in response to F756 – Failure to document the reason to continue dose of medication identified by the pharmacist to increase falls (1 of 26 sampled).** 1. **Corrective Action for Identified residents:** No direct impact identified to resident from the deficient practice of the physician not documenting his rationale for not following the pharmacist's recommendation. The covering physician appropriately addressed the resident's medications based on the pharmacist's recommendation on September 13, 2019. 2. **Identification of Other residents having the Potential of be affected:** Other residents who had pharmacist's recommendations on medications. "*Medication Regimen Review and Concurrent Drug Utilization Review*" (policy # REN 035) was reviewed with medical staff stressing the need for acknowledging pharmacist's recommendation and rationale for continuing medication against recommendation. The resident's medication was changed by the Medical Director and physicians were re-educated by email sent out by the Medical Director on September 13, 2019. 3. **Systemic Changes to Prevent Recurrence:** The following systemic changes will be put into place to ensure the deficient practice will not recur: a. *Medication Regimen Review and Concurrent Drug Utilization Review*" (policy # REN 035) was reviewed with the pharmacist by the Director of Pharmacy September 18, 2019. b. The pharmacist will escalate any recommendation that have not been addressed by the physician to the Medical Director, the Director of Nursing (DON) and the Administrator September 18, 2019 4. **Monitoring and Incorporation into Quality Assurance / Performance Improvement Process:** A weekly audit will be performed 100% of the time where the pharmacist recommendation is made and a physician response is required. Audit will be conducted for at least 3 months and started on September 23, 2019. Result will be reported at monthly Renaissance Sub-committee meeting and quarterly Quality Compliance and Performance Improvement Meeting.	

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F 756	Continued From page 15 requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review and interview, an attending physician failed to document the reason for the continued dose of a medication identified by the pharmacist to increase falls for one (1) of 26 sampled residents (Resident #18). Findings include ... Review of Resident # 18's current medical record starting on 09/11/19 at 9:45 AM showed that the resident was admitted on 07/11/19 with several diagnoses, including Insomnia (unspecified type). Further review of the record revealed that the resident was ordered Temazepam (pharmacologic class: benzodiazepine) 30 mg, orally, nightly as needed for sleep on 07/11/19. Continued review of the record revealed that the facility's pharmacist recommended decreasing the dose of the Temazepam, during three (3) medication regimen reviews, as evidenced below: 07/12/19- "Consider reducing the dose of Temazepam to 7.5 - 15 mg (milligrams) if you wish to continue therapy. Patient is at increased risk of falling." 08/09/19- "Please consider discontinuing Temazepam 30 mg (milligrams), which patient get [sp] every night on a regular basis. Please decrease the dose slowly and monitor for withdrawal [sp], recommended dose is 7.5 mg (milligrams). Per manufacture concomitant of benzodiazepine and opioids may result in	F 756	**5. Dates when corrective action will be completed:** The corrective action will be completed by November 11, 2019.	

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F 756	Continued From page 16	F 756		

profound sedation, respiration depression. Also benzodiazepine have been associated with falls and traumatic injury."

09/06/19- "Patient is at risk for sedation/fall secondary to medications as was noted in previous review. Attending has been notified."

Continued review of the previously mentioned pharmacist medication regimen reviews showed that the attending physician counter-signed all the previously mentioned reviews. The attending physician, however, failed to document his rationale for continuing the order of Temazepam 30 mg, orally, nightly as needed for sleep.

During a face-to-face interview with the pharmacist on 09/13/19 at 1:00 PM, the pharmacist stated that when the physician counter-signed her reviews, it indicated he was aware of her recommendations. When asked if she verbally made the physician aware of her recommendation for decreasing the dose of Temazepam for Resident #18, the pharmacist stated that she might have spoken with the physician, but she could not recall the date.

Further review of Resident #18's current medical record revealed that the resident fell off the bedside commode, hit her forehead on the floor, sustained a quarter size hematoma and slight abrasion to the forehead on 08/08/19 at 1:43 AM. After the fall, the resident was immediately assessed by a physician.

During an interview via telephone on 09/13/19 at 12:50 PM, the Medical Director was asked if he thought the resident's fall 08/08/19 was caused by the Temazepam 30 mg, he stated, "I did

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F 756	Continued From page 17 review the fall, and I don't think it was due to the medication but more to the resident's debilitation." The Medical Director then stated "I think [resident's name] needs the 30mg like she has used for years at home." The Medical Director also said, during a recent hospital admission, the Temazepam was decreased to 15mg, but it was not effective for [resident's name]. There was no evidence the attending physician documented in the resident's medical record his rationale to the pharmacist medication regimen in the resident's medical record. During a face-to-face interview on 09/13/19 at 1:00 PM, the Director of Nursing acknowledged the findings.	F 756	**The following comments are in response to F757 – Failure to monitor and document response to PRN medication (1 of 26 sampled).** 1. **Corrective Action for Identified residents:** There are no further corrective actions as the resident has been discharge home. All other residents receiving PRN medications were reviewed by staff for their response to PRN medications and order request for changes are made as indicated. No concerns were identified. 2. **Identification of Other residents having the Potential of be Affected:** All residents have the potential of being affected by the deficient practice. 3. **Systemic Changes to Prevent Recurrence:** The following systemic changes were put in place to ensure the deficient practice does not recur: a. Nursing staff who administer sleep agent will reassessed the resident within 1 hour of administration of sleep agent. Documentation of resident's response to the sleep agent will be documented in the Nursing notes. b. Sleep Agent Reassessment was discussed in Daily Safety Huddles by the Nurse Manager, Quality Compliance Coordinator Nurse and the Charge Nurse during the week of September 16, 2019 and during staff meeting by the Director of Nursing on September 18, 20, and 23, 2019. 4. **Monitoring and Incorporation into Quality Assurance / Performance Improvement Process:** The RN Quality Compliance Coordinator will perform random chart audit on ten residents monthly for 3 months for 100% compliance. Result will be reported on monthly Renaissance Sub-committee meeting and quarterly Quality Compliance and Performance Improvement Meeting. 5. **Dates when corrective action will be completed:** Corrective action completed by September 30, 2019.	
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse	F 757		

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F 757	Continued From page 18 consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility's staff failed to: monitor and document Resident #18's response to a PRN (as needed) medication for one (1) of 26 sampled residents. (Resident #18). Findings include ... The facility's staff failed to monitor and document Resident #18's response to a PRN medication. Review of Resident #18's current medical record starting on 09/11/19 at 9:45 AM showed that the resident was admitted on 07/11/19, with several diagnoses, including Insomnia (unspecified type). Further review of the record revealed that the resident was ordered Temazepam (used to treat insomnia) 30 mg, orally, nightly as needed for sleep on 07/11/19. Further review of the record showed the following physician's order, "Temazepam 30 mg, orally, nightly as needed for sleep on 07/11/19". Continued review showed the Medication Administration Record dated from 07/11/19 through 09/11/19 which documented the resident received the Temazepam 30 mg, orally every night except on 07/17/19, 07/26/19, and 09/10/19 when the resident was on "Leave of Absence."	F 757		

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F 757	Continued From page 19 Further review of Resident #18's current medical record showed a pharmacy note dated 08/09/19 that recorded, "Please consider discontinuing Temazepam 30 mg (milligrams), which patient get [sp] every night on a regular basis..." Continued review of Resident # 18's current medical record revealed Nursing Notes, Medication Administration Records, and Flowsheets dated from 07/11/19 to 09/12/19 lacked documented evidence that the nurses monitored the resident's response to Temazepam. During a face-to-face interview on 09/13/19, at 11:30 AM, the unit manager stated that the nursing staff should have documented in their nursing notes Resident #18's response to Temazepam. During a face-to-face interview on 09/13/196, starting at 2:00 PM, the Unit Manager acknowledged the finding.	F 757		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility	F 812	**The following comments are in response to F812 – Failure to store, prepare and distribute foods under sanitary conditions.** 1. **Corrective Action for Identified residents:** No direct impact identified to residents from the deficient practice. The following actions were taken: a. Stored juice exceeded "best before date" – Items discarded immediately while the surveyor was onsite. b. Stored broth exceeded "use by" date – Items discarded immediately while the surveyor was onsite. c. Soiled convection oven and oven racks – Ovens and racks were cleaned immediately while the surveyor was onsite. d. Soiled food warmer (Alto Shaam) – warmer was cleaned immediately while the surveyor was onsite. e. Soiled food warmer with shelves (Trauslen) – The out-of-service warmer was discarded on 9/13/2019. f. Soiled and cracked cold food plastic containers - All 24 containers were thrown out immediately while the surveyor was onsite. The 24 plastic containers had not been in use for production. g. Cracked food trays – Trays with broken handles were removed from service immediately while the surveyor was onsite. 2. **Identification of Other residents having the Potential of be Affected:** No additional residents were identified being affected by deficient practices. 3. **Systemic Changes to Prevent Recurrence:** The Food and Nutrition management team will review compliance with expired items and maintain the cleaning schedule of major equipment.	

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F 812	Continued From page 20 gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and interview, it was determined that facility staff failed to store, prepare and distribute foods under sanitary conditions as evidenced by expired food items: 11 of 11 forty-six fluid ounce containers of cranberry juice cocktail and one (1) of three (3) plastic containers of ready-for-use vegetable broth, soiled equipment - four (4) of six (6) convection ovens and oven racks, one (1) of one (1) Alto Shaam brand food warmer, one (1) of one (1) Trauslen brand food warmer with shelves, 24 of 24 plastic containers of various sizes, and 40 of 80 food trays stored in the dishwashing area that were cracked at the handles. Findings included ... The following observations were made during a walkthrough of dietary services on September 9, 2019, at approximately 10:05 AM: 1. 11 of 11 forty-six fluid ounce containers of cranberry juice cocktail located in the dry storage room were labeled with a 'best before' date of January 22, 2019. 2. One (1) of three (3) plastic container of	F 812	4. **Monitoring and Incorporation into Quality Assurance / Performance Improvement Process:** Close monitoring will occur for high use ovens that may need to be cleaned ahead of the schedule. Monthly checks of trays and containers will take place to remove any items that may be cracked by the Patient services manager. Ongoing monitoring will be included in the annual report to the Environment of Care Committee. 5. **Dates when corrective action will be completed:** All corrective actions were completed by September 13, 2019.	

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F 812	Continued From page 21 ready-for-use vegetable broth stored in refrigerator box #1 had a 'use by' date of July 24, 2019. 3. Four (4) of six (6) convection ovens and oven racks were soiled throughout with burnt food residue. 4. One (1) of one (1) Alto Shaam brand food warmer was soiled throughout. 5. One (1) of one (1) Trauslen brand food warmer including the shelves (9) were soiled. 6. 24 of 24 plastic containers of various sizes, used to store cold foods were soiled and cracked throughout. 7. 40 of 80 food trays stored in the dishwashing area were cracked at the handles. Employee #4 acknowledged the findings during a face-to-face interview on September 9, 2019, at approximately 11:00 AM.	F 812	**The following comments are in response to F880 – (1) Failure to develop a system of surveillance to identify infections or communicable diseases.** 1. **Corrective Action for Identified residents:** No known direct impact to any residents from the deficient practice of the failure to develop a system of surveillance to identify infections or communicable diseases that facility or community acquired. Revisions were made to the Excel workbook to include tracking of residents with UTI, C. difficile and start of antibiotic therapy. Additional columns included: a. Any infection present on admission b. Community vs Healthcare onset c. Targeted infection (UTI, BSI, MRSA bacteremia, SSI, C. difficile) 2. **Identification of Other residents having the Potential of be Affected:** Other patients with the potential of being affected by the same deficient practice will be addressed by the following plan of correction. 3. **Systemic Changes to Prevent Recurrence:** The Infection Prevention staff were educated as to the importance of capturing surveillance in the setting of the Renaissance and its population. 4. **Monitoring and Incorporation into Quality Assurance / Performance Improvement Process:** Currently data is received around the 15th of each month from Patient Safety's Data Analyst and Report Writer. Patients will be reviewed by the 1st of every month to monitor for trends. Infection Prevention will continue to monitor possible healthcare-associated infections (HAIs) on a weekly basis. The monitoring data will be reported quarterly to the Quality Assurance and Performance Improvement (QAPI) Committee meeting. 5. **Dates when corrective action will be completed:** Corrective action was completed and shared with surveyor at the time of finding on 9/13/2019.	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention	F 880		

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SIBLEY MEM HOSP RENAISSANCE	5255 LOUGHBORO ROAD NW WASHINGTON, DC 20016

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 22 and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed	F 880	**The following comments are in response to F880 -- (2) Failure to store drinkware under sanitary conditions.** 1. **Corrective Action for Identified residents:** No direct impact identified as being affected by the deficient practices. All of the wet stacked cups were sent to the dish room to be rewashed and air-dried. 2. **Identification of Other residents having the Potential of be Affected:** No additional residents were identified as being affected by the deficient practices 3. **Systemic Changes to Prevent Recurrence:** The Food and Nutrition Services Management Team have met with and re-educated staff about the importance of proper washing, drying, and storage of drinkware. 4. **Monitoring and Incorporation into Quality Assurance / Performance Improvement Process:** The staff was in-serviced on proper ware washing. Cups are left in the racks to air dry before being brought to the service line for use. This is monitored by the patient services team leads and Patient services manager. Ongoing monitoring will be included in the annual report to the Environment of Care Committee. 5. **Dates when corrective action will be completed:** Corrective action completed by September 13, 2019.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095030	A. BUILDING _____ B. WING _____	09/13/2019

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F 880	Continued From page 23 by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the facility staff failed to develop a system of surveillance to identify infections or communicable diseases; and failed to store drinkware under sanitary conditions as evidenced by 55 of 55 clean drinking cups were stacked wet in the dishwashing room. The census on the first day of survey was 27. Findings included... 1. Facility staff failed to develop a system of surveillance to identify infections or communicable diseases that are facility or community acquired. Review of the facility's Infection Control Surveillance logs for May, June and July 2019, list the following information: "Medical record number, [resident] name, admit date, culture	F 880		

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F 880	Continued From page 24 date, organism, unit/room, comments, opportunities for improvement, unit manager notified ..." The surveillance logs lacked evidence that the facility staff established a system for surveillance inclusive of the following components: a systematic collection, analysis, interpretation, and dissemination of surveillance data to identify infections acquired within the facility and from the community. During a face-to-face interview on September 13, 2019, at approximately 9:53 AM, Employee # 7 acknowledged the findings. 2. Facility staff failed to store drinkware under sanitary conditions. During a walkthrough of the dishwashing area on September 9, 2019, at approximately 10:05 AM, 55 of 55 clean drinking cups were observed stacked wet, on a storage shelf and ready for use. Employee #4 acknowledged the above findings during a face-to-face interview on September 9, 2019, at approximately 11:00 AM.	F 880		