Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0026	A. BUILDING: _____ B. WING _____	08/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIBLEY MEM HOSP RENAISSANCE	5255 LOUGHBORO ROAD NW WASHINGTON, DC 20016

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L 000	Initial Comments A Licensure Survey was conducted August 17, 2015 through August 24, 2015. The deficiencies are based on observation, record review, resident and staff interviews for 27 sampled residents. 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 DCMR- District of Columbia Municipal Regulations D/C Discontinue Dl - deciliter DMH - Department of Mental Health EKG - 12 lead Electrocardiogram EMS - Emergency Medical Services (911) G-tube Gastrostomy tube 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	L 000	Please begin typing your responses here: The Sibley Renaissance is filing the following plan of correction for purposes of regulatory compliance, in response to the annual license survey conducted on August 17, 2015 through August 24, 2015. 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.	

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L 000	Continued From page 1 volume) mg/dl - milligrams per deciliter mm/Hg - millimeters of mercury MN midnight Neuro - Neurological NP - Nurse Practitioner 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 Rp, R/P - Responsible party s/he she/he SCC Special Care Center Sol- Solution TAR - Treatment Administration Record	L 000		
L 052	3211.1 Nursing Facilities Sufficient nursing time shall be given to each resident to ensure that the resident receives the following: (a)Treatment, medications, diet and nutritional supplements and fluids as prescribed, and rehabilitative nursing care as needed; (b)Proper care to minimize pressure ulcers and contractures and to promote the healing of ulcers: (c)Assistants in daily personal grooming so that the resident is comfortable, clean, and neat as evidenced by freedom from body odor, cleaned and trimmed nails, and clean, neat and	L 052		

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L 052	Continued From page 2 well-groomed hair; (d) Protection from accident, injury, and infection; (e)Encouragement, assistance, and training in self-care and group activities; (f)Encouragement and assistance to: (1)Get out of the bed and dress or be dressed in his or her own clothing; and shoes or slippers, which shall be clean and in good repair; (2)Use the dining room if he or she is able; and (3)Participate in meaningful social and recreational activities; with eating; (g)Prompt, unhurried assistance if he or she requires or request help with eating; (h)Prescribed adaptive self-help devices to assist him or her in eating independently; (i)Assistance, if needed, with daily hygiene, including oral acre; and j)Prompt response to an activated call bell or call for help. This Statute is not met as evidenced by: Based on record review, and staff interview for two (2) of 27 sampled residents, it was determined that sufficient nursing time was not provided as evidenced by failure to clarify a physician ' s order as it relates to parameters of administration for an antihypertensive medication [Metoprolol] for one (1) resident; failed to follow physician ' s orders for the application of a scrotal	L 052		

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L 052	Continued From page 3 support garment and failure to clarify the physician ' s order to identify a wearing schedule for the support garment for one (1) resident. Residents #139 and 195. The findings include: 1. Facility staff failed to clarify a physician ' s order for blood pressure parameters for Resident #139 who was prescribed Metoprolol [Anti-hypertensive medication]. On August 24, 2015 at approximately 10:00 AM, a review of the Admission Minimum Data Set dated August 3, 2015 revealed that the resident was admitted to the facility on that day with diagnoses that included a Left Hip Infection and Hypertension. The physician's orders dated August 15, 2015, directed the following: "Metoprolol Succinate (Toprol-XL) [Anti-hypertensive medication] 50mg [milligrams] oral daily. Hold for SBP [Systolic Blood Pressure] less than [missing numeric value] mmHg or HR [Heart Rate] less than 55 beats per minute. Do not crush or chew. Diagnosis Association: Hypertension." The physician's medication order lacked documented evidence of a numeric value in the space of the order allotted for " Systolic blood pressure " [the space remained blank]. On August 24, 2015 at approximately 10:02 AM, a face-to-face interview was conducted with Employee #8 who was asked what the blood pressure parameters were on the order. He/she reviewed the order and stated, " They are not	L 052	**Response to L052-1 (3211.1) - Missing Parameters for Metoprolol Orders:** 1. There are no further corrective actions for the resident found to have been affected by this deficient practice as the resident has been discharged. This deficiency was noted and addressed in staff meetings by the Director of Nursing (DON) on August 28th, 31st, September 2nd and 4th. 2. Other residents having the potential to be affected by the same deficient practice will be identified and staff re-education on policy number# 01-28-13, "Parameters for administering anti -hypertensive medication" will be completed. 3. The following systemic changes will be put in place to ensure the deficient practice will not recur: orders for anti- hypertensive medications must include parameters for administration to be considered complete. 4. The education & training specialist will conduct random medication passes to observe staff administration of anti-hypertensive medication in accordance to parameters for administration. In addition, two Quality Compliance Coordinators will monitor performance through random monthly audits of the medication administration record and physician orders for residents prescribed anti-hypertensive medication to ensure proper administration and order completeness. The findings will be presented at the quarterly meeting of the Renaissance Compliance & Quality Assurance Committee. The Chief Medical officer will notify the ordering physician of this finding in writing by 9/30/15. 5. Education will be completed by 9/30/15	9/30/15

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L 052	Continued From page 4 written here on the order, but I will get this clarified." Facility staff failed to clarify the missing numeric value in the " hold for ... " parameters of administration of the physician ' s Metoprolol order. The record was reviewed on August 24, 2015. 2. A review of the clinical record for Resident#195 lacked evidence that facility staff followed physician ' s orders for the application of a scrotal support garment. Further, it was determined that staff failed to clarify the physician ' s order for use of the device as evidenced by the lack of a wearing schedule for the garment. A. Facility staff failed to apply a scrotal support garment that was ordered by the physician to manage scrotal edema for Resident #195. Resident #195 was admitted August 1, 2015 with diagnoses that included " scrotal edema. " A face-to-face interview was conducted with Resident #195 on August 19, 2015 at approximately 10:00 AM. In response to the query " do you feel there is enough staff to give you assistance when needed ..., " Resident #195 responded " no. " S/he further stated that [he/she] was unable to get assistance to apply a scrotal support garment that the doctor ordered, " or either they just don ' t know how to put it on ...I don ' t even wear it. " A review of physician ' s orders dated August 1, 2015 revealed " Scrotal Support. " A review of the Medication and Treatment Administration Record [MAR/TAR] for August 2015 lacked evidence of the application of the scrotal support	L 052	**Response to L052-2 (3211.1) – Lack of Wearing Schedule on Order for Scrotal Support:** 1. No further corrective actions for the resident found to have been affected by this deficient practice as the resident has been discharged This deficiency was noted and addressed in staff meetings by the Director of Nursing (DON)on August 28th, 31st;September 2nd and 4th. 2. Other residents having the potential to be affected by the same deficient practice will be identified via chart reviews verifying complete orders for medical devices/apparel to include instructions for application, duration, and frequency. 3. The following systemic changes will be put in place to ensure the deficient practice will not recur: specific staff and staff in general will be re-educated (nurse and physician) regarding physician orders for application of medical devices/apparel to include instructions for application, duration and frequency. 4. Random monthly audits of MD orders for medical devices/apparel (i.e. scrotal support) to include instructions for application, duration and frequency will be conducted by quality nurses. Two Quality Compliance Coordinators will monitor performance through monthly random audits to ensure MD orders for medical devices/apparel (i.e. scrotal support) includes instructions for application, duration and frequency. The quality assurance process will be utilized to maintain and sustain 90% or above compliance. The findings will be presented at the quarterly meeting of the Renaissance Compliance & Quality Assurance Committee. The Chief Medical officer will notify the ordering physician of this finding in writing by 9/30/15.	

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L 052	Continued From page 5 garment. A face-to-face interview was conducted with Employee #13 on August 24, 2015 at 3:00 PM. In response to a query regarding the prescribed scrotal support garment; s/he stated that the resident was very private and didn ' t want assistance with the application of the garment. Towels were offered to the resident so that s/he was able to elevate [his/her] scrotum when seated. A nurse ' s entry dated August 14, 2015 at 8:01 PM, " ...Scrotum still swollen pt [patient] encouraged to keep same elevated ... " A physician ' s entry dated August 19, 2015 at 3:51 PM, " Scrotum is mildly edematous - less so than previous exam ...continue scrotal elevation/sling when ambulating ... " The clinical record lacked evidence of application of the scrotal garment and/or rejection of its application by the resident. There was no evidence of the order for the scrotal support garment on the MAR/TAR. B. Facility staff failed to clarify the physician ' s order for the application of the scrotal support garment. The physician ' s order dated August 1, 2015 read, " Scrotal Support. " The resident ' s admitting diagnoses included scrotal edema. The order lacked evidence of a wearing schedule for the scrotal support and/there was no evidence that facility staff queried the physician for clarity regarding the application of the scrotal support.	L 052	5. Corrective action will be completed by 9/30/15.	9/30/15

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L 052	Continued From page 6 The findings were acknowledged during a face-to-face interview with Employee #13 on August 24, 2015 at 3:00 PM.	L 052	**Response to L099-1 (Soiled Convection Ovens):** 1. Cited convection ovens were cleaned on 8/17/15. 2. Daily monitoring by management will prevent residents from having the potential to be affected by the same practice. 3. The following systemic change will be put in place to ensure the deficient practice will not recur. All sanitation staff and production staff will be in-serviced by 10/2/15. Management team will need to sign off that this process is being completed consistently. 4. The Chef, Sous Chef or manager on duty will monitor this daily to maintain compliance. The quality assurance process will be utilized to maintain and sustain 90% or above compliance. These findings will be presented during our monthly managers meeting. 5. Corrective action will be completed by 10/2/15.	10/2/15
L 099	3219.1 Nursing Facilities Food and drink shall be clean, wholesome, free from spoilage, safe for human consumption, and served in accordance with the requirements set forth in Title 23, Subtitle B, D. C. Municipal Regulations (DCMR), Chapter 24 through 40. This Statute is not met as evidenced by: Based on observations made on August 17, 2015, it was determined that the facility failed to prepare food under sanitary conditions as evidenced by two (2) of eight (8) soiled convection ovens, five (5) of five (5) six-inch deep third pans and 12 of 12 six-inch one-sixth pans and seven (7) of seven (7) that were stored wet, and two (2) of seven (7) half sheet pans that were dented in several areas. The findings include: 1. Two (2) of eight (8) convection ovens were soiled at the bottom with burnt food deposits. 2. Five (5) of five (5) six-inch deep third pans and 12 of 12 six-inch one-sixth pans were stored wet. 3. Seven (7) of seven (7) half sheet pans were stored wet and two (2) of the seven (7) were dented in several areas and needed to be discarded. These observations were made in the presence of Employee #9 and Employee #11 who acknowledged the findings.	L 099	**Response to L099-2 (Stored Wet Pans):** 1. Cited pans that were stored wet were washed and sanitized and then placed on drying rack on 8/17/15. 2. Daily monitoring by management will prevent residents from having the potential to be affected by the same practice. 3. The following systemic change will be put in place to ensure the deficient practice will not recur. All sanitation staff will be in-serviced by 10/2/15 on requirements for storing wet pots and pans properly. 4. This practice will be monitored daily by management to maintain and sustain compliance at 90% or above. Sanitation leader will do pot and pan audits to help maintain consistency. 5. Corrective action will be completed by	10/2/15

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L 201	3231.12 Nursing Facilities Each medical record shall include the following information: (a)The resident's name,age, sex, date of birth, race, martial status home address, telephone number, and religion; (b)Full name, addresses and telephone numbers of the personal physician, dentist and interested family member or sponsor; (c)Medicaid, Medicare and health insurance numbers; (d)Social security and other entitlement numbers; (e)Date of admission, results of pre-admission screening, admitting diagnoses, and final diagnoses; (f)Date of discharge, and condition on discharge; (g)Hospital discharge summaries or a transfer form from the attending physician; (h)Medical history, allergies, physical examination, diagnosis, prognosis and rehabilitation; (i)Vaccine history, if applicable, and other pertinent information about immune status in relation to vaccine preventable disease; (j)Current status of resident's condition; (k)Physician progress notes which shall be written at the time of observation to describe significant changes in the resident's condition, when medication or treatment orders are	L 201	Con't **Response to L099-3 (Dented Pans):** 1. Cited dented pans were purged on 8/17/15. 2. Monthly monitoring by management will prevent residents from having the potential to be affected by the same practice. 3. The following systemic change will be put in place to ensure the deficient practice will not recur. Sanitation manager will due monthly checks on pots and pans to ensure that dented pans are purged. Staff will be educated to bring any dented pans to management's attention. 4. The Chef, Sous, or manager on duty will monitor this daily to maintain compliance. The quality assurance process will be utilized to maintain and sustain 90% or above compliance. 5. Corrective action will be completed by 10/2/15.	10/2/15

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L 201	Continued From page 8 changed or renewed or when the resident's condition remains stable to indicate a status quo condition; (l)The resident's medical experience upon discharge, which shall be summarized by the attending physician and shall include final diagnoses, course of treatment in the facility, essential information of illness, medications on discharge and location to which the resident was discharged; (m)Nurse's notes which shall be kept in accordance with the resident's medical assessment and the policies of the nursing service; (n)A record of the resident's assessment and ongoing reports of physical therapy, occupational therapy, speech therapy, podiatry, dental, therapeutic recreation, dietary, and social services; (o)The plan of care; (p)Consent forms and advance directives; and (q)A current inventory of the resident's personal clothing, belongings and valuables. This Statute is not met as evidenced by: Based on record review and staff interview for one (1) of 27 sampled residents, it was determined that facility staff failed to document the treatment plan/instruction(s) for the care of Resident # 150 ' s wound post discharge from the facility.	L 201	**Response to L201 (3231.12) - Missing Wound Post Discharge Documentation:** 1. No further corrective actions for the resident found to have been affected by this deficient practice as the resident has been discharged This deficiency was noted and addressed by the Director of Nursing (DON) in staff meetings on August 28th, 31st, September 2nd and 4th. 2. Every resident having the potential to be affected by the same deficient practice will be identified on admission. Staff will be re-educated on documentation of identified pressure ulcers/wounds and documentation of education provided regarding the care of the wound. Case coordinators are to read and acknowledge notes regarding wound care documented by nursing staff, wound care nurses and physicians 3. The following systemic changes will be in place to ensure that the deficient practice does not recur: a. All pressure ulcers and wounds will be identified and documented on admission and documented in the daily nursing assessment b. The nurse who has identified the wound will notify the physician of the wound and that a wound care consult has been initiated c. Wound care education will be documented by nursing staff d. A list of residents with pressure ulcers/wound care will be added to the charge nurse shift report sheet.	

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L 201	Continued From page 9 The findings include: A review of the Clinical Notes revealed the following: · A review of a Nurses ' Progress Note dated May 11, 2015 revealed, " ...[sacrum] stage 2, lotion applied ... " · A review of a Nurses ' Progress Note dated May 12, 2015 revealed, " Patient seen for pressure ulcer assessment and care. Location: Right medial buttocks, at the edge of the sacrum, Stage II ... Assessment: small 1 x 0.5 s 0.1 cm stage II with clean red wound bed ...Plan of care and goals: Prevent further breakdown with use of a pressure reduction mattress and regular turning of patient. · A review of a Dietitian ' s Progress Note dated May 13, 2015 revealed, " ...Physical: Altered skin: ...Stage 2 on buttocks ... " A review of the " Pressure Ulcer Wound Care " order dated May 12, 2015 directed, " Three times daily and PRN [as needed], apply skin barrier cream to area after cleansing skin with disposable cleaning wipes. " A review of the " Discharge Instructions " dated May 12, 2015 lacked evidence that the patient and/or responsible party was provided a documented treatment plan/ instruction(s) on how to care for his/her sacral wound post discharge from the facility. A face-to-face interview was conducted on August 24, 2015 at approximately 3:30 PM with Employee #7. He/she acknowledged the findings. The record was reviewed on August 24, 2015.	L 201	Con't **Response to L201 (3231.12) - Missing Wound Post Discharge Documentation:** e. A list of residents on pressure ulcer/wound care treatment will be provided to case coordinators every Monday and shared during daily leadership meetings at 0815 weekdays. f. All residents undergoing pressure ulcer/wound care treatment will be updated in care plan meetings where the case coordinator is present. 4. Random chart audits of discharge notes of those residents who have required wound care will be completed by the quality nurses to ensure documentation of wound care instructions/education at time of discharge. Two Quality Compliance Coordinators will monitor performance through monthly random audits to ensure discharge notes of those residents who have required wound care are completed. The quality assurance process will be utilized to maintain and sustain 90% or above compliance. The findings will be presented at the quarterly meeting of the Renaissance Compliance & Quality Assurance Committee. 5. Corrective action will be completed by 9/30/15	9/30/15

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L 235	Continued From page 10	L 235	**Response to L236 (3236.4) – Water Temperatures Greater 110:** 1. The domestic hot water temperature to the 4 out of 12 rooms was reading above 110 degrees. The temperature was corrected on 8/21/15. The water was retested within 1 hour and met temperature requirements. 2. To address future water temperature variances, Plant Operations will conduct random water temperature checks to monitor compliance. 3. The following systemic change will be put into place to ensure the deficient practice will not recur: Plant Operations staff will perform monthly Environment of Care (EOC) rounds. The Nursing staff will conduct daily EOC checks on the water temperature. 4. The plan of correction will be integrated into the quality assurance system through environmental rounds and reporting to the EOC Committee. Environmental rounds are aggregated and monitored for deficient trends and correction measures are implemented as necessary. Plant Operations monitors the work order system for completion and satisfaction rates. Both measurements are reported quarterly to the Environment of Care Committee. 5. Corrective action was completed the 08/21/15	8/21/15
L 235	3236.4 Nursing Facilities The temperature of hot water of each fixture that is used by each resident shall be automatically controlled and shall not exceed one-hundred and ten degrees Fahrenheit (110 F) nor be less than ninety-five degrees Fahrenheit (95 F). This Statute is not met as evidenced by: Based on observations made on August 21, 2015 at approximately 3:15 pm, it was determined that the facility failed to maintain water temperatures in resident's rooms at an acceptable level as evidenced by elevated water temperatures in four (4) of 12 resident's rooms. The findings include: Water temperatures were greater than 110 degrees Fahrenheit in four (4) of 12 resident's rooms including room # 301, # 303, # 304, and # 321. These observations were made in the presence of Employee #3 and Employee #10 who acknowledged the findings.	L 235		
L 410	3256.1 Nursing Facilities Each facility shall provide housekeeping and maintenance services necessary to maintain the exterior and the interior of the facility in a safe, sanitary, orderly, comfortable and attractive manner.	L 410	**Response to L410-1 & 2 (3256.1) – Torn or Unattached Privacy Curtains:** 1. No direct impact identified to residents from this deficient practice. Curtains were reattached, replaced, repaired or added in rooms #304A, #311 A&B, #314B, #329 by 9/2/15. The areas were revisited on 9/12/15.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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) COMPLETE DATE
L 410	Continued From page 11 This Statute is not met as evidenced by: Based on observations made during an environmental tour of the facility on August 21, 2015 at approximately 3:15 PM, it was determined that the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. The findings include: 1. Privacy curtains were torn in two (2) of 12 resident's rooms including rooms #304A and # 311A. 2. Privacy curtains were not attached in three (3) of 12 resident's rooms (#311B, #314B, #329). 3. The grab bar located in the bathroom of room #314 was loose in one (1) of 12 resident's rooms. These observations were made in the presence of Employee #3 and Employee #10 who acknowledged the findings.	L 410	2. In order to prevent other residents from being affected by the same deficient practice staff have been reminded to place work orders for defective curtains in a timely manner. 3. The following systemic changes will be put in place to ensure the deficient practice will not recur: Curtains will be visually inspected during scheduled, quarterly Environment of Care (EOC) rounds. 4. The plan of correction will be integrated into the quality assurance system through quarterly scheduled environmental rounds. The nursing staff currently places work orders for defective curtains. 5. The corrective action was completed on 9/2/15. **Response to L410-3 (3256.1) – Loose Grab Bar:** 1. No direct impact identified to resident from this deficient practice. The loose hand rail was re-secured to the wall in room #314. 2. In order to prevent other residents from being affected by the same deficient practice Plant Operations staff will monitor unit for loose hand rails and fix as needed to stay in compliance. 3. The following systemic change will be put into place to ensure the deficient practice will not recur: Plant Operations staff will perform monthly Environment of Care (EOC) rounds. 4. The plan of correction will be integrated into the quality assurance system through environmental rounds and reporting to the EOC Committee. Environmental rounds are aggregated and monitored for deficient trends and corrective measures are implemented as necessary. Plant Operations monitors the work order system for completion and satisfaction rates. Both measurements are reported quarterly to the Environment of Care Committee. 5. The corrective action was completed on 8/21/15	9/2/15 8/21/15