PRINTED: 03/05/2008 FORM APPROVED STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING 095019 02/11/2008 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **5000 BURROUGHS AVE. NE GRANT PARK CARE CENTER** WASHINGTON, DC 20019 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (XS) COMPLETE DATE ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (EACH CORRECTIVE ACTION SHOULD BE CROSS OR LSC (DENTIFYING INFORMATION) REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG TAG L 000 L 000 Initial Comments An annual licensure survey was conducted on February 3 through 11, 2008. The following deficiencies were based on observations, record L 051 3210.4 Nursing Facilities reviews, and facility staff interviews. The sample 1. Resident #W4's PT/PTT/INR was repeated included 30 residents based on a census of 242 on 2/5/08, 2/6/08, 2/7/08 and 2/8/08. The MD residents on the first day of the survey and 32 was notified of laboratory results for all dates supplemental residents. listed and new orders were noted. 02/07/08 2. Chart reviews will be conducted on residents L 051 3210.4 Nursing Facilities L 051 receiving coumadin to ensure physician notification and follow through. 03/27/08 A charge nurse shall be responsible for the 3. Licensed nursing staff will be reeducated on PT/PTT/INR lab results and documentation. following: Laboratory requests will be reviewed daily by (a)Making daily resident visits to assess physical the Director of Nursing or designee as part of the nursing administration meeting to and emotional status and implementing any ensure all ordered labs have been drawn. required nursing intervention; Nurse Managers will QI monitor daily X 2 weeks and then weekly to ensure ordered (b) Reviewing medication records for completeness, 03/27/08 accuracy in the transcription of physician orders. PT/PTT/INR orders have been drawn. 4. Findings will be submitted to the Risk and adherences to stop-order policies; Management/Quality Improvement committee 03/27/08 monthly X 12 months. (c)Reviewing residents' plans of care for appropriate goals and approaches, and revising them as needed: 1. Resident W7 has been reassessed and an elopement care plan has been initiated. 02/09/08 (d)Delegating responsibility to the nursing staff for 2. A resident review will be conducted to direct resident nursing care of specific residents; identify residents at risk for elopement and to ensure care plans have been initiated and (e)Supervising and evaluating each nursing updated appropriately. 03/27/08 employee on the unit; and 3. Licensed nursing staff and non-licensed staff will be reeducated on elopement risk (f)Keeping the Director of Nursing Services or his or assessment, elopement prevention and the her designee informed about the status of residents.

Health Regulation Administration

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

resident, it was determined that

This Statute is not met as evidenced by:

Based on record review and staff interview for 14 of

30 sampled residents and three (3)supplemental

MINE (Sexte

place for resident safety.

monthly X 12 months.

elopement process. The nurse managers or

4. Results will be submitted to the facility Risk

Management/Quality Improvement committee

designee will QI monitor daily X 2 weeks, weekly X 4 weeks, then monthly to ensure new

admits are appropriately assessed for elopement risk and interventions are put in

(X6) DATE

03/27/08

03/27/08

PRINTED: 03/05/2008 FORM APPROVED

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(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(XQ) MULTIPLE CONSTRUCTION

(X3): DATE SURVEY COMPLETED

095019

A. BUILDING B. WING

02/11/2008

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

MDANT DARK CARE CENTER			RROUGHS AVE. NE STON, DC 20019			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGU OR LSC IDENTIFYING INFORMATION)	LATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS- REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XB) COMPLETE DATE	
L 051	the charge nurse failed to: notify the physicial PT/PTT/INR levels as ordered for one (1) resident that nursing interventions were implied to provide adequate supervision for one (1) who eloped, ensure that Dialysis communications were completed and initiate and/or up care plan with approaches and goals for one resident who refused showers, one (1) resident pain, one (1) resident for wandering, one (1) resident with a pacemaker, one (1) resident fluctuating weights, one (1) residents with dehydration, two (2) residents with weight of one (1) resident for anemia, one (1) resident the initial admission care plan, two (2) resident entitial admission care plan, two (2) resident and ensure that 10 residents were reweighed a change in weight. Residents W4, W7, 4, 13, 15, 17, 19, 20, 23, 24, 25, 26, 27 and W7 The findings include: 1. The charge nurse failed to notify the phys PT/PTT/INR levels as ordered for Resident a recent history of vaginal bleeding. A review of Resident W4's record revealed following physician's telephone orders: January 22, 2008 at 3:15, "Appointment so on Feb 1st @ 12:00 noon with [Doctor]. due bleeding @ [hospital name and address]". January 22, 2008 at 1800 [6:00 PM], "(1) liccoumadin to 7.5 mg PO QD due to INR of 1 drawn today 1/22/08. (2) Repeat PT/PTT/IN days, call MD with results". The consultation for vaginal bleeding was de February 1, 2008 and the assessment was	esident, emented resident eation odate the e (1) dent for) with changes, at after dents for fin and esidents; ed after 5, 7, 10, 11. sician of VV4 with the cheduled e vaginal ncrease 1,02 NR in 3	L 051	1. Resident #4 has been re-weighed and the weight has been documented on the weight record. The Dietitian has taken action to address weight loss/gain for this residents. 2. A record review will be conducted on residents that have experienced weight gain or loss to ensure resident weights have been taken and documented on the weight record. 3. Licensed nursing staff and Dieticians will be reeducated on when to re-weigh residents and document on the weight record. The Dietitian will QI monitor weekly weights to ensure that re-weights have been completed and documented. 4. Findings will be submitted to the Risk Management/Quality Improvement Committee monthly X 12 months. #4A 1. Resident #5's Dialysis communication forms have been completed to include medications administered in dialysis on 12/6/07, 12/13/07, 12/15/07, 12/20/07, 1/8, 1/10, 1/12, 1/15, 1/17, 1/19, 1/129 and 2/2/08. 2. A review of dialysis residents will be conducted to ensure dialysis communication forms are complete. Deficient forms will be returned to the Dialysis center for immediate correction. 3. Licensed nursing staff will be reeducated on effective dialysis communication as it relates to dialysis providing a complete listing of medications administered during dialysis. QI monitoring will be conducted by nurse managers/designee daily X 2 weeks, then weekly to ensure communication forms are completed property. 4. Findings will be submitted to the Risk Management/Quality Improvement committee monthly X 12 months.	03/27/08 03/27/08 03/27/08 03/27/08 03/27/08 03/27/08	
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(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION A. BUILDING

(X3) DATE SURVEY COMPLETED

095019

B. WING __

02/11/2008

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

5000 BURROUGHS AVE. NE

(X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS- REFERENCED TO THE APPROPRIATE DEFICIENCY) L 051 Continued From page 2 Postmenopausal bleeding. L 051 #4B 1. The care plan for refusal of showers was initiated on 2/8/08 for Resident #5.	(X6) COMPLETE DATE
Postmenonausal bleeding 1. The care plan for refusal of showers was	
The PT/PTT/INR was drawn on January 25, 2008.	02/08/08
The levels were as follows: PT- 30.2 [normal range 12.2-15.01] PTT - 41.6 [normal range 23.5 - 36] worksheets to determine if other residents have refused showers. Residents identified will have care plans initiated to address refusal of	
and INR - 2.77 [normal range 2.0 -3.0]. On January 25, 2008 the physician was not notified of the PT/PTT/INR results. There were no routine or standing orders for further PT/PTT/INR levels. 3. Nursing staff will be reeducated on the process of caring for residents that refuse showers and initiating care plans for refusal of showers. The unit managers will conduct reviews of ADL sheets to ensure that residents	03/27/08
A face-to-face interview was conducted with Employee #11 on February 8, 2008 at 10:15 AM. He/She stated, "Those are the evening supervisor's initials [written on the January 25, 2008] He/She stated, "Those are the evening who have refused showers have care plans and appropriate interventions in place. The Unit Manager, or designee, will QI Monitor daily X 2 weeks, weekly X 4 weeks and Monthly X	`
laboratory form]. The nurse would note on the lab [form] that the MD was made aware ". He/She acknowledged the absence of a notation on the lab acknowledged the absence of a notation on the lab acknowledged the absence of a notation on the lab acknowledged the absence of a notation on the lab acknowledged the absence of a notation on the lab acknowledged the absence of a notation on the lab acknowledged the absence of a notation on the lab acknowledged the absence of a notation on the lab acknowledged the absence of a notation on the lab acknowledged the absence of a notation on the lab acknowledged the absence of a notation on the lab acknowledged the absence of a notation on the lab acknowledged the absence of a notation on the lab acknowledged the absence of a notation on the lab acknowledged the absence of a notation on the lab acknowledged the absence of a notation on the lab acknowledged the absence of a notation on the lab acknowledged the absence of a notation on the lab acknowledged the lab ac	03/27/08
laboratory form of notification of the physician and no orders for further PT/PTT/INR levels. Committee for Review X 12 months.	03/27/08
A review of the record revealed that the physician was notified of all previous PT/PTT/INR levels and new orders for PT/PTT/INR levels were given at the time of notification. 1. Resident #7 has been discharged from the facility. 2. Nursing has conducted a review of residents who have complained of pain to	02/18/08
The physician wrote an order on February 4, 2008 as follows: "PT, PTT, INR in AM call MD/NP (Nurse Practitioner) with results ". The PT/PTT/INR levels were drawn on February 5, 2008. ensure that a pain management care plan has been initiated. 3. Licensed Nursing Staff and Interdisciplinary Care Team members will be reeducated on the facility Pain Management policy and how to thoroughly complete a pain assessment/	03/27/08
A nurse's progress note dated February 5, 2008 at 1:25 PM revealed, "Writer called NP and reported lab results PT - 76.6 PTT - 92.2 INR 9.21 - new orders given" observation and pain management care plans. The unit managers will QI Monitor pain management care plans to ensure care plans are effective and updated timely daily, M-F, X 2 weeks, weekly X 4 weeks, and monthly X	
12 months. 4. Results of the review will be submitted to the Risk Management/Quality Improvement Committee for Review X 12 months.	03/27/08



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED

095019

B. WING

02/11/2008

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NAME OF PROVIDER OR SUPPLIER GRANT PARK CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE					
			ROUGHS AY				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REC OR LSC IDENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS- REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE		
L 051	The physician's telephone order on Februa 2008 at 4:00 PM directed: "(1) Hold Counfurther notice (2) Give Vit K 10 mg IM x 1 for PT - 76.6, INR 9.21 called in from the Repeat PT/INR daily x 3 days. (4) Call NP before resuming Coumadin (5) Monitor for bleeding/bruising, if any bleeding noted, shospital (6) Monitor V/S (vital signs) q (ex x 3 days." There had been no evidence of vaginal bleeding from any other source since Jane 2008. The record was reviewed on Februar 2008. The charge nurse failed to ensure that interventions were implemented to provide adequate supervision for Resident W7 who cognitive impairment and eloped from the Resident W7's record revealed the following progress note: February 8, 2008 at 11:00 PM, "Resident of [facility] without the knowledge of staff. He found at [street name] by security staff and to [facility] at 10:30 PM. Resident was as writer. No visible injury observed at the timessessment. V/S (vital signs) T (temperate P (pulse) 89, R (respirations), BP (blood p 148/90" The resident was admitted to the facility of December 7, 2007. The nurse's admission progress note dated December 7, 2007 at included, "Alert, oriented to name, place a fine resident was ambulatory. According to the admission Minimum Data assessment, the resident was coded in Seconds.	nadin until dose now lab. (3) y/MD or end to very) shift eeding or uary 22, ary 8, nursing to had facility. In nurses' left e/she was d brought sessed by me of ture) 98.4, ressure) or end time."	L 051	1. The care plan for Resident #15 has been updated to reflect the discontinuation of the Ferrous Sulfate. The care plan has also been discontinued. 2. A review will be conducted on residents who have medications that are discontinued. The care plans for these residents will be reviewed to make appropriate updates. 3. The licensed nursing staff will be reeducated on identifying residents who have discontinued medications and updating care plans as needed. QI Monitoring daily X 2 weeks, weekly X 4 weeks and monthly X 12 months reviews by the nurse manager or designee to confirm compliance. 4. Findings from the review will be submitted to the Risk Management/Quality Improvement Committee for review X 12 months. #7 1. The Dietlitian has reviewed the medical record and the care plan for Resident #17 was updated on 3/8/08 to address the resident's weight gain. 2. A review will be conducted on residents experiencing significant weight gain to ensure care plans are updated to reflect weight gain. 3. The Dietlitians and Interdisciplinary Care Plan Team members will be reeducated on the development and implementation of care plans to address weight gain. The Dietitian will complete QI Monitoring weekly X 4 weeks and monthly X 12 months to ensure weight gains have been care planned. 4. Findings from QI Monitoring will be submitted to the Risk Management/Quality Improvement committee X 12 months.	02/08/08 03/27/08 03/27/08 03/08/08 03/17/08 03/27/08 03/27/08		
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STATEMENT OF DEFICIENCIES AND PI,AN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

(X3) DATE SURVEY COMPLETED

095019

A. BUILDING B, WING_

02/11/2008

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

SOOD BURROUGHS AVE NE

GRANT P	ARK CARE CENTER		ROUGHS A' TON, DC 20		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REG OR LSC IDENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS- REFERENCED TO THE APPROPRIATE DÉFICIENCY)	(XS) COMPLETE DATE
L 051	B, "Cognitive Patterns" as having short to memory problems and modified independency stills for daily decision-making; S "Physical Functioning and Structural Problems ambulating independently. A care plan dated December 8, 2007 incluproblem, "Resident has Cognitive Impairmevidenced by: Memory problems - short to impaired ability to make daily decisions." A nurse's progress note dated December 8, 330 PM included, "Resident alert but confidency by included by included, and will be going home today. At dialysis in removed the tubing from the graft before the could do so." The social service progress notes revealed following: December 8, 2007 at 11:30 AM, "He/she but exhibits slight confusion. He/she ambut independently He/she will be a long term secondary to need for supervision" January 1, 2008 at 2:50 PM, "Care confere on this date with resident and his/her [faminember] via phone. It was agreed that resort able to manage alone in his/her apt. the he/she will vacate his/her apt. and become term resident at [facility]." The "Incident/Accident" Report dated Feb 2008 included the following: "Resident's confident left [facility] without signing out. It stated that he/she was going to work. Reserturned at 10 by [facility] security. A&O (a oriented) x 2."	ded the ment as erm, 8, 2007 at tissed, e facility he/she he nurse of the e is alert culates in resident is erefore, e a long ruary 8, condition to PM Resident sident si	L 051	1. Resident #19 has been discharged from the facility. 2. Nursing will conduct a review of medical records to ensure care plans address the residents' current diagnoses. 3. Licensed nursing staff and Interdisciplinary Care Plan Team Members will be reeducated on the development of care plans with goals and approaches for residents with multiple medical problems. Nurse managers or designee wilf QI Monitor medical records daily, M-F, X 2 weeks, Weeldy X 4 weeks, and monthly X 12 months to ensure care plans appropriately address residents with multiple problems. 4. Results of the review will be submitted to the Risk Management/Quality Improvement Committee for Review X 12 months. #9 1. A care plan was initiated for Resident #20 to address wandering. 2. A review of records for residents exhibiting wandering behavior will be conducted to verify care plans are in place to address wandering behavior. 3. Licensed nursing staff will be reeducated on identifying wandering behavior and initiating care plans with appropriate goals and approaches. Nursing managers or designees will complete QI Monitoring daily X 2 weeks, weekly X 4 weeks and monthly X 12 months of residents identified as wanderers to ensure care plans are in place. 4. Findings from the QI Monitoring will be submitted to the Risk Management/Quality Improvement Committee for review X 12 months.	03/27/08 03/27/08 03/27/08 03/27/08 03/27/08
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Jun 14/05

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED

095019

B. WING

02/11/2008

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NAME OF PROVIDER OR SUPPLIER		5000 BURROUGHS AVE. NE					
GRANT P	ARK CARE CENTER	Washing					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REG OR LSC IDENTIFYING INFORMATION)	SULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS- REFERENCED TO THE APPROPRIATE DEFICIENCY)	(AS) COMPLETE DATE		
L 051	L 051 Continued From page 5		L 051	#10 1. A care plan was developed to address the			
	A face-to-face interview was conducted wi Employee #4 on February 8, 2008 at appro	oximately		pacemaker for Resident #24 on 2/18/08, 2. Nursing will conduct a review of residents with pacemakers to ensure an appropriate care	02/18/08		
temployee #4 on February 8, 2008 at appliance 12:00 PM. He/she stated, "[Resident] we was discharged but [he/she] wasn't taking medications and was readmitted. [He/she found near the subway station by a securiwho was riding by and though [he/she] locally familiar. [Security guard] called out his/he		[his/her] was ly guerd ked r name		plan is in place to address the device. 3. Nursing Staff and Interdisciplinary Care Plan Team members will be reeducated on ensuring care plans are in place for residents with pacemakers. Nurse managers and designee will conduct QI Monitoring daily X	03/27/08		
	and [resident] responded to [his/her] name There was no evidence that facility staff in	itiated		2 weeks, weekly X 4 weeks and monthly X 12 months to ensure residents with medical devices such as pacernakers have care plans			
interventions to increase the monitoring of W7, after identifying that the resident was cognitively impaired, confused and had she/she was "going home" prior to the relopement. The record was reviewed on 8, 2008.				in place. 4. Findings from the review will be submitted to the Risk Management/Quality improvement	03/27/08		
		sident's		Committee for review X 12 months. #11 1. The care plan for Resident #26 was	03/27/08		
	The charge nurse failed to update Resi care plan with goals and approaches after weight loss.			updated with new approaches. 2. Social services staff will complete review of charts on residents who have had aggressive behavior to ensure that care plans	02/10/08		
	A review of Resident #4's record revealed "Weight Record" which included the follow weights: August 15, 2007 - 148.2 pounds (lbs)			are current and that they show a progression of goals and intervention. 3. Social services staff will be reeducated on the importance of keeping care plans current	03/27/08		
	September 19, 2007 - 132 lbs October 10, 2007 - 143 lbs			and up to date. Social services will perform QI Monitoring of aggressive behavior care plans to ensure that they reflect current goals and approaches, daily, M-F, X 2 weeks, weekly X			
·	The resident's weight loss was 8.9% in Ser 2007 and weight gain of 9.2% in October 2	2007.		4 weeks, and monthly X 12 months. 4. Findings from QI Monitoring will be submitted to facility Risk Management/Quality	03/27/08		
The care plan included the problem, "Reside Risk for Aspiration Due to Resident Receiving Nutrition By: G/T (Gastrointestinal Tube) was		ring		Improvement committee monthly X 12 months.	03/27/08		
	March 16, 2007. One of the approaches in 3) Monitor weight q (every) month		a •				
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02/11/2008

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(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION

A. BUILDING

(X3) DATE SURVEY COMPLETED

095019

B. WING _______
STREET ADDRESS, CITY, STATE, ZIP CODE

	ROVIDER OR SUPPLIER	5000 BUR	ress, city, s' Roughs a '	VE. NE	
GRANIF	PARK CARE CENTER	WASHING	INGTON, DC 20019		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL RE OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS- REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETE DATE
L 051	Continued From page 6		L 051	#12	·
	and prn, report loss or gain of 5% to M.D. and I			A care plan to address Resident #27's fluctuating weight was initiated on 2/10/08. The Registered Dietitian will complete an	02/10/08
	The care plan was signed as last reviewe September 20, 2007 with an entry, "Feed		ı	review of residents that have experienced recent fluctuations in weight verify the weight problem has been care planned.	03/27/08
	unchanged." A face-th-face interview was conducted w	rith	1	The Dietitian and licensed nursing staff will be reeducated on how to create and implement	
	A face-to-face interview was conducted with Employee #11 on February 4, 2008 at 10:22 AM. He/She acknowledged that the care plan was not updated after the weight loss.			effective care plans for residents with fluctuating weights. QI Monitoring daily X 2 weeks, weekly X 4 weeks and monthly X 12 months will be conducted by the nurse	
The care plan was not updated to include weight loss or the recommended addition		of		managers to ensure care plans are in place for residents with fluctuating weights. 4. Results from the reviews will be submitted to	03/27/08
	DiabetaSource AC, at 5:00 AM initiated September 2007 to prevent weight loss. The record was reviewed on February 4, 2008.			the Risk Management/Quality Improvement Committee for review X 12 months.	03/27/08
	4. The charge nurse failed to ensure that communication forms were completed and a care plan for Resident #5 who frequent showers.	d develop		13 A. 1. The resident identified in this report as Resident W1 is Resident W2. Resident W2 has been seen by the psychiatrist on 2/7/08. Resident was placed on one to one monitoring	·
	A. A review of the resident's Dialysis			during waking hours (approximately 16 hours/day) X 1 week, until psychiatrist review	
	communication forms revealed the following			determined 1:1 no longer necessary for resident safety, instead resident to be	40.07.00
	The forms were not consistently complete medications administered at the dialysis center on the following dates:	ed for		monitored with frequent checks. 2. Social services staff will complete review of charts on residents who have had aggressive behavior to ensure that care plans are current	03/27/08
	December 6, 13, 15 and 20 2007. January 8, 10, 12,15,17,19, and 29 2008 and February 2, 2008. A face-to-face interview was completed with employee #13 on February 5, 2008 at approximately 10:45 AM. He she acknowledged that facility staff failed to ensure that the dialysis center completed the communication log for Resident # 5.			and that they show a progression of goals and intervention. 3. Social services staff will be reeducated on the importance of keeping care plans current	03/27/08
				and up to date. Social services will perform QI Monitoring of aggressive behavior care plans to	
				ensure that they reflect current goals and approaches, dally, M-F, X 2 weeks, weekly X 4 weeks, and monthly X 12 months. 4. Findings from QI Monitoring will be	03/27/08
	TOLONG () ET J.			submitted to facility Risk Management/Quality Improvement committee monthly X 12 months,	03/27/08

Juny 9/1/08

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (XZ) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A PUNDING B. WING 095019 02/11/2008 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **5000 BURROUGHS AVE. NE GRANT PARK CARE CENTER** WASHINGTON, DC 20019 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X1) COMPLETE DATE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PRFFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-OR LSC IDENTIFYING INFORMATION) REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG TAG L 051 L 051 Continued From page 7 The care plan for Resident W2 has been updated to include Warfarin and the B. On February 6, 2007 at 9:10 AM, Resident #5 discontinuation of Aspirin. 03/27/08 was observed in the doorway of his/her room crying 2. A record review of all residents at risk for out refusing his/her shower. increased bleeding was conducted by the nurse managers or designee to ensure care A face-to-face interview was conducted with plans were updated to reflect changes in Employee #13 on February 5, 2008 at 9:12 AM. physician orders for blood thinning agents. 03/27/08 He/She stated, "Resident) refuses showers. Today 3. The licensed nursing staff will be reeducated is his/her shower day. I told the CNA to give on identifying residents who are at risk for increased bleeding and updating care plans. him/her a bed bath. [Resident] doesn't like sitting following order changes for blood thinning on the chair. It's not showers, it's the chair. That's agents. QI Monitoring will be conducted daily it, it's not the bath. [Resident] said okay to the X 2 weeks, weekly X 4 weeks and monthly X 12 bath." Employee #13 acknowledged that there was months by the nurse manager or designee to no care plan developed for the resident's refusals of 03/27/08 confirm compliance. showers. 4. Findings from the review will be submitted to the Risk Management/Quality Improvement The Activities of Daily Living Care Records for Committee for review X 12 months. 03/27/08 September, October, November and December 2007 and January and February 2008 included two 14. (2) showers given to the resident, September 28, 1. Residents #4, #5, #10, #13, #17, #23, #24, 2007 and February 2, 2008. #25, #27 and W1 have been re-weighed and the weight has been documented on the weight A review of the record failed to show documented record. The Dietitian has taken action to evidence of development of a care plan with goals address weight loss/gain for these residents. 03/27/08 and approaches for the resident's refusal of 2. A record review will be conducted on showers. The record was reviewed on February 6, residents that have experienced weight gain or 2008. loss to ensure resident weights have been taken and documented on the weight record. 03/27/08 5. The charge nurse failed to develop a care plan 3. Licensed nursing staff and Dieticians will be for Resident #7 for the management of pain. reeducated on when to re-weigh residents and document on the weight record. The Dietilian A review of Resident #7's record revealed that the will QI monitor weekly to ensure that resident was admitted to the facility on February 1. re-weights have been completed and 2008. The History and Physical dated February 2. 03/27/08 documented. 2008 included the following diagnoses: Breast 4. Findings will be submitted to the Risk Cancer with metastasis, Chronic Obstructive Management/Quality Improvement Committee Pulmonary Disease, Pulmonary Embolus, Obesity, monthly X 12 months. 03/27/08 Diabetes Mellitus, Hypertension and Dyslipidemia.

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	The nurse's progress note [admitting note] dated February 1, 2008 at 2200 [10:00 PM] included, "Pt (patient) c/o (complained of) pain in the (Lt) rib cage and (Rt) shoulder. Pt on Morphine sulfate 15 mg for pain" The initial care plan dated February 2, 2008 included interventions checked for fall risk reduction and skin. Pain management was also included on the aforementioned care plan. However, no interventions were checked for pain management.						
	A face-to-face interview was conducted with Employee #11 on February 4, 2008 at 12:30 PM. He/She acknowledged that a care plan was not developed for pain management. The record was reviewed on February 4, 2008.						
		e failed to update Res r a change was made					
		e plan included the pro Resident currently take					
	A review of the physician's order form for February 2008 which was signed by the physician on February 1, 2008 did not include an order for an iron supplement. A consultation report from the pharmacist dated May 11, 2007 recommended: " D/C (discontinue) ferrous sulfate " . The Nurse Practitioner signed the consultation on May 18, 2007 and wrote " D/C Ferrous Sulfate " .		on .			·	
,						·	
	A face-to-face intervented Employee #15 on F	view was conducted w ebruary 4, 2008 at	ith			·	

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L 051	that the care plan wadiscontinuation of the was reviewed on Fe 7. Facility staff failed plan after changes in A review of the care a Therapeutic Diet and added salt) and low 10, 2007 included the Weigh q mo./prn (evencessary) - report of the "Weight Recorveights: October 1, 2007 - 18 November 1, 2007 - December 1, 2007 - January 1, 2008 - 20 The resident's weight 9% and 9.6% in January 1, 2008. However, the the changes in the rweight gain in November 1, 2007 - 100 the changes in the rweight gain in January 1, 2008. The charge nurse Resident #19. Resident #19 was a December 17, 2007	PM. He/She acknown as not updated to include Ferrous Sulfate. The bruary 5, 2008. It to update Resident # h his/her weight. plan problem, "Resist evidenced by: N.A. fat/cholesterol)" date following approach: rery month/whenever 5% loss/gain to M.D. at d' included the following approach: 210.3 210.4 la.1 Int gain in November 2 uary 2008. ast reviewed on Januare was no updates to esident's weight: 21.3 mber 2007 and a 7.7 pary 2008. failed to develop care admitted to the facility with diagnoses of ES	ded the erecord 417's care dent is on S (no ed October "4) and R.P. " wing 007 was ary 7, include pound cound e plans for on RD (End	L 051			
	Type 2), HTN (Hype	e), DM 2 (Diabetes Mortension), Glaucoma, Methicillin Resistant			n es		

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L 051	noted on the record for minimizing the riachieving a comfort were initiated for bodated February 4, 2 There was no evide and approaches we aforementioned diag. A face-to-face interventiony Employee #14 at approaches we reviewed on February 7, 2008. If were no care plans interventions for the was reviewed on February 7.	reus). Idated December 17, 2 This care plan was on the sk of skin impairment and bladder incont well and bladder well	checked and plans tinence th goals ith on that there The record e plan for	L 051			
	On February 4, 2008 at approximately 11:20 AM, Resident #20 was observed on the elevator and exiting on the first floor. When the elevator arrived at the first floor, the resident stepped off of the elevator. He/she was observed by facility staff and escorted back onto the elevator to be returned to the appropriate floor. A review of the psychiatric evaluation dated September 29, 2007 revealed, "Other Somatic Problems: Wandering- yes, within the facility " A review of the care plans last reviewed December 12, 2007 lacked evidence that a care plan was initiated with goals and approaches to						

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	address the resident's wandering behaviors. A face-to-face interview was conducted with Employee #14 on February 6, 2008 at 10:15 AM. He/she acknowledged that the care plan was not amended to address the residents wandering behavior. The record was reviewed on February 6, 2008.		rs.					
	10. The charge nurse failed to develop a care plan for Resident #24 who had a pacemaker.				· · · · · · · · · · · · · · · · · · ·			
	The History and Physical dated May 11, 2007 included, "S/P Pacemaker" The January 2008 physician order sheet, signed by the physician on January 4, 2008, included, "F/U (follow up) ICD (Internal Cardiac Defibrillator [pacemaker]) check in 3 months due 2/28/08"							
		ord fâiled to show docu relopment of a care pla	I					
	A face-to-face interview was conducted with Employee #15 on February 6, 2008 at 2:50 PM. He/She acknowledged that there was no care plan developed for the pacemaker. The record was reviewed February 6, 2008.							
	26's care plan with a	rse failed to update Re appropriate goals and resident's agitated beh						
	A review of the resident's record revealed the following nurses' notes: November 7, 2007 at 12:30 PM: "Resident remains alert and verbally responsive, noted with severe agitation"							
	November 22, 2007	at 0700 (7:00 AM): "R	Resident					

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	alert and verbally responsive. Severely agitated this [morning]. Cursing staff members and other residents."						
	November 25, 2007 at 2:25 PM: "Writer called to assess resident's behavior. Resident hit [another resident] on the head "						
	December 5, 2007 at 8:00 AM: "Resident alert and verbally responsive. Noted with agitation (calling residents and staff [names])attempting to hit staff/residents"						
	alert and verbally res	at 2:45 PM: "Resident sponsive. Noted with ter staff/residents to h	severe				
	alert and verbally red during this shift. Pull right side of the head	7 at 0600 (6:00 AM): "I sponsiveseverely a led Fire alarm, hit write dAtivan 1 ml IM nper [physician] ord	igitated er on the				
	November 25, 2007 "Resident was physi	plan problem dated J documented respecti ically abusive to staff sically abusive to othe	ively: and others				,
	November 5, 2007 a plan lacked evidence	eviewed on July 30 ar and January 21, 2008. e that goals and appro after each behavior inc	. The care oaches		-		
	Employees #4 and 1	riew was conducted w 15 on February 7, 200 PM. They acknowledg	8, at				
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L 051	Continued From page 13		L 051						
	the resident's care plan lacked the initiation of goals and approaches after each of the above cited behavior incidents. The record was reviewed on February 7, 2008.					·			
	12. The charge nurse failed to initiate a care plan for Resident #27's fluctuating weights.		are plan						
,	A review of Resident #27's record revealed the following weights according to the "Weight Record."				·				
	September 1, 2007 182.9 pounds October 1, 2007 179.1 November 1, 2007 199.9 January 2, 2008 165.6								
	progress note, the re 2007 was 192 poun	cember 11, 2007 dieta esident's weight in De ds. Re-weights were i etician in the Decembe ss note.	cember nitially						
·		nce that a care plan wand approaches to add g weights.					4		
	A face-to-face interview was conducted with Employee #13 on February 5, 2008 at 3:15 PM. He/she acknowledged that there was no record of re-weights. The record was reviewed February 5, 2008.								
	13. Facility staff failed to update Resident W1's care plan after he/she physically assaulted two (2) residents and after a change in the medication regimen.								
		dent W2' s record reve in the annual Minimu							

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L 051	Continued From pag			L 051			
	Data Set (MDS) dated May 19, 2007: Diabetes Mellitus, Congestive Heart Failure, Hypertension, Peripheral Vascular Disease, Missing limb, Schizophrenia and Glaucoma. The record included the following nurse's progress notes:						
	December 13, 2007 said writer by the ac staff reported to him resident [Resident S 12/11/07 in the ever Spoke with resident the resident from the stated that he slappinformed to notify so he has this type of p money to other resident ade aware. To F/I notify them. Will sughis behavior. Resid signs) taken at this t	at 8:15 AM, "It was retivity director that one that this resident hit at approximating shift at approximathis AM in bed, he stated him. The resident omeone in charge the problem and also not to dents. Social worker to J with MD and attorned gest psych consult to the entrefused to have Vime, was awaken up to the total worker progress not all worker progress not	of his another on tely 7 PM. ated that He was next time o give o be evaluate /S (vital by writer."				
	2007 at 9:00 AM dire monitor behaviors". On December 24, 20 psychiatric Nurse Prorder, "Psychiatric SBID - Agitation ". To documentation of a December 24, 2007. A review of the Behaviors of the Behaviors and the serious control of the serious control	avior Data Collection f	the Howing O.5 mg de				

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L 051	1 Continued From page 15			L 051.	,			
	residents. Patterns: pattern. Duration: f problem leads to restests, procedures). difficulties in dealing Intervention: Redirect intervention: Do not money - Effectivene Medication for treatr Risperdal 0.5 mg Bll Nurse's progress no January 31, 2008 at	abuse towards staff a Frequency: Unpredi ew moments. Behavi sistance to care: yes (Behavior problem cau with people & coping ct resident to appropri veness: Still being mo t confront residents or ss: Still being monitor ment of behavior symp D - Date started 12/24 tes revealed the follow 3:00 P, "Reported to	ctable, no or Refusing ises in facility. ate conitored. give them red. ctoms: L/07."					
	face. Charge nurse Social Worker for po	in [room #] [Resident to F/U. Will notify ME essible relocation to an al of these episodes"), RP and nother					
		5:30 PM, "Resident rhitting a resident in hhis way"						
	A physician's telephone order dated January 31, 2008 at 5:15 PM revealed, "Psych evaluation Stat upon return to facility for aggressive behavior". There was no documentation of a psychiatric consult found in the record after January 31, 2008.		ation Stat vior " tric					
	The care plan dated May 19, 2007 and last reviewed on January 31, 2008 revealed the problem "Resident has moods that are easily altered by staff interventions as evidenced by: Repetitive anxious concerns regarding schedules and things occurring with other residents". Some of the approaches listed were as follows: "1.							

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	resolve the issue. 2 participate in activiti- interventions that ar- resident's mood [th- listed]. 4. Documen record [there were noted towards others done members need emediscuss resident's bi- interventions listed i effective in altering the state of	then they are upset and the courage resident es. 3. Inform all staff of the effective in altering the effective in altering the effective in altering the effective in interventions in the condition interventions documed the effect of the ef	to of the the tions clinical nented] ault ly ce to ere no ould be				
	physically assaulted physically assaulted	Resident S4 and sub	sequently				
	increase bleeding R	/T (related to) Blood T 24, 2007 and last revie	hinning	·		·	
	The physician order included, "Warfarin a fibrillation".	sheet for October 200 2.5 mg 1 tab po daily f	07 for atrial	-			
	The most recent physician order sheet dated February 2008 and signed by the physician on February 1, 2008 included, "November 4, 2007 [origination date], Warfarin 2 mg 1 po daily for A-Fib." Aspirin was not included on this order sheet. A face-to-face interview was conducted with Employee #15 on February 6, 2008 at 2:50 PM. He/She acknowledged that the care plan was not updated to include Warfarin and discontinuation					· .	
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	of Asprin. The record was reviewed on February 6, 2008. 14. The charge nurse failed to ensure that 10 residents were reweighed as per the facility policy. Residents 4, 5, 10, 13, 17, 23, 24, 25, 27 and W1. The "Nursing Procedure Manual" revised October 2005 included, "Weights. Purpose: To maintain accurate information about weight change7. Note weight reading. If a weight change is noted, reweigh the resident/patient to verify accuracy before reporting Record weight on the Weight Record. Report weight changes to nursing supervisor"			l		•		
						`		
	A. A review of the "#4 revealed the follo September 19, 2007 October 10, 2007 - 1	- 132 pounds (lbs)	Resident			·		
	There was no reweig 2007.	ght entered for Octobe	er 10,					
	A face-to-face interview was conducted with Employee #11 on February 4, 2008 at 10:22 AM. He/She acknowledged that there was no reweight after an 11 pound weight loss. The record was reviewed on February 4, 2008.		22 AM. eweight	ı 				
	B. A review of the "\revealed the following	Weight Record" for R	esident #5					
	March 1, 2007 - 88.8 lbs March 19, 2007 - 81.6 lbs May 16, 2007 - 82.5 lbs May 24, 2007 - 76.6 lbs June 2007 - 88.7 lbs July 2007 - 104 lbs							

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L 051	record. A face-to-face interployee #5 on File/She stated, "Comonth, they are greenerate a sheet the 10th they [diet He/She acknowle done. The record 2008. C. A review of Record" revealed June 18, 2007 - 22 July 30, 2007 - 22 July 30, 2007 - 22 There was no evic resident in the record acknowledged that resident in the record resident resident in the record resident r	93.6 lbs 93.6 lbs 7 - 97.4 lbs 83.6 lbs 7 - 88.2 lbs 105.8 lbs dence of reweights on the erview was conducted with the erview was conducted with the erview was reweights are done for the erview was for a reweight did that they were nown as reviewed on February 4, 2008. He/litt there was no reweight or d. The record was reviewed was conducted with the erview was conducted with the erview was reviewed was r	with 00 AM. for the d they v around at. " reweights uary 6, Veight the with She at for the eviewed on	L 051				

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	There was no evidence of a reweight on the weight record. A face-to-face interview was conducted with Employee #15 on February 4, 2008 at 10:10 AM. He/She acknowledged that there was no reweights for the resident in August or September 2007. The record was reviewed on February 4, 2008. E. A review of Resident #17's "Weight Record " revealed the following: May 2007 - 209.8 lbs June 2007 - 189.2 lbs October 1, 2007 - 189 lbs November 1, 2007 - 210.3 lbs December 1, 2007 - 210.4 lbs January 1, 2008 - 218.1 lbs						
ŧ							
		nce of reweights on th 7, November 2007 an					
	Employee #15 on Fe He/She acknowledg done for the aforeme	view was conducted webruary 5, 2008 at 11: ged that reweights wer entioned months. iewed on February 5,	:20 AM. re not			·	
	F. A review of Resid Revealed the followi	dent #23's "Weight Re ing:	ecord"				
	July 1, 2007 - 204.5 August 1, 2007 - 198 September 1, 2007 - October 1, 2007 - 19 November 1, 2007 - December 1, 2007 - January 1, 2007 - 20	9.0 lb - no weight recorded 90.6 lb - 206.1 lb - 182.6 lb					
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L 051	Continued From pag	ge 20		L 051			
	There was no evider aforementioned date	nce of re-weights for t es.	he				
	Employee # 23 on F approximately 9:00 had asked the nurse	view was conducted w February 11, 2007 at AM. He/she stated th es to reweigh the resid e record was reviewed	at he/she dent but it				
	G. A review of Resident #24' s "Weight Record " revealed the following: December 1, 2007 - 169.5 lbs January 1, 2008 - 179.6 lbs		Record "				
	There was no evider 2008.	nce of a reweight for .	January				
	Employee #15 on Fe approximately 2:00 I a reweight was not o	view was conducted w ebruary 6, 2008 at PM. He/She acknowl done for January 2008 d on February 6, 2008	edged that 8. The				
	H. A review of Resid revealed the followin April 2007 - 175.5 lb May 2007 - 165.5 lb December 1, 2007 - January 1, 2008 - 17	os es - 160.7 lbs	ecord "				
,	There was no evider record for May 2007	nce of reweights on th and January 2008.	ne weight				
	Employee #15 on Fe approximately 2:00 I a reweight was not o	riew was conducted w ebruary 6, 2008 at PM. He/She acknowl done for May 2007 an as reviewed on Februa	edged that d January	·	·		
			i				1

	TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 095019 IAME OF PROVIDER OR SUPPLIER STREI		BER: A. BUILDING			(X3) DATE SURVEY COMPLETED		
			,	B. WING	·	02/11	1/2008	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	ATE, ZIP CODE	•		
GRANT P	ARK CARE CENTER			RROUGHS AVE. NE GTON, DC 20019				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REC NTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE	BE CROSS-	(X5) COMPLETE DATE	
L 051	Continued From pag	ge 21		L 051		_		
	I. A review of Resident #27 's record revealed the following weights according to the "Weight Record" September 1, 2007 - 182.9 pounds October 1, 2007 - 179.1 November 1, 2007 - 199.9 January 2, 2008 - 165.6				,			
	According to the December 11, 2007 dietary progress note, the resident's weight in December 2007 was 192 pounds.							
	Dietary progress notes were written on September 28, October 31, November 11, and December 11, 2007. Re-weights were initially requested by the dietician in the December 11, 2007 dietary progress note.							
	weighed in October,	nce that the resident v November or Decem ewed February 5, 200	ber 2007.					
	J. A review of Resid revealed the followir September 1, 2007 October 1, 2007 - 12	- 119.6 lbs	ecord "					
	There was no evider record for October 2	nce of a reweight on the 007.	he weight			. ,		
	Employee #15 on Fe approximately 2:00 la reweight was not of	iew was conducted webruary 6, 2008 at PM. He/She acknowledone for October 2007 ewed on February 6, 2	edged that 7.					
			•					

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/OF IDENTIFICATION NUMB		(X2) MULTIF A. BUILDING B. WING	· -	(X3) DATE SUF COMPLETE		
		095019				02/11	1/2008	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE					
GRANT P	ARK CARE CENTER			ROUGHS AV				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REC ENTIFYING INFORMATION)	GULATORY	ID PREFIX . TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD B REFERENCED TO THE APPROPRIATE DE	BE CROSS-	(X5) COMPLETE DATE	
L 052	Continued From page	ge 22		L 052				
L 052	3211.1 Nursing Fac	ilities		L 052	L 052 3211.1 Nursing Facilities			
	resident to ensure the receives the following (a) Treatment, medicular supplements and fluorehabilitative nursing (b) Proper care to micontractures and to (c) Assistants in daily resident is comfortate evidenced by freedot trimmed nails, and cohair;	ng: cations, diet and nutriti uids as prescribed, and	ional d s and of ulcers: to that the s eaned and roomed		#1 1. Resident #5 PT/PTT/INR was dr 3/10/08. The physician's order has clarified and the PT/PTT/INR lab will every 6 months. 2. A record review will be conducte residents with PT/INR labs to ensur been drawn as requested by the ph labs are present on the chart and pl taken action to address abnormal la 3. The nursing staff will be reeduca to follow PT/PTT/INR orders. The r managers or designee will QI monit 2 weeks, then weekly, PT/INR orde residents on blood thinning agents to compliance. 4. Findings from QI monitoring will submitted to the Risk Management/Improvement committee monthly X	been II be drawn d on e labs have ysician, hysician has ab values. ated on how nurse or daily X rs for to verify be //Quality	03/10/08 03/27/08 03/27/08	
	care and group active (f)Encouragement a	and assistance to:			#21. Resident #7 has been discharged from the facility.2. A review of medical record will be conducted on new admissions to ensure			
	(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		e; and		medications administered had/have order in place prior to administration 3. Licensed nursing staff will be recobtaining a physicians order prior to administration. The nurse manager designee will QI monitor daily X 2 was the X 4 was to the proof of the control	n. educated on o medication is or reeks, then	03/27/08	
	 (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 				weekly X 4 weeks, then monthly X 1 the medical record and MARs to encompliance. 4. Findings will be submitted to the Management/Quality Improvement of monthly X 12 months.	sure Risk	03/27/08	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		095019		B. WING		02/1	1/2008		
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	DRESS, CITY, STATE, ZIP CODE					
GRANT P	ARK CARE CENTER			RROUGHS AVE. NE GTON, DC 20019					
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIATE DE	(X5) COMPLETE DATE			
L 052	including oral acre; a j)Prompt response to help. This Statute is not not a sased on record rev (3) of 30 sampled re (1)supplemental resifacility staff failed to monitored as ordere physician's order primedication for one (insulin per physician Residents 5, 7, 22 a The findings include 1. Facility staff failed International Normal the physician. According to the Not Form signed by the 2007, directed, "PT/INR laboratore record for November evidence in the record laboratory studies we According to the Dec Form, signed by the	ded, with daily hygiend and o an activated call bell onet as evidenced by: liew and staff interview sidents and one ident, it was determined ensure that PT/INR led for two (2) residents or to administration of 1) resident and adminits orders for one (1) rend S5. I to monitor Resident idea Ratio (INR) as or wember 2007 Physician on November T1/INR q week." Tory values were present 12, 2007. There was red that additional PT/ere drawn for November 2007 Physician on December 2007 Physician physician on December 2007 Physician physician on December was included: "	v for three ed that evels were c; obtain a a ister esident. # 5's rdered by an's Order er 4, ant in the s no PTT/INR per 2007. an's Order per 9,	L 052	#3 1. The sliding scale for Insulin Novohas been clarified by the physician of insulin is being administered correct Resident #22. 2. A review of sliding scale orders we conducted by the nurse managers to insulin is administered in accordance physician's order. 3. Licensed nurses will be reeducate medication administration, clarification physician orders and the proper admost insulin. The nurse managers will medical records and MARs for residus sliding scale to verify compliance da 2 weeks, weekly X 4 weeks and more thereafter. 4. Findings from the reviews will be to the Risk Management/Quality Imprommittee monthly X 12 months. #4 1. The PT/PTT/INR for Resident S5 drawn as ordered by the physician. 2. A review of residents on coumadic conducted to ensure requests for PT are drawn per physician order. 3. Licensed nursing staff will be ree PT/PTT/INR lab results and docume Nurse Managers will QI monitor daily weeks and then weekly to ensure or PT/PTT/INR orders have been draw 4. Findings will be submitted to the Management/Quality Improvement of monthly X 12 months.	order the ly to vill be or ensure e with the ed on on of ininistration QI monitor ents on ily X onthly submitted provement or will be T/PTT/INR ducated on intation. Y X 2 dered in. Risk	03/27/08 03/27/08 03/27/08 03/27/08 03/27/08 03/27/08		
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		(X1) PROVIDER/SUPPLIER/IDENTIFICATION NUMB			PLE CONSTRUCTION	(X3) DATE SUI COMPLET			
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		095019	CTREET ARR	DECC CITY CT/	ATE ZID CODE	02/1	1/2008		
NAME OF PE	ROVIDER OR SUPPLIER			RESS, CITY, STA					
GRANT F	PARK CARE CENTER			5000 BURROUGHS AVE. NE WASHINGTON, DC 20019					
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES FBE PRECEDED BY FULL REG INTIFYING INFORMATION)	GULÁTORY	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE ACTIC REFERENCED TO THE APPI	N SHOULD BE CROSS-	(X5) COMPLETE DATE		
L 052	PT/PTT/INR results was no evidence in was obtained on De A face-to-face intervence in the Employee #13 on Fapproximately 10:45 that the resident's In ordered. This record 2008. 2. Facility staff faile physician's order for and order a pain metimely for Resident #7 A. Facility staff faile physician's order for Resident #7 was ad 1, 2008. The nurse dated February 1, 2 following: "Patien (lower left) rib cage Morphine Sulfate 15 for breakthrough pamg two tabs was given According to the Met (MAR), Tylenol 500. February 1, 2008. Tadministration of Tylenol 500.	at # 5's record revealed for December 12, 200 the record that the PT cember 3, 2007. View was conducted webruary 5, 2008, at 5 AM. He / She acknow R was not monitored I was reviewed February 5 at 10 to ensure that there Tylenol prior to administration from the phate of the pain. Tyle of the prior pain" Indication Administration from the phate of the pain" Indication Administration from the phate of the pain"	or. There r/PTT/INR with the wledged as ary 5, was a nistration rmacy was a nistration n February s note ded the n the LL atient on be ask [ed] anol 500 on Record given on ed for the	L 052					
	·	-							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER				A. BUILDING	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		095019		B. WING		02/1	1/2008	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	ATE, ZIP CODE			
GRANT P				ROUGHS AV TON, DC 20				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTION REFERENCED TO THE APPRO	SHOULD BE CROSS-	(X5) COMPLETE DATE	
L 052	Continued From pag	ge 25		L 052				
	B. Facility staff faile timely for Resident #	d to order a pain med ‡7.	ication					
	A review of the admission orders dated February 1, 2008 included, "MS Contin 15 mg po (by mouth) Q (every) 12 h (hours) "							
		with Resident #7 on F ned that the MS Conti rmacy						
	A face-to-face interview was conducted with Employee #11 on February 4, 2008 at approximately 10:00 AM. He/She stated, "The nurse said that he/she sent the C2 (controlled medication prescription) on Friday (February 1, 2008) and again on Sunday (February 3, 2008). I need to find the fax [confirmation] form. The Morphine was delivered on Sunday [February 3, 2008] at 4:30 PM."							
	5, 2008 at approxima "He/She [nurse] said	again interviewed on ately 2:30 PM and sta d she didn't send it [C2 ewed on February 4, 2	ted, 2] Friday."					
		d to administer insulin physician's orders for		,				
	The January 2008 physician orders signed by the physician on December 31, 2007 revealed, "Sliding Scale: Check blood sugar [BS] 201-250= 2 units, 251-300= 5 units, 301-350=7 units, 351-400=10 units, greater than 400= 12 units and call MD, If BS < 60 or > 400 call MD "				·			
	A review of the Janu	ary 2008, MAR revea	led the					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X2) MULTIF	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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NAME OF PR	OVIDER OR SUPPLIER			RESS, CITY, STA				
GRANT F	ARK CARE CENTER			ROUGHS AV				
(X4) ID PREFIX TAG.	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REC NTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTION REFERENCED TO THE APPRO	SHOULD BE CROSS-	(X5) COMPLETE DATE	
L 052	administered- the rephysician was notified January 14- blood standinistered January 16 - blood standinistered January 19-blood standinistered January 30-blood standinistered January 30-blood standinistered A review of the January 2008 Insulin Novolin accordance with the physician's order. A face-to-face interve Employee #14 on February 4 and Februa	sugar reading = 436, cord lacked evidence	that the 2 units 2 units units units units d nd 30, en in ith 15 AM. s not ician's lary 6, IR blood lident S5. I a 2008)" ts e record for	L 052				

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		095019		B. WING	<u> </u>	02/1	1/2008	
NAME OF PR	ROVIDER OR SUPPLIER		STREET ADD	PRESS, CITY, STA	ATE, ZIP CODE	VAI :	1/2000	
GRANT P	PARK CARE CENTER			ROUGHS AVE. NE STON, DC 20019				
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY			ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-			
L 052	Continued From page 27			L 052				
	Employee #13 on February 8, 2008 at 10:45 AM. He/she stated, "It just wasn't done." The record was reviewed February 8, 2008.							
L 054	facilities of thirty (30) more shall not include Services or any other who is not providing This Statute is not in Facility staff failed to at 3.5 nursing hours. The findings include The "Nursing Daily Swith Employee #4 for The number of nursing were as follows: Date February 3, 2008 February 4, 2008 February 5, 2008 February 6, 2008 February 6, 2008 Facility staff failed to nursing hours per refour (4) days reviewed A face-to-face intervicenducted on February Conducted on February 1 in February Conducted on February Con	ments of subsection 3) licensed occupied be de the Director of Nurser nursing supervisor of direct resident care, met as evidenced by: maintain nursing staff per resident per day. e: Staffing" sheets were or February 3, 4, 5, and ing hours per resident Nursing Hours 3.37 3.4 3.3 3.6 comaintain nurse staffiresident per day for three	eds or sing employee	L 054	L 054 3211.3 Nursing Facilities 1. Facility will maintain minimum starequirements. 2. Facility will review staffing at daily meeting to ensure staffing is meeting standards. Facility will increase bas pay for PRN staff in an effort to enhance recruitment efforts. 3. Nursing staffing coordinator and managers will be reeducated on mass taffing requirements and how to cald adily staffing hours. Facility will revidaily Stand Up meeting to ensure the is meeting minimum requirement. Facility will be advertising for vacant positions and holding weekly oriental staffing is stabilized. 4. Findings from daily staffing meeting submitted to facility Risk Management Improvement Committee monthly X	y Stand Up g minimum ee rate of ance unit ndated lculate ew during at staffing t nursing ations until ing will be ent/Quality	03/17/08 03/17/08 03/27/08 03/27/08	
L 100	3219.2 Nursing Faci	ilities		L 100				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		095019		B. WING		02/1	1/2008		
NAME OF PE	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	ATE, ZIP CODE				
GRANT F	PARK CARE CENTER			RROUGHS AVE. NE GTON, DC 20019					
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY				ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS- TAG REFERENCED TO THE APPROPRIATE DEFICIENCY)				
L 100	Each facility shall enemployees who are carry out the function. This Statute is not in Based on observation review, it was determensure sufficient cerpresent in the dietar of operations and cocooking vessels were observations were in Employees #1, 2, and 3:40 PM. The findings include 1. Facility staff to enhandler was present during hours of oper Upon initiation of the February 3, 2008 at a certified food servithe dietary department. The dietary department of the February 3 are certified food servithe dietary department. The dietary scheduler reviewed. Employee review, "We have twow. One works from 12:30 in when the kitchen closure of the february in the dietary department of the february in	inploy sufficient food so competent and qualifins of the dietary servinet as evidenced by: on, staff interview and mined that the facility of tified food handlers way department during to impetent staff to ensure properly sanitized and in the presence of 8 on February 3, 20 minutes that a certified for in the dietary department ation. The inspection of the kitomatic and personnel record the stated at the time wo certified food hand in 5:30 in the morning the afternoon until 8 coses. We are training but [he/she] has not the result of the stated.	record failed to vere he hours are that These of 2008 at cood ment chen on mined that resent in	L 100	L 100 3219.2 Nursing Facilities #1 1. A certified food handler is presendietary department during hours of of the certified food handlers on staff areplaced following resignation/terminemployment to prevent other reside being affected. 3. The Assistant Food Services Direvamp the daily schedule to clearly certified food handler present on easix members of the dietary department been scheduled to attend a safe food and sanitation course. 4. The Food Services Director shall review the schedule weekly to ensure certified staff member reported for easischeduled. Copies of the weekly shall be submitted to the Risk Mana Quality Improvement committee on basis for review and comment. #2 1. Employee #5 has been trained oproperly sanitize cooking vessels. 2. Pots and pans were rewashed as sanitized. 3. Food Services staff shall be reed the proper sanitation of cooking vessels. 2. Pots and pans were rewashed as sanitized. 3. Food Services Director or his/her deshall conduct reviews daily X 2 week the proper sanitation of cooking vessels. 2. Y 4 weeks, then monthly X 12 month three (3) compartments sink station staff compliance with sanitation guid 4. Copies of the review shall be su the Risk Management/Quality Improcommittee each month for review X	peration. I ensure are nation of ints from ector shall reflect the ch shift. ent have id handling review/ re a each shift reviews gement/ a monthly In how to ind properly ducated on sels. The esignee eks, weekly hs, of the to verify delines. bmitted to ovement	03/20/08 03/20/08 03/27/08 02/03/08 02/03/08 03/21/08 03/27/08		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/ NO PLAN OF CORRECTION IDENTIFICATION NUMBER			A. BUILDIN	PLE CONSTRUCTION .	(X3) DATE SU COMPLET				
		095019	•	B. WING_		02/1	1/2008		
NAME OF PE	ROVIDER OR SUPPLIER		STREET ADDI	DDRESS, CITY, STATE, ZIP CODE					
GRANT F	PARK CARE CENTER			ROUGHS A' TON, DC 21					
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	ATEMENT OF DEFICIENCIES I BE PRECEDED BY FULL RE ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRES (EACH CORRECTIVE ACTION SHOUL) REFERENCED TO THE APPROPRIATE	BE CROSS	(XS) COMPLETE DATE		
L 100	asked when he/she took the course, Employee #6 stated, "I took the course some time in 2004 or 2005. It's been a couple of years." 2. Facility staff failed to ensure that competent staff was available to ensure that cooking vessels were properly sanifized. On February 3, 2008 at 3:15 PM, it was observed that litmus paper to test the pH of the sanifizer was not immediately available to Employee #5, who was washing cooking vessels at the three (3) compartment sink. After locating litmus paper, Employee #5 was not able to state the color the litmus paper should be when the sanifizing water was tested or the concentration of the sanifizer in the water (parts per million). Employee #5 acknowledged that he/she had not participated in training that covered this information. Employee #5 stated that he/she had been working at the facility about one (1) year.			L 100					
L 108	forty-five degrees (4 foods shall be above degrees (140°F) Fai to the resident. This Statute is not a Based on observation determined that facilitoods at 45 degrees hot foods at 140 F or The findings include A test tray was conditioned.	r cold foods shall not e 5°F) Fahrenheit, and e one hundred and for hrenheit at the point of met as evidenced by: ons of a test tray, it wan lity staff failed to serve Fahrenheit (F) or below above.	for hot rty f delivery is c cold ow and	L 108	L 108 3220.2 Nursing Facilities 1. Tray line temperatures are being at proper temperatures. 2. Tray line temperatures were of beginning, middle and the end of service to ensure safe temperature food services department will take temperatures three times weekly units to ensure compliance. 3. The food services and nursing reeducated on the importance of resafe temperatures and serving for after the food trucks arrive on the nursing units. The Food Services designee will QI monitor daily X 2 weekly to ensure compliance. 4. Findings from the QI Monitoring submitted to the Facility Risk Man Quality Improvement committee manual properties.	necked at the the meal es. Facility edelivery on the nursing staff will be naintaining od to residents managers or weeks, then g will be agement/	02/05/08 /2/05/08 /2/08		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIDENTIFICATION NUMBER				(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		095019		B. WING		02/11/2008			
NAME OF PR	ROVIDER OR SUPPLIER			RESS, CITY, ST					
GRANT F	PARK CARE CENTER			ROUGHS AV TON, DC 20					
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES FBE PRECEDED BY FULL REG NTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-				
L 108 L 109	recorded: rice - 130. 47.7 F and strawber 47.4 F. 3220.3 Nursing Faci	1 F, orange juice - 54 ry whipped topping de	essert -	L 108	L 109 3220.3 Nursing Facilities 1. A listing of alternate foods approved				
	of comparable nutrit same mealtime. This Statute is not rought of the statute in the		ered at the ew and / staff ar There was ffered on with PM dents. and is in the ese, viches. " ith PM ailable to ok chooses eat, a getable utes are		Registered Dietitian has been included menu for each meal offered to reside 2. A review of weekly menus posted throughout the facility was conducted Food Services Director to ensure alto food choices are listed and the signal Registered Dietitians approval was particular and the Food Services Director importance of including a listing of a foods for each meal offered on the national Food Services Director or Registere shall QI monitor daily X 2 weeks, the reviews of the daily alternates offered meal substitutes of similar nutritional offered to the residents. 4. Copies of the weekly reviews shall submitted to the Risk Management of Improvement committee on a month review X 12 months.	led on the ents. ed by the ernates ature of the cresent. Itian will be nenu. The d Dietitian en weekly ed to ensure I value are Quality	02/03/08 02/03/08 03/27/08		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		095019		B. WING		02/1	1/2008	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDI	RESS, CITY, STA	ATE, ZIP CODE			
GRANT P	ARK CARE CENTER			RROUGHS AVE. NE GTON, DC 20019				
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY				ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS- TAG REFERENCED TO THE APPROPRIATE DEFICIENCY)			
L 161	Continued From pag			L 161				
· L 161	3227.12 Nursing Fac	cilities		L 161	L 161 3227.12 Nursing Facilities			
	Each expired medication shall be removed from usage. This Statute is not met as evidenced by: Based on observations of the facility's medication storage areas, it was determined that expired medications were not removed from the emergency box. The findings include: On Wednesday, February 6, 2008, at approximately 1:00 PM, during the inspection of the facility's medication storage areas, the Emergency Box #5S				1. Emergency box on 5 South was a with a current Emergency Medicatio Pharmacy. 2. Review of emergency medication current dates has been completed. 3. Licensed nurses reeducated on cemergency medication boxes expiral Third shift nurses will check emergenightly to ensure it is in date. Nurse will QI monitor emergency medication monthly X 12 months. 4. Findings of the QI monitoring will reported to the Risk Management/Q Improvement committee X 12 months.	n Box by n boxes for checking tion dates. ncy box Managers on boxes be uality	03/07/08 03/27/08 03/27/08	
L 168	3227.19 Nursing Facilities			L 168	L 168 3227.19 Nursing Facilities 1. Undated multi-dose vials were di and reordered. 2. Multi-dose medication vials were and any opened, undated vials were	reviewed	02/6/08	
	The facility shall label drugs, and biologicals in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and their expiration date. This Statute is not met as evidenced by:				and reordered. 3. Licensed nurses reeducated on comulti-dose vials when opened. The nurses are responsible for checking vials for dating nightly. Nurse manamonitor dating of multi-dose vials daweeks, weekly X 4 weeks, and then	dating third shift multi-dose gers will QI ily X 2	03/27/08	
	medication carts and determined that the	ons for six (6) of eight d staff interview, it was facility staff failed to d dose medication vials	ate and	٠.	12 months. 4. Findings of the QI monitoring will reported to the Risk Management/QI Improvement committee X 12 month	be uality	03/27/08	

		(X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUMB			PLE CONSTRUCTION	(X3) DATE SU COMPLE	
				A. BUILDING B. WING	<u> </u>		•
<u> </u>		095019		D. WING		02/1	1/2008
NAME OF PR	OVIDER OR SUPPLIER			RESS, CITY, ST			
GRANT F	PARK CARE CENTER			ROUGHS AV TON, DC 20			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES • (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATO OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTION REFERENCED TO THE APPRO	SHOULD BE CROSS-	(X5) COMPLETE DATE
L 168	Continued From page 32			L 168			
	first opened.						
	The findings include	e:					
	PM and 4:30 PM and between 9:00 AM at	oruary 5, 2008, between and Thursday, Februar and 12:00 PM, the med ors were inspected on	y 6, 2008, dication				
,	The facility staff failed to date and initial opened multi-dose medication vials. The medication included:						
	3N -Xalatan ophthalmic drops, two (2) vials 3S - Xalatan ophthalmic drops, four (4) vials						
	4N - Foradil Aerolie	r, one (1) vial					
	5N -Xalatan ophthal 5S - Foradil Aerolier	lmic drops, four (4) via r, one (1) vial	als				
		19 and 20 acknowled e were not dated and eservations.					
L 179	3229.1 Nursing Fac	ilities		L 179			
	and maintain the hig mental, and psycho- resident.	wide social services to ghest practicable phys social well-being of ea met as evidenced by:	sical,				
	Based on record revinterviews for seven facility staff with a hi and/or inappropriate and/or staff and illici	view and staff and res (7) of 11 residents id- istory of assaultive, ago behaviors towards re it drug use, it was dete ed to provide appropri	entified by ggressive esidents ermined				

XNHI11

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General or B

(X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B WING 095019 02/11/2008 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **5000 BURROUGHS AVE. NE GRANT PARK CARE CENTER** WASHINGTON, DC 20018 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX MPI,ETE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS OR LSC IDENTIFYING INFORMATION) REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG TAG L 179 L 179 Continued From page 33 L 179 3229.1 Nursing Facilities #1 three (3) residents who physically assaulted 1. Resident W2 was placed on "Line of sight" residents and/or staff, one (1) resident for one on one monitoring X 3 days, until inappropriate sexual behaviors, three (3) residents psychiatric evaluation and clearance. A care for drug use, and five (5) residents for verbal conference was held with resident, his quardian aggression. Residents W2, #26, #2, 3, S1, S2 and and the ombudsman to address resident's **S4**. behavior and voluntary entry into an anger management program. Resident W2 agreed to The findings include: enter an anger management program on 2/27/08 02/27/08 1. Facility staff failed to implement appropriate 2. Facility has reviewed residents with social service interventions for Resident W2 after abusive/aggressive behavior to determine he/she physically assaulted two (2) residents. if they need to be reassessed and evaluated for new interventions and treatment protocols. 03/27/08 A review of Resident WZ's record revealed the 3. Facility social services staff will be following diagnoses in the annual Minimum Data re-educated on behavior Management Crisis Set (MDS) dated May 19, 2007; Diabetes Mellitus. Escalation. Facility will develop library of Congestive Heart Failure, Hypertension, Peripheral periodicals and magazines that will assist in Vascular Disease, Missing limb, Schizophrenia and education of staff that target aggressive Glaucoma. behaviors in LTC setting. Social services will utilize the following approaches to address The record included the following nurse's progress residents who display abusive/aggressive December 13, 2007 at 8:15 AM, "It was reported to a. Social Services will meet with the family and solicit the family's support in encouraging the said writer by the activity director that one of his resident to enroll in an appropriate anger staff reported to him that this resident hit another resident [Resident \$4] from the 2nd floor on management program. b. Arrange psych referrals for residents with 12/11/07 in the evening shift at approximately 7 PM. a history of aggressive behavior when there is Spoke with resident this AM in bed, he stated that a change in the resident's mood or behavior. the resident from the 2nd floor took his \$4. He Social Services staff will establish weekly stated that he slapped him. The resident was One to One visits with the resident to discuss informed to notify someone in charge the next time any mood or behavior issues that might trigger he has this type of problem and also not to give aggressive behavior and perform basic "Touch money to other residents. Social worker to be Therapy" made aware. To F/U with MD and attorney (RP) to d. Social Workers will work with resident and notify them. Will suggest psych consult to evaluate family to identify community based group his behavior. Resident refused to have V/S (vital housing, assisted living, or independent living signs) taken at this time, was awaken up by writer." arrangements that would be suitable for the There were no social worker progress notes after resident's care needs. 03/27/08 this incident. 4. Social Services staff will QI monitor resident records with abusive/aggressive behaviors

daily M-F X's 2 weeks, weekly X's 4 weeks.

and monthly X's 12 months,

03/27/08

		(X1) PROVIDER/SUPPLIER/G IDENTIFICATION NUMB			PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		095019		B. WING		02/1	1/2008		
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, ST	ATE, ZIP CODE	, , , ,			
GRANT P	ARK CARE CENTER			RROUGHS AVE. NE GTON, DC 20019					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENȚIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD B REFERENCED TO THE APPROPRIATE DE	(X5) COMPLETE DATE			
L 179	2007 at 9:00 AM dire monitor behaviors". On December 24, 20 psychiatric Nurse Prorder, "Psychiatric SBID - Agitation". The documentation of a poecember 24, 2007. A review of the Behavior: See below physical abuse towar Patterns: Frequency Duration: few mome resistance to care: yprocedures). Behavior dealing with people Intervention: Redirection of the Effectivenes Medication for treatmers in the Effectivenes Medication f	none order dated Dece ected, "Psych cons 007, eleven days later actitioner wrote the form Service Start Risperda he record did not inclu- psychiatric consult for avior Data Collection for revealed the following w. Behaviors(s): Verb ards staff and resident y: Unpredictable, no pents. Behavior proble yes (Refusing tests, ior problem causes di le & coping in facility. It resident to appropri veness: Still being mo- confront residents or ss: Still being monitor nent of behavior symp D - Date started 12/24 tes revealed the follow 3:00 P, "Reported to in [room #] [Resident to F/U. Will notify MD essible relocation to ar al of these episodes" 5:30 PM, " Resident hitting a resident in h	wing:	L 179	#2 1. We are seeking a support group Resident #2 manage his anger. Psy has evaluated resident to assist with of behavior treatment plan. 2. Social Services staff will review is sexual behavior, inappropriate exponsitation behavior incidents to deter facility social services staff has applied addressed and implement intervential address behaviors. 3. Social Services staff will be re-eximportance of addressing resident is behavior, inappropriate exposure, a behaviors and implementing interversacility social services staff will commonitoring daily X 2 weeks, weekly and monthly X 12 months for resided display sexual behavior, inappropriate exposure, agitation behavior to ensiappropriate interventions and action in place to address this behavior. 4. Findings from QI Monitoring will submitted to Facility Risk Managem Improvement Committee monthly X	rchiatrist in initiation resident resid	02/15/08 03/21/08 03/21/08		
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(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

(X3) DATE SURVEY COMPLETED

095019

A. BUILDING B. WING_

02/11/2008

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

5000 BURROUGHS AVE. NE

DATE OF THE CONTRIBUTION OF LIST DEPCHANCES OF LIST	COANT DADY CADE CENTED			INGTON, DC 20019			
A physician's telephone order dated January 31, 2008 at 5:15 PM revealed, "Psych evaluation Stat upon return to facility for aggressive behavior." There was no documentation of a psychiatric consult found in the record after January 31, 2008. The care plan dated May 19, 2007 and last reviewed on January 31, 2008 revealed the problem "Resident has moods that are easily aftered by staff interventions as evidenced by. Repetitive anxious concerns regarding schedules and things occurring with other residents." Some of the approaches listed were as follows: "1. Listen to resident when they are upset and by to resolve the issue. 2. Encourage resident to participate in advisibles. 3. Inform all staff of the interventions that are effective in altering the resident possible on by resident. 7. Family members need emergency care conference to discuss resident's behavior." There were no interventions listed in the care plan that would be effective in altering the resident's mood. Social services progress note revealed the following: There was no social service progress note following the December 2007 incident. February 1, 2008 at 6:30 AM, "Progress Note: Resident seem by a CNA hitting a fermale resident finamed in the face. According to nuise, heishe hit [resident] behavior and staff of the interventions and action plans are in place to address this behaviors and action plans are in place to address this behavior. 4. Findings from QI Monitoring daily X 2 weeks, weekly 4 weeks and monthly X 12 months for residents whool display aggressive behavior to ensure that appropriate interventions and action plans are in place to address this behavior. 5. Social Services staff will complete QI Monitoring daily X 2 weeks, weekly 4 weeks and monthly X 12 months for residents whool department of any assault towards others done by resident. 7. Family members need emergency care conference to discuss resident? behavior and proposed to a discussion of the proposed to a discussion of the proposed to a discussion of the proposed to a	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGU	AATORY	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-	(X5) COMPLETE DATE	
CORD K DOWGHOD ACTIONSTISTON		A physician's telephone order dated Janua 2008 at 5:15 PM revealed, "Psych evaluat upon return to facility for aggressive behavior There was no documentation of a psychiatric consult found in the record after January 31. The care plan dated May 19, 2007 and last reviewed on January 31, 2008 revealed the "Resident has moods that are easily aftered interventions as evidenced by: Repetitive a concerns regarding schedules and things owith other residents". Some of the approachisted were as follows: "1. Listen to reside they are upset and try to resolve the issue. Encourage resident to participate in activitie inform all staff of the interventions that are of in altering the resident's mood [there were interventions listed]. 4. Document intervent documented] 6. Notify the police departriany assault towards others done by resident Family members need emergency care conto discuss resident's behavior" There we interventions listed in the care plan that wore effective in altering the resident's mood. Social services progress note revealed the following: There was no social service progress note to the December 2007 incident. February 1, 2008 at 6:30 AM, "Progress No Resident seen by a CNA hitting a female re [named] in the face. According to nurse, he [resident] because he/she was in his/her was police were called and arrested him/her	rry 31, tion Stat lor " ric I, 2008. I, 2008. I problem d by staff anxious accurring thes end then 2. I ses 3, effective end tions in ons ment of nt. 7. Inference were no uld be following the: I stident estident estate hit	L 179	 Resident 26 has been enrolled in Day Break program beginning 3/19/08. Social Services staff will review resident behavior incidents to determine if facility social services staff has appropriately addressed and implement interventions to address aggressive behaviors. Social Services staff will be re-educated on importance of addressing resident behaviors and implementing interventions. Facility social services staff will complete QI Monitoring daily X 2 weeks, weekly X 4 weeks and monthly X 12 months for residents who display aggressive behavior to ensure that appropriate interventions and action plans are in place to address this behavior. Findings from QI Monitoring will be submitted to Facility Risk Management/Quality 	03/21/08 03/21/08	

NAME OF PROVIDER OR SUPPLIER GRANT PARK CARE CENTER SITERET ADDRESS, CITY, STATE 2IP CODE SOD BURROUGHS AVE. NE MASHINGTON, DC 20019 PROVIDERS NAME CORRECTION OR LISC IDENTIFYING INFORMATION) L 179 Continued From page 36 The incident occurred on the evening 1/31/08." February 4, 2008 at 10:20 AM. "Resident returned to [facility] on the evening of 2/1/08. Charges were not filed after the hearing. He/She was counseled re. his/her behavior and it was explained that if he/she hit/s another the police will be called." A face-to-face interview was conducted with Employee #14 on February 7, 2008 at 9:45 AM. He/She stated. "It he social worker spoke with him/her, so Isocial worker] had a 1:1 with [resident]. We talked to [resident] and he other resident. The last incident [resident] and he other resident. The last incident [resident] and he other resident. The last incident [resident] and be content of the social worker spoke with he/She stated. "It has been quiet." A face-to-face interview was conducted with Resident W2 on Pebruary 6, 2008 at 9:02 AM. Resident W2 on Pebruary 6, 2008 at 9:02 AM. Resident W2 on Pebruary 6, 2008 at 9:02 AM. Resident W2 on Pebruary 6, 2008 at 9:02 AM. Resident W2 on Pebruary 6, 2008 at 9:02 AM. Resident W2 on Pebruary 6, 2008 at 9:02 AM. Resident W2 on Pebruary 6, 2008 at 9:02 AM. Resident W2 on Pebruary 6, 2008 at 9:02 AM. Resident W2 on Pebruary 6, 2008 at 9:02 AM. Resident W2 on Pebruary 6, 2008 at 9:02 AM. Resident W2 on Pebruary 6, 2008 at 9:02 AM. Resident W2 on Pebruary 6, 2008 at 9:02 AM. Resident W2 on Servary 8, 2008 at 9:02 AM. Resident W2 on Servary 8, 2008 at 9:02 AM. Resident W2 on Servary 8, 2008 at 9:02 AM. Resident W2 on Pebruary 8, 2008 at 9:02 AM. Resident W2 on Servary 8, 2008 at 9:02 AM. Resident W2 on Pebruary 8, 2008 at 9:02 AM. Resident W2 on Servary 8, 2008 at 9:02 AM. Resident W2 on Pebruary 8, 2008 at 9:02 AM. Resident W2 on Pebruary 8, 2008 at 9:02 AM. Resident W2 on Servary 8, 2008 at 9:02 AM. Resident W2 on Servary 8, 2008 at 9:02 AM. Resident W2 on			(X1) PROVIDER/SUPPLIER/OIDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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WASHINGTON, DC 20019 CALL TO SUMMARY STATEMENT OF DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY ON LGC DENTIFYING INFORMATION DREFFIX TAG PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-PREFIX AGE OF THE APPROPRIATE DEFICIENCY OF LGC DENTIFYING INFORMATION DREFFIX TAG PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-PREFIX AGE OF THE APPROPRIATE DEFICIENCY DREFFIX TAG 1. Resident #3 was evaluated by psychiatrist on March 3, 2008 to address sexual behavior, inappropriate exposure, agitation and oppositional behavior. Care plan session was held with resident and responsible party to discuss interventions and appropriate placement of resident. The last incident free social worker spoke with him/her, so [social worker] had a 1:1 with [resident] We talked to [resident] and the other resident. The last incident [resident] and an other resident. The last incident [resident] and an other resident. The last sedent W2 on February 6, 2008 at 20.0 PM. He/She stated, "I don't want to takk to you. I don't know why everybody wants to come and see me. You all need to leave me alone". A face-to-face interview was conducted with Resident W2 on February 8, 2008 at 9:02 AM. Resident W6 on February 8, 2008 at 9:02 AM. Resident W6 on February 8, 2008 at 9:02 AM. Resident W6 on February 8, 2008 at 9:02 AM. Resident W6 on February 8, 2008 at 9:02 AM. Resident W2 asked bother the incident. He/She stated, "I was more frightened and was caught off guard. [Resident W2] asked me to move and I didn't [move] fast enough. I took one roll backward [in my wheelchair]. [Resident W2] said he wanted me to move up. I didn't move where he/she wanted and [Resident W2] threw his/her punch, it just brushed my cheek. [Resident W2] steam before the he/she came by	NAME OF PR	OVIDER OR SUPPLIER	Ţ	STREET ADD	RESS, CITY, STA	ATE, ZIP CODE		
L 179 Continued From page 36 The incident occurred on the evening 1/31/08." February 4, 2008 at 10:20 AM, "Resident returned to [facility] on the evening of 2/1/08. Charges were not filed after the hearing. He/She was counseled re: his/her behavior and it was explained that if he/she hits another the police will be called." A face-to-face interview was conducted with Employee #14 on February 7, 2008 at 9:45 AM, He/She stated. "The social worker spoke with him/her, so [social worker] had a 1:1 with [resident]. We talked to [resident] and the other resident. The last incident [resident] spoke with has been quiet." A face-to-face interview was conducted with Resident W2 on February 6, 2008 at 2:00 PM. He/She stated, "I off want to talk to you. I don't know why everybody wants to come and see me. You all need to leave me alone". A face-to-face interview was conducted with Resident W6 on February 8, 2008 at 9:02 AM. Resident W6 was asked about the incident. He/She stated, "I off was more frightened and was caught off guard. [Resident W2] asked me to move and I didn't [move up. I didn't move where he/she wanted me to move up. I didn't move where he/she wanted and [Resident W2] attempted to kink the wheelchair and it tilted on one wheel. [Resident W2] pulled hisher fist back and he/she was going to hit me. When [Resident W2] three hisher punch, it just brushed my cheek. [Resident W2] three hisher punch, it just brushed my cheek. [Resident W2] three hisher punch, it just brushed my cheek. [Resident W2] three hisher punch, it just brushed my cheek. [Resident W2] three hisher punch, it just brushed my cheek. [Resident W2] three hisher punch, it just brushed my cheek. [Resident W2] three hisher punch, it just brushed my cheek. [Resident W2] three hisher punch, it just brushed my cheek. [Resident W2] three hisher punch, it just brushed my cheek. [Resident W2] three hisher punch, it just brushed my cheek. [Resident W2] three hisher punch, it just brushed my cheek. [Resident W2] three hisher punch, it just brushed my che	GRANT P	ARK CARE CENTER						
The incident occurred on the evening 1/31/08." February 4, 2008 at 10:20 AM, "Resident returned to [facility] on the evening of 21/108. Charges were not filed after the hearing. He/She was counseled re: his/her behavior and it was explained that if he/she hits another the police will be called." A face-to-face interview was conducted with Employee #14 on February 7, 2008 at 9:45 AM. He/She stated, "The social worker spoke with him/her, so [social worker] had a 1:1 with [resident]. We talked to [resident] spoke with Employee #3. [Resident] has been quiet." A face-to-face interview was conducted with Resident IV2 on February 6, 2008 at 2:00 PM. He/She stated, "I don't want to talk to you. I don't know why everybody wants to come and see me. You all need to leave me alone". A face-to-face interview was conducted with Resident W6 on February 8, 2008 at 9:02 AM. Resident W8 mas asked about the incident. He/She stated, "I was more frightened and was caught off guard. [Resident W2] asked me to move and I didn't [move] fast enough. I took one roll backward [in my wheelchair]. [Resident W2] aid he wanted me to move up. I didn't move where he/she wanted and [Resident W2] attempted to kick the wheelchair and it tilled on one wheel. [Resident W2] pulled his/her fist back and he/she was going to hit me. When [Resident W2] threw his/her punch, it just brushed my cheek. [Resident W2] started yelling and screaming at me. Since then he/she came by	PREFIX	(EACH DEFICIENCY MUST	T BE PRECEDED BY FULL REG		PREFIX	(EACH CORRECTIVE ACTION SHOULD BI	E CROSS-	COMPLETE
	L 179	The incident occurred February 4, 2008 at to [facility] on the even not filed after the here: his/her behavior he/she hits another to he/she hits another to he/she hits another to he/she stated, "The him/her, so [social we we talked to [resider last incident [resider [Resident] has had resident where has been quiet." A face-to-face interved Resident where to heave to he was as stated, "I was more guard. [Resident who as stated, "I was more guard. [Resident who has had resident who he he has had resident who had	ed on the evening 1/31 10:20 AM, "Resident vening of 2/1/08. Chartering. He/She was coand it was explained to the police will be called view was conducted with ebruary 7, 2008 at 9:4 e social worker spoke vorker] had a 1:1 with lent] and the other resident] spoke with Employeno problems since. [Review was conducted with bruary 6, 2008 at 2:00 by wants to come and size me alone". View was conducted with the was conducted with a come and size me alone with a composite was conducted with a co	returned rges were ounseled that if ed." with 15 AM. with [resident]. dent. The ee #3. Resident] with PM. I don't see me. with the leady off and I backward e wanted wheelchair pulled hit me. it just d yelling came by	L 179	 Resident #3 was evaluated by ps on March 3, 2008 to address sexual inappropriate exposure, agitation an oppositional behavior. Care plan se held with resident and responsible p discuss interventions and appropriate placement of resident. Social Services staff will review to behavior incidents to determine if fassocial services staff has appropriate addressed and implemented interve to address behavior. Social Services staff will be reed importance of addressing resident be and implementing interventions. Fassocial services staff will complete QI Monitoring daily X 2 weeks, weekly and monthly X 12 months for reside aggressive behavior to ensure that a interventions and action plans are in address behavior. Findings from QI Monitoring will be submitted to Facility Risk Manageme Quality Improvement Committee money in the properties of the province o	behavior, ad ession was earty to te resident cility social ely entions ucated on ehaviors cility I X 4 weeks nts who disp appropriate n place to	03/21/08 olay 03/21/08

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L 179	didn't report it. I pre W2's] way. I'm alres comfortable around been in other situatic [facility] should have those other incidents. The record was revired. Facility staff failer social service intervents he/she physically and resident, exhibited subserved smoking in A review of the resident, exhibited subserved smoking in A review of the resident, exhibited subserved smoking in A review of the resident, exhibited subserved smoking in A review of the resident with a subserved smoking in A review of the resident will assisting resident of writer using in abusive to staff but September 21, 2007 front of writer using in abusive to staff but September 21, 2007 held today with [resident today with	efer to stay out of [Residedy scared. I don't feel him/her. [Resident Williams before me. I feel to stepped up to the plats happened." estepped up to the plats happened." estepped up to the plats happened." ed to implement approprentions for Resident and verbally assaulted sexual deviant behavior manijuana in the facility dent's record revealed estes: 1900, "Resident alert a erbailty abusive to staff dent in [resident] room. 7 at 2130, "Resident profanity such as MI ut still kept abusing ver to at 9:30 AM, "A meetident] R/T [related to] iff andresidents" at 1400, "Report given at the resident was obsort Nursing] smoking magnetic states and smoking magnetic states are stated to smoking magnetic states and smoking magnetic states are stated as a smoking magnetic states are stated as a smoking magnetic states.	they atte when 2008. I they atte when 2008. I they atte when 2008. I priate IZ after staff and or and was y. If the and I members in" It was inFerbally" Iting wassexual in to writer served by earijuana and was last m sick and	L 179	1. Resident S1 has qualified for socioenefits and the facility will assist restransitioning to a more appropriate lein the community. The resident's call updated to address verbal and physiaggressive behaviors and drug use on the community of the resident's language of the charts on residents who have had in inappropriate behavior. 2. Social services staff will complete charts on residents who have had in inappropriate behavior related to alcoholic abuse or drug abuse to ensure that interventions are put in place to addresident behavior. 3. Social services staff and nursing streeducated on importance of early a interventions when residents exhibit inappropriate behavior. Reeducation cover various types of interventions is could implement to monitor residents. Services staff will QI Monitor residents Services staff will QI Monitor residents. Services staff will QI Monitor residents who have exhibited inappropriate be related to alcohol or drug abuse to dimerventions are being implemented immediately appropriately, daily, M-F weeks, weekly X 4 weeks, and montal 12 months. 4. Findings from the QI Monitoring wireported to the Risk Management/Qt Improvement committee for Review X 12 months.	sident in evel of care plan was sical on 2/19/08, ed by this e review of estances of cohol estaff will be and timely en will also that staff is. Social intrecords ehavior determine if a fight of the chart of the c	
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STREET ADDRESS, CITY, STATE, 2P CODE SOOD BURNOUTHS AVE. IN WASHINGTON, DC 20019 L 179 CAND GEACH DEPTICATION WITH GENERAL DE SOOD BURNOUTHS AVE. IN GEACH DEPTICATION WITH GENERAL DE SOOD BURNOUTHS AVE. IN GEACH DEPTICATION WITH GENERAL DE SOOD BURNOUTH OF LANGUAGE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) L 179 Continued From page 38 November 27, 2007 at 10.45 AM, "Resident in front of lobby threatening CNA I'm going to fet your a fire d. Security withessed the incident" December 23, 2007 at 10.30 AM, "Another resident [complained] that resident hit his/her [wheelchair] to the residents [wheelchair] and his / her [wheelchair] to the residents [wheelchair] and his / her [wheelchair] light came off" December 26, 2007 at 2.00 PM, "Resident stated to writer that [resident] dislike CNA [Certified Nursing Assistant], Resident stated to nurse that I'm going to hit [him/her] face" January 23, 2008 at 5.30 PM, "Residenton elevator with [a staff] prior to going to his/her support group. [Resident grabbed the staff by the arm and pulled him/her [Resident was very aggressive with this staff person" A review of the social worker's notes revealed the following: September 21, 2007, "Meeting with Resident along with DON, Nurse Manager and the Executive Director. Complaint from Nursing staffresident's verbal abuse, exposing self to staff and general sexual devant behavior" November 9, 2007 at 8:30AM. "Resident was observed smoking marijuana in the patio 11/8/07Police warned resident and the possibility of going to jail. This writer offered to arrange drug treatment forhowever [resident refused" November 29, 2007 at 10:20 AM, "MDS review:Monitored for behavior and drug use"			095019				02/1	1/2008	
SOUR BURNOUGHS AVE., NE WASHINGTON, DC 20019 PREFIX CACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY ON LSC IDENTIFYMO INFORMATION) TAGO	NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, ST.	ATE, ZIP CODE			
L 179 Continued From page 38 November 27, 2007 at 10.45 AM, "Resident in front of lobby threatening CNAI'm going to Fyou up, I'm going to get your afired. Security witnessed the incident" December 23, 2007 at 10.30 AM, "Another resident [complained] that resident hit his/her [wheelchair] light came off" December 26, 2007 at 2.00 PM, "Resident stated to writer that [resident] silke CNA [Certified Nursing Assistant]. Resident stated to nurse that I'm going to hit [him/her]face" January 23, 2008 at 5.30 PM, "Residenton elevator with [a staff] prior to going to his/her support group. [Resident grabbed the staff by the arm and pulled him/her[Resident was very aggressive with hits staff person" A review of the social worker's notes revealed the following: September 21, 2007, "Meeting with Resident along with DON, Nurse Manager and the Executive Director. Complaint from Nursing staffresident 's verbal abuse, exposing self to staff and general sexual deviant behavior" November 9, 2007 at 13.30AM: "Resident was observed smoking marijuana in the patio 11/8/07Police warned resident and the possibility of going to jail. This writer offered to arrange drug treatment forhowever [resident resident reside	GRANT F	ARK CARE CENTER							
November 27, 2007 at 10:45 AM, "Resident in front of lobby threatening CNAI'm going to Fyou up, I'm going to get your afired. Security witnessed the incident" December 23, 2007 at 10:30 AM, "Another resident [complained] that resident his/her [wheelchair] to the resident's [wheelchair] and his / her [wheelchair] tight came off" December 26, 2007 at 2:00 PM, "Resident stated to writer that [resident] dislike CNA [Certified Nursing Assistant]. Resident stated to nurse that I'm going to hit [him/her]face" January 23, 2008 at 5:30 PM, "Residenton elevator with [a staff] prior to going to his/her support group. [Resident grabbed the staff by the arm and pulled him/her[Resident was very aggressive with this staff person" A review of the social worker's notes revealed the following: September 21, 2007, "Meeting with Resident along with DON, Nurse Manager and the Executive Director. Complaint from Nursing staffresident's sverbal abuse, exposing self to staff and general sexual deviant behavior" November 9, 2007 at 8.30AM: "Resident was observed smoking marijuana in the patio 11/8/07Police warned resident rand the possibility of going to jail. This writer offered to arrange drug treatment forhowever [resident refused" November 29, 2007 at 10:20 AM, "MDS review:Monitored for behavior and drug use"	PREFIX	(EACH DEFICIENCY MUST	BE PRECEDED BY FULL REG	GULATORY	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD B	BE CROSS-	(X5) COMPLETE DATE	
	L 179	November 27, 2007 of lobby threatening I'm going to get your the incident" December 23, 2007 [complained] that rethe resident's [whee light came off" December 26, 2007 writer that [resident] Assistant]. Resident to hit [him/her]face January 23, 2008 at elevator with [a staff support group. [Resiarm and pulled him/aggressive with this A review of the sociafollowing: September 21, 2007 along with DON, Nu Director. Complaint verbal abuse, expossexual deviant behallowed by the sociation of the sociation	at 10:45 AM, "Resided CNAI'm going to For afired. Security with at 10:30 AM, "Another sident hit his/her [whe dichair] and his / her [whe dislike CNA [Certified estated to nurse that I'm" 5:30 PM, "Resident" 5:30 PM, "Resident" 5:30 PM, "Resident" 5:30 PM, "Resident" at worker's notes reveal worker's no	er resident selchair] to wheelchair] of Nursing m going on her ff by the ery aled the sident Executive esident 's eneral was 11/8/07 ty of going treatment "	·	1. Resident S2's care plan has bee with new interventions that address aggressive behavior and alcohol or 2. Social Services staff will review behavior incidents to determine if fa services staff has appropriately add implement interventions to address 3. Social Services staff will be reeimportance of addressing resident I and implementing interventions. Fa services staff will complete QI Moni X 2 weeks, weekly X 4 weeks and r X 12 months for residents who disp aggressive behavior to ensure that interventions and action plans are in address this behavior. 4. Findings from QI Monitoring will submitted to Facility Risk Management in the staff of th	his/her drug abuse. resident acility social dressed and behaviors. ducated on behaviors acility social itoring daily monthly appropriate n place to	03/21/08	

AND PLAN OF CORRECTION IDENTIFICATION NU		(X1) PROVIDER/SUPPLIER/O IDENTIFICATION NUMB		A. BUILDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
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	ROVIDER OR SUPPLIER PARK CARE CENTER		5000 BUR	RESS, CITY, ST. ROUGHS A\ TON, DC 20	/E. NE				
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L 179	incidents. A care plan initiated indicated "Resident outburst and behavid document as per ord. A face-to-face interved Employees #13 and approximately 2:30 Mappropriate social seinitiated after the afformand physical aggress on February 4, 2008 3. Facility staff failed social service intervents he/she physically as A review of the resifullowing nursing no PM, "Resident remain responsive, noted with November 22, 2007 is alert and verbally this [morning], cursing residents." November 25, 2007 assess resident's be agitated with bizarre resident. Resident headResident pactical day room attacking or given 1 mg of Ativantical and service intervents.	s after the aforementical July 28, 2006 and lass continues to have angor. Continue to monitoder." iew was conducted was confucted was conducted was conducted was conducted was confucted was rementioned incident sion. The record was	at updated, gry or and ith 08, at dged that ere not s of verbal reviewed riate 26 after dents. ed the 7 at 12:30 Resident agitated other alled to emely at the earea of the lent was nce"	L 179	1. Resident #S4's care plan was up new approaches and interventions to alternative treatment 2. Social Services staff will review rewith aggressive behavior incidents to if facility social services staff has appenderessed and implement intervention address behaviors. 3. Social Services staff will be re-economic implementing interventions. Fastervices staff will complete QI Monit X 2 weeks, weekly X 4 weeks and not 12 months for residents who display behavior to ensure that appropriate interventions and action plans are in address this behavior. 4. Findings from QI Monitoring will submitted to Facility Risk Managem Quality Improvement Committee modulating Improvement Committee Improvement Committ	hat address esident o determine propriately ons to ducated on eshaviors cility social coring daily nonthly X v aggressive n place to be ent/	03/10/08 03/21/08 03/21/08		

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L 179	Continued From pa	age 40		L 179				
	quiet, [he/she] said	I sorry for what [he/she	e] did."		· .			
		7 at 3:00 PM, "Police on by (Resident A1), aw ht"						
	November 25, 2007 at 3:45 PM, "Resident left facility walking accompanied by two police. Resident was taken to [hospital] psychiatric division for further evaluation and assessment." December 4, 2007 at 2:45 PM, "Resident remains alert and verbally responsive. Noted with severe agitation, running after staff / residents to hit, screaming and yelling"				•			
	verbally responsive	at 8:00 AM, "Residen Doted with agitation [names]attempting to	(calling					
	alert and verbally r during this shift. Pu right side of the he	7 at 0600 (6:00 AM), "i esponsiveseverely a illed Fire alarm, hit writ adAtivan 1 ml IM enper [physician] ord	gitated ter on the					
	verbally responsive Throwing things, (b Screaming, cursing	7 at 2:30 PM, "Resider e noted with severe agi pelongings) upside dow g staff /residents and a Ativan 1 mg given at	itation. vn in room. ttempting					
	Klonopin 0.5 mg P.	7 at 1:00 PM, "Refus O. for agitation. Residation (cursing staff and 1 mg given"	ent					

Health Regulation Administration STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE				(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
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NAME OF PR	ROVIDER OR SUPPLIER		STREET ADD	ADDRESS, CITY, STATE, ZIP CODE					
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(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES TBE PRECEDED BY FULL REC ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SHO REFERENCED TO THE APPROPRI	OULD BE CROSS-	(X5) COMPLETE DATE		
L 179	Continued From page	_		L 179					
	January 9, 2008 at 2000 (8:00 PM), "Resident was cursing and abusive to other residents. Threw [his/her] tray on the floor" January 12, 2008 at 11:00 AM, "Resident remains."								
	January 12, 2008 at 11:00 AM, "Resident remains alert and verbally responsive. Resident observed with severe agitation. Throwing things and attempting to hit resident/staff. Fortunately nobody was touched or injured. Ativan 1 mg given"						,		
	January 26, 2008 at 12:00 PM, "Observed with severe agitation yelling, loud screaming and running around. Attempting to hit staff and residents. Throwing [his/her] belongings (pocket book and clothes). Ativan 1mg IM given"								
	throwing [his/her] cl screaming. Residen	t 11:30 AM, "Reside othes on other resider it was taken back to ro aming. Ativan 1 mg giv	nts and oom but						
	February 4, 2008 at 12:15 [AM/PM not indicated "Throwing [his/her] shoes on the staff. Scream very loud and cursing other residents. Using fou language, Ativan 1 mg administered" A review of the social service notes revealed the following:		creaming						
			led the						
	November 25, 2007 at 2:00 PM, "This writer was on the unit when [writer] observed [Resident #26] approach [Resident A1] and [Resident #26] started attacking [Resident A1]. Nursing staff quickly intervened and removed [Resident #26] to the other side of the unit[Resident A1] advised the [he/she] was going to call the police to report [Resident #26]. [Resident #26] during the time staff was trying to calm [him/her] was hitting at nursing staff and did hit the charge nurse, who								
			-						

STATE FORM

STREET ADDRESS, CITY, STATE, ZIP CODE 5000 BURROUGHS AVE. NE WASHINGTON, DC 20019 PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY) L 179 Continued From page 42 sustained red welts on [his/her] arm." The next entry was a quarterly review dated January 18, 2008 at 11:15 PM, "During this review period the resident has had an incident in which [he/she] became physically abusive towards another resident and staff emphers" January 21, 2008 at 4:15 PM, "Resident was observed pulling the fire alarm on 5N side. The resident became verbally aggressive towards the staff when staff attempted to redirect [him/her]Resident camed sometime later and stated [he/she] pulled the alarm to save [his/her] life from a fire" A care plan initiated July 30, indicated "Resident was physically abusive to other residents by hitting them. No injury noted." The rew as no evidence that the social workers initiated appropriate social service interventions after the aforementioned incidents of verbal and physical aggressive behaviors. A face-to-face interview was conducted with Employees #4,15 and 16 on February 7, 2008, at approximately 2:30 PM. They acknowledged that interventions were not initiated after the incidents of	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER. IDENTIFICATION NUMBER				(X2) MULTIPI	LE CONSTRUCTION	(X3) DATE SUI COMPLET			
STREET ADDRESS, CITY, STATE, ZIP CODE 500 BURROUGHS AVE. NE WASHINGTON, DC 20019 PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FILL REGULATORY) TAG CEACH DEFICIENCY MUST BE PRECEDED BY FILL REGULATORY TAG CEACH DEFICIENCY MUST BE PRECEDED BY FILL REGULATORY TAG L 179 Continued From page 42 sustained red welts on [his/her] arm." The next entry was a quarterly review dated January 18, 2008 at 11:15 PM, "During this review period the resident has had an incident in which [he/she] became physically abusive towards another resident and staff members" January 21, 2008 at 4:15 PM, "Resident was observed pulling the fire alarm on 5N side. The resident became verbally aggressive towards the staff when staff attempted to redirect [him/her]Resident calmed sometime later and stated [he/she] pulled the alarm to save [his/her] life from a fire" A care plan initiated July 30, indicated "Resident was physically abusive to staff and others." The care plan was reviewed on November 25, 2007 with a hand written entry, "Resident was physically abusive to other residents by hitting them. No injury noted." There was no evidence that the social workers initiated appropriate social service interventions after the aforementioned incidents of verbal and physical aggressive behaviors. A face-to-face interview was conducted with Employees #4,15 and 16 on February 7, 2008, at approximately 2:30 PM. They acknowledged that interventions were not initiated after the incidents of					B. WING		02/1	1/2008		
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EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY TAG COntinued From page 42 sustained red welts on [his/her] arm." The next entry was a quarterly review dated January 18, 2008 at 11:15 PM, "During this review period the resident has had an incident in which [he/she] became physically abusive towards another resident and staff members" January 21, 2008 at 4:15 PM, "Resident was observed pulling the fire alarm on 5N side. The resident became verbally aggressive towards the staff when staff attempted to redirect [him/her]Resident calmed sometime later and stated [he/she] pulled the alarm to save [his/her] life from a fire" A care plan initiated July 30, indicated "Resident was physically abusive to staff and others." The care plan was reviewed on November 25, 2007 with a hand written entry, "Resident was physically abusive to other residents by hitting them. No injury noted." There was no evidence that the social workers initiated appropriate social service interventions after the aforementioned incidents of verbal and physical aggressive behaviors. A face-to-face interview was conducted with Employees #4,15 and 16 on February 7, 2008, at approximately 2:30 PM. They acknowledged that interventions were not initiated after the incidents of	GRANT I	PARK CARE CENTER	,							
sustained red welts on [his/her] arm." The next entry was a quarterly review dated January 18, 2008 at 11:15 PM, "During this review period the resident has had an incident in which [he/she] became physically abusive towards another resident and staff members" January 21, 2008 at 4:15 PM, "Resident was observed pulling the fire alarm on 5N side. The resident became verbally aggressive towards the staff when staff attempted to redirect [him/her]. Resident calmed sometime later and stated [he/she] pulled the alarm to save [his/her] life from a fire" A care plan initiated July 30, indicated "Resident was physically abusive to staff and others." The care plan was reviewed on November 25, 2007 with a hand written entry, "Resident was physically abusive to other residents by hitting them. No injury noted." There was no evidence that the social workers initiated appropriate social service interventions after the aforementioned incidents of verbal and physical aggressive behaviors. A face-to-face interview was conducted with Employees #4,15 and 16 on February 7, 2008, at approximately 2:30 PM. They acknowledged that interventions were not initiated after the incidents of	PREFIX	(EACH DEFICIENCY MUST	BE PRECEDED BY FULL REC	GULATORY	PREFIX	(EACH CORRECTIVE ACTION S	HOULD BE CROSS-	(X5) COMPLETE DATE		
approximately 2:30 PM. They acknowledged that interventions were not initiated after the incidents of		Continued From page sustained red welts The next entry was January 18, 2008 at period the resident I [he/she] became phanother resident and observed pulling the resident became vestaff when staff atte [him/her]Resident stated [he/she] pulle from a fire" A care plan initiated was physically abuse The care plan was rewith a hand written abusive to other resincted." There was no evide initiated appropriate after the aforementiphysical aggressive A face-to-face intervents.	on [his/her] arm." a quarterly review date 11:15 PM, "During th has had an incident in ysically abusive toward d staff members" 4:15 PM, "Resident we fire alarm on 5N side rbally aggressive towar motern to redirect calmed sometime late d the alarm to save [h July 30, indicated " F ive to staff and others eviewed on Novembe entry, "Resident was p idents by hitting them. Ince that the social wor social service interver oned incidents of verb behaviors. If yew was conducted we	is review which ds was The ards the er and his/her] life Resident " r 25, 2007 ohysically No injury rkers ntions al and hith						
verbal and physical aggression. The record was reviewed on February 7, 2008. 4. Facility staff failed to implement appropriate social service interventions and monitor Resident #3's progress after several outbursts of aggressive and inappropriate behavior.		approximately 2:30 interventions were r verbal and physical reviewed on Februa 4. Facility staff faile social service interv #3's progress after s	PM. They acknowledg not initiated after the in aggression. The recor ry 7, 2008. d to implement appropentions and monitor R several outbursts of ag	ed that cidents of d was priate esident						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER			(X2) MULTIF	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		095019		B. WING		02/1	1/2008
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L 179	Continued From page	ge 43		L 179			
	diagnosis of Multiple	t #3's record revealed e Sclerosis in the annu MDS) dated Septemb	ıal	ē			
	A review of the social services notes in the residents' record revealed the following:					·	
	On June 14, 2007 under the heading of MDS review, Employee #16 wrote "Resident is alert and oriented x 3. However, he/she is easily agitated and at times becomes hostile. His/her verbalizations are often tangential and incoherent during these episodes."			·			
·	that the resident rec Access requesting a application. Employ he/she did not want	the social worker doc eived a letter from Me in interview regarding see #16 added "He/sh to attend the interview ad about wanting Metro	tro an ie stated v and				
	On August 10, 2007 the note included, "Resident was accused by a CNA of exposing himself/herself to him/her on 10/6/07. The writer discussed how inappropriate this behavior wasResident appears to have a history of this behavior."		elf/herself ed how				
,		007 the MDS review nonal outbursts of ange his/her way."					
	"Resident engaged i with engineering sta	7 the social worker wr in verbal altercation or ff member. The nurse . Officer spoke with the the situation."	n 1/15/08 on duty				

Health Regulation Administration STATE FORM

AND PLAN OF CORRECTION IDENTIFICATION NUM		(X1) PROVIDER/SUPPLIER/G IDENTIFICATION NUMB		(X2) MULTIF A. BUILDING B. WING_	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
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L 179	Continued From page	ge 44		L 179					
	Admissions Coordin administrator on 2/5, another resident as on the 1st floor. I spinappropriate behavior The documentation Met with resident and to address his/her dimoney and verbal all	on February 14, 2008 d with Admissions Co splaying large amoun tercations with staff.	culity cursed out elevator his/her included " fordinator its of Resident						
	stated he/she will handle his/her money his/her way." A review of the Interdisciplinary Care Plans								
·	revealed two (2) recommended social services interventions. 1. "Firmly approach resident that behaviors are not acceptable and document conversation and actions of resident" and 2. Inform direct care givers on methods to assist them in handling res. (resident) behaviors while providing care." These entries were entered to the care plan on October 16, 2007 and a care planning meeting was held on January 4, 2008. There was no				· .				
	reviewed" or "Status recommendations w The record lacked ev		the						
	Employee #16 on Fe approximately 11:00 was initially working resident but no famil	iew was conducted webruary 5, 2008 at AM. He/she stated hon a plan to discharge y member was willing anowledged that at this	e/she e the to take						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER				(X2) MULTIF	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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L 179	Continued From pag	ge 45		L 179			
	there were no planned interventions to improve and/or monitor the resident's mental, physical and psychosocial behavior. The record was reviewed of February 4, 2008. 5. The social worker failed to provide interventions.						
	5. The social worker failed to provide interventions for Resident S1's aggressive behaviors and alcohol and drug use.						
•	According to the annual history and physical examination, completed by the physician on September 14, 2007, the resident had a "history of crack/cocaine".				·		
	A review of Resident S1's record revealed the following social worker's notes:						
	June 4, 2007 at 4:30 PM: "Resident attended funeral with a friend/resident (Resident A1) on 6/1/07. It was reported [he/she] consumed alcohol and had a confrontation with CNA (certified nurse aide) who escorted [Resident A1). According to (Resident S1), the argument was regarding (Resident S1's) actual consumption. This writer asked resident if (he/she) will attend AA meetings and (he/she) denied the invitation. On going monitoring will continue re: resident's behavior and alcohol consumption."						
	August 30, 2007 at 4:00 PM: "Special care conference held on this date to address resident's drug activity. (He/she) denied having an addiction, however agreed to attend (outside facility) for treatment."						
	August 31, 2007 at 2:00 PM: "Met with resident again. (He/she) changed (his/her) mind and refused to attend any treatment program."						
	October 18, 2007 at 1:00 PM: "Resident engaged						
		•					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER IDENTIFICATION NUM			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
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L 179	Continued From page	 ge 46		L 179			
	in an altercationwith another resident re: drug transaction. When this writer met with resident, (he/she) denied giving (Resident S4) money for drugs. (He/she) stated (he/she) gave (Resident S4) money for cigarettes. (Resident S1) denied using drugs. However, (he/she) was offered the opportunity to participate in a program. (Resident S1) refused any treatment centers. On going monitoring will continue." December 14, 2007 at 2:00 PM: "MDS Review: Resident is alert and oriented x 3. (He/she) requires minimal assistance with ADLs (Activities of Daily Living). (He/she) ambulates with walker or wheelchair. (He/she) receives occasional visitors. (His/her) interactions have been appropriate. There has been no altercations this period. On going monitoring will continue as (he/she) remains concern." A pre-printed care plan entitled, "Behavior Management" was initiated September 2006 with a goal date of June 2007. One (1) intervention was identified under the behavior entitled, "Wanting to go 'Home'" which was "Phone call from family to offer reassurance." There were no behaviors or interventions identified by facility staff regarding verbal or physical aggressive behaviors or alcohol use.						
				4			
	There was no evidence in the resident's record that interventions were initiated by the social worker or that the resident was referred to alternate treatment programs after refusal of the above cited program. The record was reviewed February 8, 2008.		ı				
	The record was reviewed February 8, 2008. 6. The social worker failed to provide interventions for Resident S2's aggressive behaviors and alcohol and drug use.						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CI IDENTIFICATION NUMBE					(X3) DATE SURVEY COMPLETED		
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L 179	Continued From page	ge 47		L 179			
	According to the annual history and physical examination, completed by the physician on June 6, 2007, the resident was diagnosed with "drug addiction". A review of the resident's record revealed the					·	
,		dent's record revealed ker's progress notes:	the				
	April 18, 2007 (no time indicated): "SW met briefly to discuss the establishment of Alcohol and Substance abuse awareness group. Resident indicated that (he/she) has previous knowledge of such group, but insists that no staff be present, "only resident." Resident was told date and time of meeting."						,
	April 24, 2007 (no time): "SW offered and reminded resident of alcohol substance abuse group meeting 4/26/07 at 10:00 AM."						
	The resident was hospitalized on April 26 through May 3, 2007 and as follows: June 8 thorough June 11, 2007. June 28 through July 4, 2007. July 16 through July 19, 2007. August 21 through August 23, 2007.		through				
	The next social worker's entry was dated January 23, 2008 at 3:10 PM: "Resident encountered an altercation with security worker on 1/22/08 re: smoking in front of bldg (building). According to the report, resident cursed the employee after (he/she) was asked to move from the front of the bldg. Resident was counseled re: (his/her) behavior and reminded of the importance of following the smoking policy."						
		entitled, "Res has a h or, verbal aggression,					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SUI COMPLET			
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L 179	Continued From page 48			L 179				
;	resistance to care" was dated December 5, 2007. There was no evidence that interventions had been initiated to address the above cited incidents.							
	A face-to-face interview was conducted with Employee #26 on February 8, 2008 at 11:30 AM. He/she stated, " [Resident S2] came to some of the AA meetings, but not consistently. The residents' group hasn't met since the summer."							
	There was no evidence in the record that appropriate treatment and services were provided for verbal and physical aggression and the resident's drug use after each above cited episode. The record was reviewed February 8, 2008.							
		failed to provide inter gressive behaviors ar				,		
	A review of Resident following social work	t S4 's record reveale er 's notes:	d the			·		
	by nursing staff that bed. This writer spo [He/she] stated the s [he/she] has no idea denied using any dru	PM: "Resident was rasyringe was found in the with resident re: the syringe was not [his/he how it got there. [He/wigs or needing treatmost will continue to most resident was resident re: the was resident resident re: the was resident resi	n [his/her] e incident. ers] and she] ent for					
	Set) review: Resider [He/she] uses a whe [he/she] refuses care) AM: " MDS (Minimu at is alert and oriented elchair for mobility. At a and is verbally abus spected of substance nies it and refuses	x 3. times ive toward					
	,							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER				(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
	. 095019			B. WING_			02/1	1/2008	
NAME OF PR	OVIDER OR SUPPLIER	·	STREET ADD	RESS, CITY, ST.	ATE, ZIP CODE			,	
GRANT P	ARK CARE CENTER			00 BURROUGHS AVE. NE ASHINGTON, DC 20019					
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REC NTIFYING INFORMATION)	GULATORY	ID PREFIX TAG		PLAN OF CORRECTION EACTION SHOULD BE E APPROPRIATE DE	E CROSS-	(X5) COMPLETE DATE	
L 179	Continued From pag	ge 49		L 179				_	
	treatment "								
	1/22/08 and became because [he/she] sta	7:50 AM: "Resident e very belligerent towa ated after calling for he me before someone a	ards staff elp on the						
	accept treatment for	8:15 AM: "Resident [his/her] drug abuse. ne on 1/15/08 by the i	He was						
	January 24, 2008 at 9:10 AM: "MDS ReviewResident continues to engage in occasional verbal (abuse) toward staff."								
	A care plan problem, "Resident has recent history of drug abuse " was initiated November 6, 2006. There was no evidence that the care plan was updated after the July 5, 2007 incident mentioned above. A hand written entry dated January 9, 2008 documented the following: "8 1 cc syringes found at [his/her] bedside with clear substance. 1 burned teaspoon and lighter."			·	,	·			
	A care plan problem, "Resident is verbally abusive to staff, cursing to staff and old roommate" was initiated November 6, 2006. There was no evidence that interventions were initiated after the above cited episodes of verbal abuse.				·				
	There was no evidence in the record that the social worker initiated interventions regarding the resident 's drug use prior to January 24, 2008. Additionally, there was no evidence in the record that the social worker initiated interventions to address the resident 's verbal abuse. The record was reviewed February 8, 2008.								

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/G IDENTIFICATION NUMB		(X2) MULTIF	PLE CONSTRUCTION	COMPLETI	
		095019		B. WING		02/1	1/2008
	PARK CARE CENTER		5000 BUR	RESS, CITY, STA ROUGHS AV TON, DC 20	Æ. NE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	TATEMENT OF DEFICIENCIES IT BE PRECEDED BY FULL RECENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETE DATE
L 179	There was no evide interventions were in that the resident was	ence in the resident's re initiated by the social was referred to alternate sal of the above progra	worker or treatment	L 179			
L 214	located, equipped, a functional, healthful, supportive environmand the visiting public This Statute is not represented that facing and hazard free environments of the scatter rug in a resign from television antercovers, a burner on towel, excessive wardish machine room, covered with duct that he kitchen doorway rooms and unsecure environmental observented to PM in the presented of the findings included the source of the findings included the source of the source of the findings included the source of	e designed, constructer and maintained to provid, safe, comfortable, and ment for each resident, slic. met as evidenced by: mental observations, it visitity staff failed to main vironment as evidence to pof closets, an unsident's room, eye guardent's room, eye guardent as oven lit with a later in shower rooms and the gas oven lit with a later in shower rooms and the gas oven lit with a later in shower rooms and the gas oven lit with a later in shower rooms and the later in shower rooms and the later in the later in the later in shower rooms and the later in shower rooms and the later in shower rooms and later in shower rooms and later in shower rooms and later in the later in shower rooms and later in the later in shower rooms and later in the late	vide a and , employee was stain a safe ed by: secured ds missing al outlet a paper and the ekitchen the floor in esident's ese on M through 1, 2, 3, 5,	L 214	#1 1. Boxes were removed from the trin resident rooms. 2. Environmental rounds were considentify rooms where items were of closets and appropriate actions take on findings. 3. Maintenance and Nursing staff reeducated on keeping the top of of boxes. Maintenance Director, or will QI monitor daily X 2 weeks, the ensure tops of closets remain free 4. Findings will be submitted to fact Management/Quality Improvement monthly X 12 months.	iducted to in top of ken based will be closets clear designee, en weekly to of boxes. cility Risk	03/27/08 03/27/08 03/27/08

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/GIDENTIFICATION NUMB		(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SUI COMPLET	
,		095019		B. WING	<u></u>	02/1	1/2008
NAME OF P	ROVIDER OR SUPPLIER	,	STREET ADDRE	SS, CITY, ST	ATE, ZIP CODE		
GRANT F	PARK CARE CENTER		5000 BURRO WASHINGTO			_	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REC NTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD B REFERENCED TO THE APPROPRIATE DE	E CROSS-	(X5) COMPLETE DATE
L 214	resident's bed. 3. Eye guards were televisions in the foll rooms; 3N and 3S d and 4S living room in observed in common observed in common observed in common observed in the followant of the fo	observed missing from lowing areas: 2S and ining rooms, 4S dining n six (6) of 16 television areas. outlet covers were observing areas: walk-in refrigerator on in the presence of Emmetween rooms 317 are our of the kitchen on lately 2:45 PM, it was attempted to light a burster towel. was observed in the din the shower room. was observed on the from the door. A bucket er and was observed edish machine room flaces are and was observed a dish machine room flaces observed on the from the form of the flaces of the flac	m 2N dining g room ons served February ployees ad 318. February observed ner on the lash, one in the lash, one in the lash, one in the lash, and the lash and the	L 214	#2 1. The scatter rug was removed from 517. 2. Scatter rugs were removed from rooms. 3. Maintenance and Nursing staff wereeducated on the inappropriateness rugs in the long term care environmentifying maintenance when a scatted discovered. Maintenance Director, owill QI monitor daily X 2 weeks, there scatter rugs are not present in reside 4. Findings will be submitted to facil Management/Quality Improvement of monthly X 12 months. #3 1. The eye guards for the television in 2 south and north dining rooms, 3 south dining rooms, and 4 south din living room will be replaced. 2. Review of resident televisions will completed to ensure that resident's antennas have eye guards present. 3. Maintenance will be reeducated densuring that television antennas haguards. Maintenance Director, or de QI monitor daily X 2 weeks, then we 4 weeks, then monthly to ensure teleantennas have eye guards. 4. Findings will be submitted to facil Management/Quality Improvement of monthly X 12 months.	resident rill be s of scatter ent and er rug is or designee, n weekly to ent rooms. lity Risk committee antennas on orth and ing and ll be television on eve eye esignee, will ekly X evision lity Risk	03/27/08 03/27/08 03/27/08 03/27/08 03/27/08 03/27/08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED				
		095019		B. WING		02/14	1/2008		
NAME OF PR	ROVIDER OR SUPPLIER		STREET ADDI	ADDRESS, CITY, STATE, ZIP CODE					
	PARK CARE CENTER			RROUGHS AVE. NE GTON, DC 20019					
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REC NTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD B	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS- REFERENCED TO THE APPROPRIATE DEFICIENCY)			
L 214	8. A bucket of water the door by the dish with the mop head la handle on the floor of the floor. 9. Extension cords with 503, and in the general floor. 10. Clean utility roor unsecured oxygen to (1) full. Employees #1, 2, 3,	and a mop was obse machine room in the aying-across the buck on February 3, 2008 a were observed in room eral dining room on the m on 5 South containe anks, three (3) empty	kitchen et and the t 2:25 PM. as 422 and e first ed four (4) and one	L 214	 #4 Broken electrical outlet cover in knear walk-in freezer and the cover of between rooms 317 and 318 were red. Review of broken electrical outlet will be completed to ensure that out are intact. Maintenance will be reeducated onoting and repairing of outlet covers Maintenance Director, or designee, monitor daily X 2 weeks, then weekl that outlet covers remain intact. Findings will be submitted to faci Management/Quality Improvement of monthly X 12 months. 	on 3 north eplaced. covers tlet covers on the . will QI y to ensure	03/27/08 03/27/08 03/27/08		
L 389	amount that is need. This Statute is not read that is not read that is not read that is not read that is not read to state in the facility failed to main (3) times the amoun occupancy. The facility occupancy. The facility occupancy. The facility occupancy is not stated. The findings include the face-to-face intervent of the face-to-	all be at least three (3) ed for the licensed occured as evidenced by: view, it was determine tain the linen par leve t needed for licensed lity's licensed occupan	ed that the lat three late late late late late late late la	L 389	L 389 3254.5 Nursing Facilities 1. The Facility Housekeeping/Laund ordered enough linen to bring the fainventory up to the required par level facility continues to place monthly lir 2. The facility Housekeeping/Laund will complete a linen inventory to enthere is ample enough linen to meet requirements as well as the needs or residents. 3. The Housekeeping/Laundry Director deducated on ensuring that the line is maintained as required by 22 DCN. The Housekeeping/Laundry Director Monitor weekly X 4 weeks, then mor 12 months linen inventories to ensur PAR levels. 4. Findings from the linen inventory presented to Facility Risk Managem Improvement committee monthly X.	cility's linen el. The nen orders. ry Director sure that the state of our ctor will be n inventory MR 3254. r will QI nthly X re required will be ent/Quality	02/06/08 03/17/08 03/09/08 03/27/08		

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	EMENT OF DEFICIENCIES (X1) PROVIDER/BUPP PLAN OF CORRECTION (DENTIFICATION :			(X2) MUILTH	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
				A. BUILDING		•		
		095019		B. WING _		02/1	1/2008	
NAME OF PR	OVIDER OR SUPPLIER	-	STREET ADD	RESS, CITY, STA	ATE, ZIP CODE			
GRANT P	ARK CARE CENTER	_,		5000 BURROUGHS AVE. NE WASHINGTON, DC 20019				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REI INTIFYING INFORMATION)	GULATORY	ULATORY ID PROVIDER'S PLAN OF COR PREFIX (EACH CORRECTIVE ACTION SHO TAG REFERENCED TO THE APPROPRIA			(XX) COMPLETE DATE	
L 214	Continued From pag	je 53		L 214	#5 1. Employee #6 has been reeducat he/she cannot light burners on the smust notify the Maintenance Director Food Services Director when burner stove are not working. Employee #4 understands that he/she may not att make any repairs to the kitchen equ 2. The Food Services Director has a review throughout the kitchen to icother equipment that is not functioninis/her findings have been forwarde Maintenance Department for appropaction/resolution. 3. The Food Services staff will be in that they cannot light burners on the they must notify the Maintenance Di Food Services Director whenever mequipment fails to operate/function prod Services Director, or designee monitor weekly X 4 weeks, then mo months to ensure maintenance is of when kitchen equipment fails to function the leaks from the dish machine, water filter, and the 5 north men's si were repaired. 2. Maintenance staff will review the locate leaks for repair. 3. Maintenance Director, or designee, monitor daily X 2 weeks, then weekleaks are found and repaired. 4. Findings will be submitted to faci Management/Quelity Improvement of monthly X 12 months.	tove and or and the rs on the rempt to ipment. Completed lentify any rig and d to the priate rector and re	03/27/08 03/27/08 03/27/08 03/27/08 03/27/08	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/GIDENTIFICATION NUMB		(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SUF COMPLET		
	·	095019		B. WING		02/1	1/2008	
NAME OF PR	OVIDER OR SUPPLIER	(STREET ADDI	RESS, CITY, ST	ATE, ZIP CODE	_l <u></u>		
GRANT P	ARK CARE CENTER			5000 BURROUGHS AVE. NE WASHINGTON, DC 20019				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL RECONTING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD I REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETE DATE	
L 214	Continued From page	ge 53 A		L 214	#7 1. The electrical outlet between the the electrical oven was replaced. 2. Review of broken electrical outlet completed to ensure that outlet are 3. Maintenance will be reeducated noting and repairing of outlet. Main Director, or designee, will QI monite 2 weeks, then weekly to ensure the remain intact. 4. Findings will be submitted to fact Management/Quality Improvement monthly X 12 months. #8 1. The mop was placed upright and to its storage area. 2. Review of kitchen was made to mops were stored properly. 3. Kitchen staff were reeducated of mop storage. Dietary Manager, or will QI monitor daily X 2 weeks, the ensure mop is stored in proper postocation. 4. Findings will be submitted to fact Management/Quality Improvement monthly X 12 months.	et will be intact. I on the tenance or daily X at outlet clitty Risk committee d returned ensure designee, en weekly to ition and cility Risk	03/27/08 03/27/08 03/27/08 03/27/08 03/27/08 03/27/08	
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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDENCIPPLE (DENTIFICATION NO. 1) 095019					(X3) DATE SUI COMPLET	
		095019				02/1	1/2008
NAME OF PR	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, ST	ATE, ZIP CODE		
GRANT P	ARK CARE CENTER			5000 BURROUGHS AVE. NE WASHINGTON, DC 20019			
(X4) ID SUMMARY STATEMENT OF DEFICIENCY PREFIX TAG SUMMARY STATEMENT OF DEFICIENCY OR LSC IDENTIFYING INFORMATION				, ID PREFIX TAG .	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD B REFERENCED TO THE APPROPRIATE DI	BE CROSS-	(75) COMPLETE DATE
L 214	Continued From pag	ge 53 B	:	L 214	#9 1. The extension cords in room 422 the first floor dining room have been		03/27/08
					Review of facility will occur to energy extension cords are present. Maintenance will be reeducated importance of removing extension of the facility. Maintenance Director, owill QI monitor daily X 2 weeks, the	on the cords from or designee, n weekly to	03/27/08
					ensure that facility remain free from cords. 4. Findings will be submitted to fac Management/Quality Improvement monthly X 12 months.	ility Risk	03/27/08
·					#10 1. The four oxygen tanks in the cleroom on 5 South were properly secretarized behind a chain. 2. The Maintenance Director or Decomplete a facility wide inspection of rooms, resident rooms and common ensure all oxygen tanks are placed chain or inside an appropriate oxygen.	ured signee will of all utility n areas to behind a	02/11/08
		* * · · · · · · · · · · · · · · · · · ·			holder. 3. The nursing staff will be reeduced importance of securing oxygen tank chain when not in use and inside an appropriate oxygen tank holder when The Maintenance Director, or design monitor daily X 2 weeks, then week ensure all oxygen tanks are stored within the facility.	ated on the is behind a on in use. nee, will QI ly to	03/27/08
		·			Findings will be submitted to faci Management/Quality Improvement of monthly X 12 months.		03/27/08

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER			A. BUILDING	PLE CONSTRUCTION	(X3) DATE SUF COMPLETI				
		095019		B. WING		02/11	1/2008		
NAME OF PR	OVIDER OR SUPPLIER	_	STREET ADD	DRESS, CITY, STATE, ZIP CODE					
GRANT P	ARK CARE CENTER			ROUGHS A\ TON, DC 20					
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REC NTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIATE DE	E CROSS-	(X5) COMPLETE DATE		
L 410	Continued From pag	ge 53	-	L 410					
	3256.1 Nursing Fakit Each facility shall promaintenance service exterior and the intersanitary, orderly, commanner. This Statute is not in Based on observation the environmental to facility failed to provimaintenance service clean, and homelike evidenced by: soiled curtains, windows, reand Air Conditioning overbed lights, stains marred/scarred/dam HVAC, doors, chairs stands, and ceiling to odors and room clutt. The findings were obtained in the findings were obtained to the finding	ovide housekeeping as a precessary to maintain of the facility in a suffortable and attractive net as evidenced by: ons and staff interview our, it was determined de housekeeping and as necessary to maintain environment for reside furniture, walls, floors eturn vents, Heating, (HVAC) units, cornice wells and elevator track aged furniture, walls, is, baseboards, panels, ides; non-functional editer. Deserved in the present est #9 and 10 on maintain experience were not ade are prepared and services and the prepared and services and machine; machine leaking; transpors and rubber on white services and missing knobor under the steaments.	during that the lain a safe, lents as s, privacy Ventilation e boards, sks; windows, television luipment, let of the land sportation heels; ice arred and sportation heels; is on the	L 410	L 410 3256.1 Nursing Facilities 1A. Furniture 1. The three chairs in the 2 South living sofa and four chairs in the 2 Norroom, the two sofas and two chairs in 3 South living room, the three chairs in 4 South living room, the two sofas in 4 South living room, the three chairs sofas in the 4 North living room, the chair and sofa in the 5 South dining two sofas and three chairs in the 5 Norom and the chair in Room 536 have cleaned. 2. Sofas and chairs throughout facin inspected and soiled furniture were on spot checking and cleaning soiled and sofas daily. The Housekeeping. Director or designee will complete Quantoring daily X 2 weeks, then we common areas and resident rooms to compliance. 4. Findings from the reviews will be the Risk Management/Quality Improcommittee monthly X 12 months.	th living in the in the the sand two soiled arm room, the North living we been eleaned. Heducated dichairs //Laundry &/Laundry	03/17/08 03/17/08 03/13/08 03/27/08		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/		(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SUP COMPLET		
			•	A. BUILDING B. WING	<u> </u>			
	MME OF PROVIDER OR SUPPLIER STR			02/11/200				
NAME OF PR	OVIDER OR SUPPLIER			RESS, CITY, STA				
GRANT F	ARK CARE CENTER			RROUGHS AVE. NE GTON, DC 20019				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES F BE PRECEDED BY FULL RE NTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD E REFERENCED TO THE APPROPRIATE DE	E CROSS-	(X5) COMPLETE DATE	
L 410	pan wash area; an a cook's preparation not sanitized. These presence of Employ initial tour of the material between 2:15 PM at 2008 at 1:30 PM. The findings include Environmental Tour 1. The following soil A. Furniture 2 S: Three (3) of the 2N: One (1) of one (2) soiled chairs in the living reads at 1:30 Ft. Two (2) of two (2) soiled chairs in the living reads at 1:30 Ft. Two (3) of three (3	unused detergent prod (prep) area and cooking e observations were madees #1, 2, 3, 5 and 6 in kitchen on February and 3:45 PM and February and 3:45 PM and February aree (3) chairs in the living toom. (2) soiled sofas, two (in the living room. (2) sofas in the living ree (3) chairs and two decorpts.	ng vessel hade in the during the y 3, 2008 uary 4, wing room. four (4) 2) of two ng room. (2) of two the living ning room. hree (3) he (1) chair main one (1) of	L 410	1B. Walls 1. The four walls in the main dining 1st floor, the dining room and living on 2 South, the dining room walls on 3 South, the dining room walls on 3 dining room walls on 4 South, the d and living room walls on 4 North, th room walls on 5 South, Rooms 536 and the dining room and living room 5 North have been cleaned 2. Walls throughout the facility have inspected and soiled walls have been 3. The housekeeping staff will be roon spot checking and cleaning soile well as notifying the maintenance if need of repair or painting. The Hou Laundry Director or designee will comonitoring daily X 2 weeks, then we common areas and resident rooms compliance. 4. Findings from the reviews will be the Risk Management/Quality Impro committee monthly X 12 months.	rooms walls ng room alls on North, the ining room e dining , 528, 527 n walls on the been cleaned. The educated ed walls as walls are in its ekeeping/omplete QI ekly of to ensure	03/20/08 03/18/08 03/13/08 03/27/08	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/GIDENTIFICATION NUMB		(X2) MULTIF A. BUILDING B. WING	PLE CONSTRUCTION G	(X3) DATE SUR COMPLETE	
	***************************************	033013	STREET AND	RESS, CITY, ST	ATE ZID CODE	<u> 02/11</u>	72006
	PARK CARE CENTER		5000 BUR	ROUGHS AV	/E. NE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES FBE PRECEDED BY FULL REC NTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD E REFERENCED TO THE APPROPRIATE DI	BE CROSS-	(X5) COMPLETE DATE
L 410	3S: Dining room waroom observed 3N: Dining room waroom observed 4S: Dining room waroom observed 4N: dining room and one (1) dining and lists: Three (3) of 13 of 528, 527 and dining dining room observed 5N: dining and living (1) dining and living (1) dining and living C. Floors 1st Floor dining room dining room observed 2S: Dining room, and in four (4) of seven (2N: Dining room and of eight (8) resident 3S: Dining room and sight (8) resident 3S: Dining and living 535 in three (3) of sight (1) of seven (7) resident of the elevators 3rd, 4th and 5th flood.	d living rooms observed lis in one (1) of one (1) d living room walls in oving rooms observed observed resident room in one (1) of one (1) or one (1) of	dining dining dining dining dining dine (1) of ms, 536, e (1) dof one de (1) dof one de (1) dof one de (2) dof one de (3) dof one de (4) dof one de (4) dof one de (5) dof one	L 410	1C. Floors 1. The 1 st floor dining room floor, the dining room floor, floors in Rooms 233 and 234, the 2 North Dining roof floors in Rooms 210 and 211, the 3 Dining room and hallway floors, the Dining room and hallway floors, the Dining and living room floors, floors 529, 532, 535, the 5 North Dining arroom floors, floors in Room 518 and floors, including the area in front of elevators and hallway floors on the 4 th and 5 th floors have been cleaned stripped and waxed. 2. Floors throughout the facility havinspected by the Housekeeping/Lau Director and a stripping and waxing has been developed to address def 3. The floor technicians will be reed maintaining clean floors through ad the stripping and waxing schedule. Housekeeping/Laundry Director will QI monitoring daily X 2 weeks, then common areas and resident rooms compliance. 4. Findings from the reviews will be the Risk Management/Quality Improcommittee monthly X 12 months.	223, 229, om floor, South 3 North 5 South in Rooms and living the hallway the 1st, 2nd, 3rd, d and/or we been undry schedule ficient areas. ducated on herence to The I complete a weekly of to ensure	03/27/08 03/27/08 03/27/08

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIES AND PLAN OF CORRECTION IDENTIFICATION NUM			(X2) MULTIF	TLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		1		B. WING					
		095018				02/11	/2008		
NAME OF PE	NOVIDER OR SUPPLIER		STREET ADD	T ADDRESS, CITY, STATE, ZIP CODE					
GRANT F	PARK CARE CENTER			Roughs av Ton, DC 20					
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES IT BE PRECEDED BY FULL REC ENTIFYING INFORMATION)	GULATORY	1D PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD B REFERENCED TO THE APPROPRIATE DE	E CROSS-	(X5) COMPLETE DATE		
L 410	3S: Room 329 A an three (3) of seven (7) E. Windows 1st Floor; Glass dou one (1) of one (1) gl 2N: Rooms 205 and resident rooms observed. 3N: Rooms 301 and resident rooms observed.	d B and room 335 mis 7) resident rooms observed. able doors in the dining lass door observed. I 209 in two (2) of eigh erved. ae (1) of seven (7) room I 309 in two (2) of seven erved. ae (1) of seven (7) residence (1)	g room in of (8) ons en (7)	L 410	1D. Privacy Curtains 1. Clean privacy curtains have replasoried curtains found in Room 236 a missing curtains in Room 329A and Room 335. 2. Privacy curtains throughout the fibeen inspected by the Housekeepin Director to identify areas with soiled curtains in need of replacement. Apactions taken from findings. 3. The housekeeping staff will be reon spot checking and notifying the Housekeeping supervisor when curt soiled or missing. The Housekeepin Director or designee will complete Compitoring daily X 2 weeks, then we privacy curtains to ensure compliant 4. Findings from the reviews will be the Risk Management/Quality Improcommittee monthly X 12 months.	and the B and acility have g/Laundry or missing propriate seducated tains are ng/Laundry all sekty of ce.	03/04/08 03/17/08 03/13/08		
	2N: One (1) in the dining room and one (1) in the living room in two (2) of two (2) vents observed. 3N: One (1) in the dining room in one (1) of two vents observed. 5N: One (1) in the dining room in one (1) of two vents observed. G. HVAC Units 3S: Dining room in one (1) of one (1) HVAC unit observed. 5S: Dining room in one (1) of one (1) HVAC unit observed. H. Cornice Boards 2S: Room 210 in one (1) of one (1) cornice observed in resident's room. 2N: Room 229 in one (1) of one (1) cornice observed in resident's room.		erved. of two (2) of two (2) AC unit AC unit		1E. Windows 1. The glass double doors in the dir on the 1st floor and the windows in F and 209 on 2 North, Room 333 on 3 Rooms 301 and 309 on 3 North and on 4 North have been cleaned. The window seals and screens will be coreplacing the windows. 2. Windows throughout the facility hinspected by the Housekeeping/Lau Director and Maintenance Director the windows in need of cleaning and/or replacement. The Maintenance Director to solicit vendor bids to have windows damaged seals and screens replaced. 3. The Housekeeping staff will be not cleaning windows in their assigned and notifying the maintenance depair windows are in need of repair. The Housekeeping/Laundry Director or deviil complete QI monitoring daily X 2 will complete QI monitoring daily X 2	Rooms 205 I South, I Room 403 Is damaged orrected by Inave been indry I control to identify ector will with ed. Eeducated ed areas ritment if	03/14/08		
	i. Overbed Lights				then weekly of windows in common resident rooms to ensure complianc 4. Findings from the reviews will be the Risk Management/Quality Impro committee monthly X 12 months.	areas and e. reported to	03/27/08		

Health Regulation Administration STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CI IDENTIFICATION NUMBE					(X3) DATE SURVEY COMPLETED			
		095019		B. WING		02/11	1/2008	
NAME OF PROV	VIDER OR SUPPLIER		STREET ADD	DRESS, CITY, STATE, ZIP CODE				
GRANT PA	RK CARE CENTER			URROUGHS AVE. NE NGTON, DC 20019				
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD B REFERENCED TO THE APPROPRIATE DE	(X5) COMPLETE DATÉ		
4 red s JNs kT vff 2 it A 2 cc 2 (2 tt a cc 3 cc r 3 n s 5 cc r 3 n s	esident rooms obset IN: Rooms 402, 408 seven (7) resident rooms obset IN: Rooms 402, 408 seven (7) resident rooms obset IN: Stairwells observed. C. Elevator tracks Three (3) of three (3) of three (3) with soiled elevator of the IN: The following markers were observed. C. The follo	ed floors in two (2) of elevator cars were of racks on five (5) of five red/scarred and damad: at the dining room, mis 225, missing footboat set door in room 236 dent rooms observed. In the dining room of eight (8) resident rooms of eight (8) rooms of eight	(4) of two (2) observed ve (5) aged sing rd in room in three tables in boms 210 oms ; missing seven (7) room; e (1) of room; ssing	L 410	1F. Return Vents in public areas 1. The return vents in the 2 North dand living room, the 3 North dining rome the 5 North dining room have been of 2. The Maintenance staff have inspreturn vents in the facility. Any soile have been cleaned. 3. The Maintenance staff will be rest the importance of inspecting and cleareturn vents as part of their daily premaintenance. The Maintenance Dirperform QI monitoring daily X 2 weekly of return vents to ensure corcompliance. 4. Findings from the reviews will be the Risk Management/Quality Improcommittee monthly X 12 months. 1G. HVAC Units 1. HVAC units in the 3 South dining the 5 South dining room have been 2. The Maintenance staff have inspecting and cleaned. 3. The Maintenance staff will be rest the importance of inspecting and cleaned. 3. The Maintenance staff will be rest the importance of inspecting and cleaned. 3. The Maintenance staff will be rest the importance of inspecting and cleaned. 4. Findings from the reviews will be the Risk Management/Quality Improcommittee monthly X 12 months.	room and cleaned. Dected ed vents educated on eaning eventative rector will eks, then intinued exported to exement entified have educated on eaning ely intenance daily X is to ensure exercised exe	02/15/08 03/17/08 03/27/08 03/27/08 03/27/08 03/27/08 03/27/08	

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER				PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		095019		B. WING_		02/1	1/2008	
NAME OF PE	ROVIDER OR SUPPLIER	00010	STREET ADD	ADDRESS, CITY, STATE, ZIP CODE				
GRANT F	PARK CARE CENTER			URROUGHS AVE. NE NGTON, DC 20019				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL RECONTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD B REFERENCED TO THE APPROPRIATE DE	CTIVE ACTION SHOULD BE CROSS-		
L 410	1st Floor dining room 2S: Training toilet ro 211 and 213 in two observed. 2N: Scarred wall in routside room 220 in rooms observed and women's bathing/sh 3S: Room 309 in on rooms observed. 3N: Dining room wall one (1) dining room 4S: Room 419 in on observed. 4N: Dining room in cobserved on 4N. 5S: Women's bath st (1) of two (2) bath st 20 of 20 hallway wall marred/scarred/damelevators and all floof floors. C. Floors Men and womens's 4th and 5th floors obtained on the served	m walls. om wall tile damaged (2) of seven (7) reside rooms 223, 233, 234, five (5) of eight (8) re d damaged wall tile in ower room. e (1) of seven (7) resi ll paper peeling in one on 3N observed. e (1) of six (6) resider one (1) of one (1) dinir tall with damaged tile alls observed. lls were observed laged, this includes in ors 1st, 2nd, 3rd, 4th hower/bath rooms on oserved with peeling, of tin eight (8) of eight (8) observed. ged window seals and e (1) of seven (7) residence 325 in two (2) of seven	ent rooms 236 and sident the dent e (1) of at rooms and room on one front of and 5th 2nd, 3rd, damaged B) I screens dent en (7)	L 410	1H. Cornice Boards 1. The cornice boards in Room 210 and Room 229 on 2 North have bee 2. The housekeeping staff will com 100% review of cornice boards in the correct any additional deficiencies. 3. The Housekeeping staff will be roon the importance of checking and cornice boards as part of their daily schedule. The Housekeeping Direct perform QI monitor daily X 2 weeks weekly to ensure continued complia 4. Findings from the reviews will be the Risk Management/Quality Improcommittee monthly X 12 months. 1I. Overbed Lights 1. The overbed lights in Rooms 413 and 435 on 4 South and the lights in 402, 408, 413 and 417 on 4 North I cleaned. 2. The Housekeeping staff have co 100% review of overbed lights in the address any deficiencies in other ar Immediate corrective action will be clean any soiled lights. 3. The Housekeeping staff will be roon the importance of checking overlas part of their daily cleaning sched Housekeeping/Laundry Director or will perform QI monitoring daily X 2 then weekly to ensure continued co 4. Findings from the reviews will be the Risk Management/Quality Improcommittee monthly X 12 months.	en cleaned. plete a he facility to h	02/18/08 03/18/08 03/27/08 03/27/08 03/04/08 03/27/08	

Health Regulation Administration STATE FORM

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/S IDENTIFICATION NUMB			(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
		095019		B. WING		02/11	1/2008		
NAME OF PR	ROVIDER OR SUPPLIER			DRESS, CITY, STATE, ZIP CODE					
GRANT F	PARK CARE CENTER			RROUGHS AVE. NE STON, DC 20019					
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REC NTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD BI REFERENCED TO THE APPROPRIATE DE	(X5) COMPLETE DATE			
•	Continued From page resident rooms obset 4S: Dining room in cobserved on 4S. 5S: Rooms 533 and resident rooms obset 5N: rooms 503 and resident rooms obset E. HVAC Units 2S: Dining room and (7) resident rooms of 4S: Dining room in cobserved on 4S. F. Doors 2N: Room 204, 205 resident rooms observed on 233 in on rooms observed. 5S: Room 508 in on observed and one (7 missing in the wome Marred/scarred entrol, 2, 3, 4 and 5, in 1 G. Chairs 5S: One (1) of five (8 and room 518 in one observed. H. Baseboards 1st Floor: Damaged	ge 59 erved. one (1) of one (1) dining 536 in two (2) of six (erved. 515 in two (2) of severe erved. d room 216 in one (1) observed. one (1) of one (1) dining and 206 in three (3) of severed.	of seven of seven of eight (8) dent of on floors oom. d on floors oserved. ning room	L 410	1J. Stairwells 1. The soiled floors in the North and stairwells have been cleaned. 2. stairwells have been inspected thousekeeping/Laundry Director to visiarwells are clean and in compliant. 3. The Housekeeping staff will be reson the importance of cleaning the stidaily. The Housekeeping/Laundry Edesignee will complete QI monitoring weeks, then weekly of stairwells to compliance. 4. Findings from the reviews will be the Risk Management/Quality Improcommittee monthly X 12 months. 1K. Elevator tracks 1. The elevator tracks for Elevators have been cleaned. 2. The Housekeeping/Laundry Dire inspect the elevator tracks are cleaned and 3 to ensure tracks are cleaned in the importance of cleaning the elevators. The Housekeeping/Laundry designee will complete a QI monitor weeks, then weekly of elevator tracensure compliance. 4. Findings from the reviews will be the Risk Management/Quality Improcommittee monthly X 12 months.	d South by the verify ce. eeducated airwells Director or g daily X or ensure reported to ovement 1, 2 and 3 ctor will ators 1, 2 thoroughly. Beducated levator Director or daily X or experies to experience to	03/18/08 03/18/08 03/27/08 03/27/08 03/17/08 03/18/08 03/20/08		
	23. KUUIII 229 II) ON	e (1) oi severi (7) fesi	ueni						

		(X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUME 095019		(X2) MULTIF A. BUILDING B. WING	PLE CONSTRUCTION	(X3) DATE SUF COMPLET			
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	DRESS, CITY, STATE, ZIP CODE					
	PARK CARE CENTER		5000 BUR	ROUGHS AV	/E. NE	· 			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	FATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD B REFERENCED TO THE APPROPRIATE DE	BE CROSS-	(X5) COMPLETE DATE		
L 410	resident rooms observed 2N: Rooms 205, 21 (8) rooms observed closet and one (1) of 3S: Room 322 in or rooms observed and 5S: Dining room in observed on 5S. 5N: Women's bathing one (1) shower room. I. Panels Marred/scarred/damnursing stations in estations observed. Elevator panels were (3) elevator cars. J. Television Stand Black television stammarred/scarred/damrooms on all units in stands observed. K. Ceiling Tiles 1st Floor: Dining rooms on all units in stands observed. K. Ceiling Tiles 1st Floor: Dining rooms (2): Rooms 223, 23 (7) resident rooms (2): One (1) of one (1) telephone (1) clean utility dining room. 3S: One (1) of one (3) of one (3): One (1) of one (1) of one (3): One (1) of one (4): One (1) of one (5): One (1) of one (6): One (7): One (erved and by the water 1 and 216 in three (3) I and one (1) of one (1) of one (1) of one (1) of seven (7) residence (1) of one (1) dining one (1) of one (1) dining/shower room in one one one one one one one one one on	of eight) janitor's ident tion. ng room e (1) of ront of the ursing of three living television of seven oom, one one (1) of ne (1)	L 410	2A. Furniture 1. The marred/scarred and damage found in the facility that included chadining room, a missing drawer front 225, a missing footboard in room 236 on chairs and tables in the dining room drawer front in rooms 210 and 211 chairs in the dining room, a missing drawer in room 335 on 3 South, chaliving room and a missing dresser droom 313 on 3 North and chairs in troom, a damaged foot board in room issing drawer in room 536 have be repaired or replaced. 2. The Maintenance staff will conduct furniture throughout the building replace items that are marred and so. 3. Maintenance staff will be reeduct importance of identifying and repair replacing marred and scarred items throughout the facility as part of the preventative maintenance. 4. Findings from the reviews will be the Risk Management/Quality Improcommittee monthly X 12 months.	airs in the in room 29 and 2 South, a, missing on 2 North, dresser airs in the drawer in the dining m 529 and een uct a review to repair/scarred. Eated on the ing/s found ir daily	03/27/08 03/27/08 03/27/08		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER					(X3) DATE SURVEY COMPLETED			
		095019		B. WING		02/1	1/2008	
NAME OF PI	ROVIDER OR SUPPLIER		STREET ADD	T ADDRESS, CITY, STATE, ZIP CODE				
	PARK CARE CENTER			JRROUGHS AVE. NE NGTON, DC 20019				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REC NTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD B REFERENCED TO THE APPROPRIATE DE	N SHOULD BE CROSS-		
L 410	telephone closet, an (7) resident rooms of 3. Non-Functional Li 2N: One (1) of one (1) we toilet stall and with mas: Room 308 in on rooms observed. 3N: Room 329 in on rooms observed and bathing/shower room 5S: Room 518 in on observed. 5N: Room 532 in on observed and one (1) broken ice mindicating the machifebruary 3, 2008 at 4S: Shower head in bathing/shower room 5N: Men's bath tub sin the tub in one (1) shower/bathing room 5. Odors During the initial tou detected in rooms 3.	1) pantry, one (1) of od room 309 in one (1) bserved. ghts 1) men's bathing/shower of cover. e (1) of seven (7) residence (1) of seven (7) residence (1) of one (1) wone (1) of one (1) wone (1) of one (1) men's n. guipment et in room 236 in one one one of one (1) of one (1) men's n. guipment et in room 236 in one one one of one (1) of one (1) wone (1) of one (1) men's n. stopper failed to releated of one (1) men's n.	wer room, er room dent ident omen's int rooms int rooms (1) of e (1) of ge il on men's se water	L 410	2B. Walls 1. Marred, scarred and damaged a walls in the 1 st floor dining room, tra wall tile, in rooms 211 and 213 on 2 223, 233, 234, 236, outside 220, an in the women's bathing/shower roor 2 North, walls in room 309 on 3 Sou wallpaper in the dining room on 3 N 419 on 4 South, the dining room on damaged tile in the women's bath st 5 South and hallway walls have be 2. The Maintenance staff will compreview of walls to ensure any additimarred/scarred walls are repaired. 3. The Maintenance staff will be rest the importance of inspecting walls at their daily preventative maintenance will perform QI monitor daily X 2 we weekly to ensure continued complia 4. Findings from the reviews will be the Risk Management/Quality Improcommittee monthly X 12 months. 2C. Floors 1. The shower rooms in the Men ar shower/bath rooms on the 2 nd , 3 rd , 4 floors have been repaired and re-paired and re-	ining toilet South, in d wall tiles m on with, peeling orth, room 4 North, the tall on en repaired. lete an conal educated on is part of e to ensure red and e Director eks, then ince. e reported to exement and womens' the and 5th ainted. expected identify educated on room floors aintenance. rm a com floors e reported to	03/05/08 03/21/08 03/27/08 03/27/08 03/27/08	

NAME OF PROVIDER OR SUPPLIER GRANT PARK CARE CENTER SITEST ADDRESS, CITY, STATE, ZIP CODE SOOD BURROUGHS AVE. NE WASHINGTON, DC 20019 L410 CACH DEPRICIPACY MUST BE PRECEDED BY FULL REGULATORY TAG CACH DEPRICIPACY MUST BE PRECEDED BY FULL REGULATORY TAG L410 Continued From page 62 of 55 resident rooms observed as follows: 2nd floor- 211, 213, 220 and 233 5th floor- 503, 505, 522, 527, 529, and 532 Dietary Services 1. Floors were observed soiled throughout the kitchen with damaged tiles in the dish machine room and the cook's prep area, under the pot and pan sink, and in the dish machine room. 3. The exterior surfaces of the tilt grill were observed soiled with grease and debris in one (1) of one (1) gial observed. 4. The interior and top surfaces of the gas oven were observed soiled with grease and debris in one (1) of one (1) gas oven observed. 5. The exterior surface of the deep fryer was observed soiled with grease and debris in one (1) of one (1) gas oven observed. 6. Cooking hood filters were observed soiled with grease and debris in one (1) of one (1) deep fryer observed. 7. The calking above the three (3) compartment sink in the pot and pan wash area was observed soiled with grease and debris in the dish machine room, the pot and pan wash area was observed soiled with grease and debris in three (3) 8. The interior surface of drains in the dish machine room supplementation one (1) of one (1) deep fryer observed. 9. The calking above the three (3) compartment sink in the pot and pan wash area was observed soiled with grease and debris in three (3) 9. The interior surface of drains in the dish machine room, by the sink in the cook's prep area and by the sink in the pot and pan wash area was observed soiled with grease and debris in three (3) 9. The Maintenance staff will complete a review of HVAC units in the facility to identify other deficient areas so immediate corrective action may be taken. 9. The Maintenance staff will complete a review of HVAC units in the facility to identify other		PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
STREET ADDRESS. CITY, STATE. JP CODE SOO BURROUGHS AVE. NE WASHINGTON, DC 20019 L 410 CALCH DEPTICIPATION INFORMATION OR LSC IDENTIFYING INFORMATION L 410 Continued From page 62 of 55 resident rooms observed as follows: 2nd floor- 211, 213, 220 and 233 Sth floor- 503, 505, 522, 523, 527, 529, and 532 Dietary Services 1. Floors were observed soiled throughout the kitchen with damaged tiles in the dish machine room and the cook's prep area, under the pot and pan sink, and in the dish machine room. 2. Baseboards were observed soiled throughout the kitchen and damaged in the cooks prep area, under the pot and pan sink, and in the dish machine room. 3. The exterior surfaces of the tilt grill were observed soiled with grease and debris in one (1) of one (1) tilt grill observed. 4. The interior and top surfaces of the gas oven were observed soiled with grease and debris in one (1) of one (1) gas oven observed. 5. The exterior surface of the deep fryer was observed soiled with grease and debris in one (1) of one (1) gas oven observed. 6. Cooking hood filters were observed soiled with grease and dust in 11 of 11 cooking hoods observed. 7. The callking above the three (3) compartment sink in the pot and pan wash area was observed soiled with direase and dust in 11 of 11 cooking hoods observed. 8. The interior surface of drains in the dish machine room, by the sink in the cook's prep area and by the sink in the pot and pan wash area ware by the sink in the pot and pan wash area were by the proposed to the Risk Management/Quality Improvement committee of checking the facility to identify other deficient areas so immediate corrective action may be taken. 3. The Maintenance stiff will complete a review of the Wash wash area was observed soiled with direase and dust in 11 of 11 cooking hoods observed. 5. The interior surface of drains in the dish machine room, by the sink in the cook's pr			095019		B. WING		02/1	02/11/2008		
MASHINGTON, DC 20019 MASHINGTON, DC 20019	NAME OF PR	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	ATE, ZIP CODE				
L 410 Continued From page 62 of 55 resident rooms observed as follows: 2nd floor- 211, 213, 220 and 233 5th floor- 503, 505, 522, 523, 527, 529, and 532 Dietary Services 1. Floors were observed soiled throughout the kitchen with damaged tiles in the dish machine room and the cook's prep area, under the pot and pan sink, and in the dish machine room. 3. The exterior surfaces of the tilt grill were observed soiled with grease and debris in one (1) of one (1) till grill observed. 4. The interior and top surfaces of the deep fryer was observed soiled with grease and debris in one (1) of one (1) deep fryer observed. 5. The exterior surface of the deep fryer was observed soiled with grease and debris in one (1) of one (1) deep fryer observed. 7. The calking above the three (3) compartment sink in the pot and pan wash area were and by the sink in the pot and pan wash area were and by	GRANT F	PARK CARE CENTER								
of 55 resident rooms observed as follows: 2nd floor- 211, 213, 220 and 233 5th floor- 503, 505, 522, 523, 527, 529, and 532 Dietary Services 1. Floors were observed soiled throughout the kitchen with damaged tiles in the dish machine room and the cook's prep area. 2. Baseboards were observed soiled throughout the kitchen and damaged in the cooks prep area, under the pot and pan sink, and in the dish machine room. 3. The exterior surfaces of the tilt grill were observed soiled with grease and debris in one (1) of one (1) tilt grill observed. 4. The interior and top surfaces of the gas oven were observed soiled with grease and debris in one (1) of one (1) deep fryer observed. 5. The exterior surface of the deep fryer was observed soiled with grease and debris in one (1) of one (1) deep fryer observed. 7. The caulking above the three (3) compartment sink in the pot and pan wash area was observed and by the sink in the pot and pan wash area was observed and by the sink in the pot and pan wash area wars observed and by the sink in the pot and pan wash area wars observed and by the sink in the pot and pan wash area were owned and by the sink in the pot and pan wash area were owned and by the sink in the pot and pan wash area were owned and by the sink in the pot and pan wash area were and by the sink in the pot and pan wash area were committee committey and pan wash area were committee to the Risk Management/Quality Improvement committee monthly X 12 months. 2D. Windows 1. The damaged window seals and screens will be cortected by replacing the windows. Bids will be collected to replace windows. Bids will be collected to replace windows. Bids will be collected to replace windows in room 25 0n 3 South, rooms 305 and 356 on 5 South and rooms 305 and 318 on 3 North, the dining room as ferview of windows and 515. 2. The maintenance staff will complete an review of windows and 515. 3. The maintenance staff will complete an review of windows and 510 and 510. 3. The maintenance staff will complete an review of wi	PREFIX	(EACH DEFICIENCY MUST	BE PRECEDED BY FULL REC	GULATORY	PREFIX	(EACH CORRECTIVE ACTION SHOULD B	(X5) COMPLETE DATE			
of three (3) drains observed.	L 410	of 55 resident room 2nd floor- 211, 213, 5th floor- 503, 505, Dietary Services 1. Floors were observitchen with damage room and the cook's 2. Baseboards were the kitchen and damunder the pot and paroom. 3. The exterior surrobserved soiled with one (1) tilt grill observed soiled with one (1) of one (1) gas ov 5. The exterior surrobserved soiled with one (1) deep fryer of 6. Cooking hood fingrease and dust in 1 observed. 7. The caulking absink in the pot and posiled with dirt and not served soiled with observed soiled with observed soiled with observed soiled with observed soiled with	s observed as follows 220 and 233 522, 523, 527, 529, and 24 soiled throughoused tiles in the dish made prep area. The observed soiled throughoused in the cooks prepare and in the dish made prepare and in the dish made prepare and in the dish faces of the tilt grill was grease and debris in the dish face of the deep fryer agrease and debris in observed. Iters were observed soiled throughout the three (3) compared to the three (4) compared to the three	t the chine roughout ep area, h machine ere one (1) of as oven bris in one was one (1) of oiled with s partment served sh prep area area were	L 410	1. The damaged window seals and will be corrected by replacing the win Bids will be collected to replace wind room 225 on 2 South, rooms 322 and 3 South, rooms 305 and 318 on 3 N dining room on 4 South, rooms 533 5 South and rooms 503 and 515. 2. The maintenance staff will complimeter of windows in the facility to cother areas are in need of correction 3. The maintenance staff will be recon the importance of checking windout of their daily preventative maintenance Maintenance Director will perform Q daily X 2 weeks, then weekly to enscontinued compliance. 4. Findings from the reviews will be the Risk Management/Quality Improcommittee monthly X 12 months. 2E. HVAC Units 1. The HVAC Units 1. The HVAC Units in the dining room 216 on 2 South and the dining 4 South have been repaired. 2. The Maintenance staff will complimeter of HVAC units in the facility other deficient areas so immediate a action may be taken. 3. The Maintenance will be reeducating importance of checking HVAC units their daily preventative maintenance that units are operable. The Maintenance that units are operable. The Maintenance of checking HVAC units their daily preventative maintenance that units are operable. The Maintenance that units are operable. The Maintenance of Checking HVAC units their daily preventative maintenance that units are operable. The Maintenance that units are operable of the reviews will be the Risk Management/Quality Impro	ndows. dows in nd 325 on orth, the and 536 on lete an determine if n. educated ows as part nce. The il monitor ure reported to ovement om and i room on lete a to identify corrective ated on the as part of it to ensure enance daily X tinued	03/27/08 03/27/08 03/27/08 03/18/08		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			A. BUILDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		095019		B. WING		02/1	1/2008
NAME OF PR	ROVIDER OR SUPPLIER				ATE, ZIP CODE		
GRANT P	PARK CARE CENTER					_	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	TBE PRECEDED BY FULL REC	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD BI REFERENCED TO THE APPROPRIATE DE	E CROSS-	(X5) COMPLETE DATE
L 410	5000 BURR		L 410	2F. Doors 1. The marred, scarred, and damag missing doors in rooms 204, 205 and 2 North, room 233 on 2 South, room two bath stall doors in the women's shower room and the entry doors of 2, 3, 4, and 5 have been repaired ar replaced. 2. The Maintenance staff will complicately to determine if other areas ar of correction. 3. The Maintenance staff will be reed the importance of checking marred/s doors and bath stall doors as part of preventative maintenance. The Main Director will perform a QI monitor data 2 weeks, then weekly to ensure concompliance. 4. Findings from the reviews will be the Risk Management/Quality Improcommittee monthly X 12 months. 2G. Chairs 1. The torn chair in the dining room 518 on 5 South have been repaired 2. The Maintenance Director will conformed and the sure any additional tom furniture in replaced. 3. The Maintenance staff will be ree inspecting furniture in assigned area immediately correct any deficiencies Maintenance Director will perform rareviews of facility furniture to ensure compliance. 4. Findings from the reviews will be the Risk Management/Quality Improcommittee monthly X 12 months.	d 206 on 508 and bathing/ floors 1, floors 1, floors 1, floors in the e in need educated on scarred their daily ntenance filly X tinued reported to vernent and room or replaced floors repaired educated on scarred educated on scarred floor replaced floor replaced floor floor replaced floor floo	03/27/08 03/27/08 03/27/08 03/27/08 03/27/08 03/27/08	
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIF	PLE CONSTRUCTION	. ,	(X3) DATE SURVEY COMPLETED			
		005040		B. WING	<u> </u>	20044			
		095019		02/11/2008					
NAME OF PROVIDER OR SUPPLI	ER			DRESS, CITY, STATE, ZIP CODE					
GRANT PARK CARE CEN	ITER	·		RROUGHS AVE. NE GTON, DC 20019					
PREFIX (EACH DEFICIENC					PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD E REFERENCED TO THE APPROPRIATE DI	(X5) COMPLETE DATE			
the pot and part of a previounder the sink electrical plug disposal. Employmen it was id 19. It was obstantize cooking them in the thit #5 stated that failed to hold was a part of the stated to hold was a stated that failed to hold was a stated that the stated that failed to hold was a stated that failed to hold was a stated that the stated that failed to hold was a stated that the stated t	the pot and pan wash area. 18. An unused detergent processor box, that was part of a previous chemical system, was observed under the sink in the cook's prep area with the electrical plug sitting in the drain under the garbage disposal. Employee #7 removed the processor box when it was identified as no longer in use. 19. It was observed that Employee #5 failed to sanitize cooking vessels after washing and rinsing them in the three (3) compartment sink. Employee #5 stated that the third compartment of the sink failed to hold water and he/she had not sanitized cooking vessels washed that day or the day before.				2H. Baseboards 1. The damaged baseboards in the room on the 1 st floor, room 229 on 2 rooms 205, 211, 216, the janitor's of the dining room on 2 North, room 3 nurse's station on 3 South, the dining 5 South and the women's bathing/s on 5 North have been replaced. 2. The maintenance staff will inspect baseboards throughout the facility to other areas in need of repair. Any observed baseboards identified during this instended. 3. The Maintenance staff will be reinspecting baseboards as part of the preventative maintenance. The Ma Director will conduct QI monitoring 2 weeks, then weekly to ensure corcompliance. 4. Findings from the reviews will be the Risk Management/Quality Improcommittee monthly X 12 months.	02/19/08 03/27/08 03/27/08			
Each facility si that the premis and shall be k might provide This Statute is Based on obse facility staff fai control progra- within the facil The findings in During the rec observed in the 2South mens and 5North me	Each facility shall be constructed and maintained so that the premises are free from insects and rodents, and shall be kept clean and free from debris that might provide harborage for insects and rodents. This Statute is not met as evidenced by: Based on observations, it was determined that the facility staff failed to maintain an effective pest control program as evidenced by pests observed within the facility. The findings include: During the recertification survey crawling pest were observed in the following areas: 2South mens bath, Room 325, 3S nursing station and 5North men's bath A roach was observed crawling up the wall by the		L 426	L 426 3257.3 Nursing Facilities 1. The pest control vendor was notified immediately of the sightings. Areas have been treated to control/eliminate pests. 2. The pest control vendor completed a full inspection of the kitchen to identify other areas in need of treatment. Areas have been addressed to control/eliminate pests. 3. The pest control vendor has been scheduled to inspect areas of the kitchen weekly and treat areas as needed. Staff will be in-serviced on reporting pest concerns immediately to the Food Services Director or designee for appropriate follow-up with the pest control vendor. Food Services Director, or designee, will QI monitor daily X 2 weeks, then to ensure communication of pest issues has occurred. 4. A summary of the inspections will be reported to the Risk Management/Quality Improvement committee monthly X 12 months.		02/05/08 03/27/08 03/27/08			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED
	095019	B. WING	02/11/2008

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

5000 BURROUGHS AVE. NE

GRANT PARK CARE CENTER			5000 BURROUGHS AVE. NE WASHINGTON, DC 20019					
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REC		(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS- REFERENCED TO THE APPROPRIATE DEFICIENCY)			
L 410	Continued From page 65		L 410	2I. Panels 1. The damaged baseboards in the dining room on the 1 st floor, room 229 on 2 South, rooms 205, 211, 216, the janitor's closet and the dining room on 2 North, room 322 and the nurse's station on 3 South, the dining room on 5 South and the women's bathing/shower room on 5 North have been replaced. 2. The maintenance staff will inspect baseboards throughout the facility to identify other areas in need of repair. Any damaged baseboards identified during this inspection will	02/19/08			
				be replaced. 3. The Maintenance staff will be reeducated on inspecting baseboards as part of their daily preventative maintenance. The Maintenance Director will conduct QI monitoring daily X 2 weeks, then weekly to ensure continued compliance. 4. Findings from the reviews will be reported to the Risk Management/Quality Improvement committee monthly X 12 months.	03/27/08 03/27/08 03/27/08			
				2J. Television Stands 1. The marred, scarred and damaged black television stands in the dining and/or living rooms on units have been repaired or replaced 2. The Maintenance Director has inspected television stands in common areas to ensure the stands are in good working condition. 3. The Maintenance staff will be reeducated on inspecting television stands during their daily furniture preventative maintenance. The Maintenance Director will conduct QI	03/27/08			
				monitoring daily X 2 weeks, then weekly of furniture to ensure continued compliance. 4. Findings from the reviews will be reported to the Risk Management/Quality Improvement committee monthly X 12 months.	03/27/08 03/27/08			

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/C EDENTIFICATION NUMBER			(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
	=	095019		B. WING_		02/11	/2008		
NAME OF PR	OVIDER OR SUPPLIER	_	STREET ADD	ADDRESS, CITY, STATE, ZIP CODE					
GRANT P	ARK CARE CENTER			ROUGHS AV TON, DC 20					
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL RECONTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIATE DE	E CROSS-	(X5) COMPLETE DATE		
L 410	Continued From pag	pe 65A		L 410	2K. Ceiling Tiles 1. Stained and/or damaged ceiling to 1st floor dining room, rooms 223, 23 on 2 South, the stretcher storage root telephone equipment room, the clear room and dining room on 2 North, the utility room on 3 South and room 33 pantry, telephone closet and room 3 North have been replaced. 2. The Maintenance staff will complication will be taken to replace stained damaged ceiling tiles in the facility, action will be taken to replace stained damaged ceiling tiles in any deficien 3. The maintenance staff will be reet the importance of checking ceiling tile of their daily preventative maintenant Maintenance Director will perform Quantitoring daily X 2 weeks, then we ensure continued compliance. 4. Findings from the reviews will be the Risk Management/Quality Improcommittee monthly X 12 months. 3. Non-Functional Lights 1. Lights and light covers have been the men's bathing/shower room toilet 308, Room 329, the women's bathin room on 3 North, Room 518, Room the men's bathing/shower room. 2. The maintenance staff will compliance on ilghts in the facility to ensure be repaired or replaced. The Maintenance of checking lights as par preventative maintenance to ensure be repaired or replaced. The Maintenance. 4. Findings from the reviews will be to the facility Risk Management/Qualimprovement committee monthly X 2 weeks, then weekly to ensure continuompliance. 4. Findings from the reviews will be to the facility Risk Management/Qualimprovement committee monthly X 2 weeks, then weekly to ensure continuompliance.	om, the nutility see clean 3 and the 09 on ete an Corrective set and/or training as partice. The lekly to reported to vernent stall, Room g/shower 532 and ete a ure are litter to fitheir lights will enance aily X 2 ued submitted lity	03/27/08 03/27/08		
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Health Regulation Administration STATE FORM

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						FORM	APPROVED	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/IDENTIFICATION NUMB		(X2) MULTI	PLE CONSTRUCTION	(X3) DATE SUR COMPLETI		
		095019				02/11	1/2008	
NAME OF PE	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, ST	ATE, ZIP CODE			
GRANT F	GRANT PARK CARE CENTER 5000 BU WASHIN				VE. NE 0019			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MU:	STATEMENT OF DEFICIENCIES ST BE PRECEDED BY FULL REG DENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ((EACH CORRECTIVE ACTION SHOULD BE CROSS- REFERENCED TO THE APPROPRIATE DEFICIENCY)			
L 410	Continued From pa	age 65 B		L 410	4. Non-Functional Equipment 1. Corrective action has been take leaking tub faucet in room 236 has repaired. The broken ice machine signage on 2 North has been fixed be placed on broken equipment the facility. The leaking shower head South women's bathing/shower rorrepaired. The tub stopper that failwater in the tub in the 5 North Merchas been repaired. 2. Maintenance staff will complete on faucets, ice machines, shower bath tub stoppers in the facility to be residents are not affected by these 3. Maintenance will be reeducated importance of checking non-functive equipment as part of their daily premaintenance. The Maintenance Deerform QI monitoring daily X 2 we weekly to ensure continued complete to the facility Quality Improvement monthly X 12 months.	s been with no l. Signs will broughout the in the 4 om has been ed to release it's bath tub e an review heads, and ensure other e deficiencies. d on the brougher eventative birector will eeks, then iance. be submitted	02/17/08 03/18/08 03/27/08 03/27/08	
					 Odors Corrective action has been take 320, 325, and 512 have been clead disinfected to eliminate the urine a odors. A 100% review of resident room offensive odors. Once identified, rocleaned and disinfected to eliminated. Housekeeping and Nursing stain-serviced on maintaining a living for the residents that is free of offee The Housekeeping Director or desconduct random reviews of residentially to ensure compliance. Findings from the daily reviews submitted to the Risk Management Improvement Committee monthly 	ned and nd fecal ms will be with strong coms will be te odors. aff will be environment insive odors. signee will nt rooms will be t/Quality	03/27/08 03/27/08 03/27/08	

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(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;

(X2) MULTIPLE CONSTRUCTION

(X3) DATE SURVEY COMPLETED

095019

A. BUILDING B. WING ___

02/11/2008

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

GRANT PARK CARE CENTER

5000 BURROUGHS AVE. NE WASHINGTON, DC 20019

FRANT P	ARK CARE CENTER	VASHINGTON, DC 21	0019	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGUL) OR LSC IDENTIFYING INFORMATION)	ATORY REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS- REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLET DATE
L 410	Continued From page 65 C	L 410	6. Clutter 1. The Housekeeping and Nursing Staff have eliminated the clutter found in Rooms 211, 213, 220, 233, 503, 505, 522, 523,527, 529 and 532. 2. Resident rooms throughout the facility have been inspected to identify rooms with clutter. Once located, rooms with excessive clutter will be cleaned and clutter will be removed. 3. The Housekeeping and Nursing staff will be reeducated on recognizing rooms that need to	03/20/0
			be de-cluttered and notifying the Housekeeping/Laundry or Nursing supervisor to address the concern. The Housekeeping/Laundry Director or designee will complete QI monitoring daily X 2 weeks, then weekly to ensure compliance. 4. Findings from reviews will be submitted to the facility Risk Management/Quality	03/27/0
			Improvement committee monthly X 12 months. Dietary Services	03/27/0
			#1 1. Floors were cleaned throughout the kitchen. 2. The Food Services Director has completed a review throughout the department to ensure floors were cleaned appropriately. Floors are to be cleaned after each meal and as needed. 3. The Food Services staff will be reeducated.	02/04/0
·			on the floor cleaning schedule. Food Services Director, or designee, will QI monitor daily X 2 weeks, then weekly for clean floors. 4. Findings from the QI monitoring will be reported to the Risk Management/Quality Improvement committee X 12 months.	03/27/0
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X3) DATE SURVEY COMPLETED (X2) MULTIPLE CONSTRUCTION A. BUILDING

095019

B. WING_

02/11/2008

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

5000 BURROUGHS AVE. NE

GRANT PARK CARE CENTER		6000 BURROUGHS AVE. NE WASHINGTON, DG 20019					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REG OR USC IDENTIFYING INFORMATION)	ULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS- REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XB) COMPLETI DATE		
L 410	Continued From page 65 D		L410	#2 1. Base boards were cleaned throughout the kitchen (02/11/08). The damaged baseboards in the cooks' prep area, underneath the pot and pan sink and in the dish machine room will be replaced. 2. The Food Services Director has completed a review throughout the department to ensure base boards were cleaned appropriately. Baseboards are to be cleaned with the floor cleaning and as needed. 3. The Dietary staff will be reeducated on the proper way and frequency to clean baseboards. Food Services Director, or designee, will QI monitor daily X 2 weeks, then weekly. 4. Findings will be reported to the Risk Management/Quality Improvement committee.	03/27/0 03/21/0 03/27/0		
				#3 1. The exterior surfaces of the tilt grill were thoroughly cleaned. 2. The Food Services Director completed a	03/27/0		
	,			review of the tift grill to ensure the exterior surfaces were cleaned appropriately. 3. Food Services staff shall be reeducated on the cleaning schedule and cleaning procedures. Food Services Director, or designee, will QI monitor daily X 2 weeks, then weekly for completion of cleaning schedule.	03/27/0		
			. •	Findings will be reported to the Risk Management/Quality Improvement committee X 12 months.	03/27/0		
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STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING 095019 02/11/2008 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **5000 BURROUGHS AVE. NE GRANT PARK CARE CENTER** WASHINGTON, DC 20019 PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE CROSS-SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (X4) ID PREFIX TAG (XS) COMPLETE DATE PREFIX OR LSC IDENTIFYING INFORMATION) REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG Continued From page 65 E L 410 1. The interior and top surfaces of the gas oven 03/27/08 were cleaned thoroughly. 2. The Food Services Director completed a review of the gas oven in the kitchen to ensure the interior and top surfaces of the gas oven were cleaned appropriately. 03/27/08 3. Food Services staff shall be reeducated on the cleaning schedule and cleaning procedures. Food Services Director, or designee, will QI monitor daily X 2 weeks, then weekly for completion of cleaning schedule. 03/27/08 4. Findings will be reported to the Risk Management/Quality Improvement committee X 12 months. 03/27/08 1. The exterior surface of the deep fryer was cleaned thoroughly. 03/27/08 2. The Food Services Director completed a review of the exterior surface of the deep fryer to ensure the deep fryer was cleaned appropriately 03/27/08 3. Food Services staff shall be reeducated on the cleaning schedule and cleaning procedures Food Services Director, or designee, will QI monitor daily X 2 weeks, then weekly for completion of cleaning schedule. 03/27/08 4. Findings will be reported to the Risk Management/Quality Improvement committee X 12 months. 03/27/08

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIDENTIFICATION N		A BUILDING		(X3) DATE SUR COMPLETI	
5		0 95019 .		B. WING		02/11	1/2008
	ROVIDER OR SUPPLIER		5000 BUR	RESS, CITY, ST. ROUGHS AV TON, DC 20	/E. NE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENT BE PRECEDED BY FULL NTIFYING INFORMATION	REGULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD BI REFERENCED TO THE APPROPRIATE DE	ECROSS-	(X5) COMPLETE DATE
L 410	Continued From pag	ge 65 F		L 410	#6 1. The cooking hood filters were rer cleaned thoroughly. 2. The Food Services Director complinspection of the cooking hood filters	pleted an	03/27/08
					ensure the cooking hood filters were appropriately. 3. Food Services staff shall be reed the cleaning schedule and cleaning Food Services Director, or designed.	ducated on procedures. will QI	03/27/08
;					monitor daily X 2 weeks, then weekly completion of cleaning schedule. 4. Findings will be reported to the Ri Management/Quality Improvement of the Riman and the Riman an	03/27/08	
					X 12 months.		03/27/08
					#7 1. The caulking above the three corsink in the pot and pan wash area w removed and replaced. 2. The Food Services Director has a review of the kitchen to ensure the is adequate throughout the kitchen.	fill be completed	03/27/08
·			;		3. Food Services staff will be reedu completing maintenance repair requi have damaged, soiled or molded car replaced. Food Services Director, or will Q! monitor daily X 2 weeks, then	ests to ulking designee,	0.00
	·				completion of cleaning schedule. 4. Findings will be reported to the Risk Management/Quality Improvement month		03/27/08
					12 months.	,	03/27/08
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PRINTED: 03/05/2008 FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MUI, TIPLE CONSTRUCTION

A. BUILDING

B. WING

D2/11/2008

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGION LSC IDENTIFYING INFORMATION)	JLATORY PR	ID EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS- REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLET DATE
L 410	Continued From page 65 G	L 41	0	#8 1. The interior surface of the drains in the dish machine room, by the sink in the cook's prep area and by the sink in the pot and pan wash area were cleaned thoroughly. 2. The Food Services Director inspected the interior surface of the drains in the dish machine room, by the sink in the cook's prep area and by the sink in the pot and pan wash	03/27/0
				area to ensure the items were cleaned appropriately. 3. Food Services staff shall be reeducated on the cleaning schedule and cleaning procedures. Food Services Director, or designee, will QI monitor daily X 2 weeks, then weekly for	03/27/0
				completion of cleaning schedule, 4. Findings will be reported to the Risk Management/Quality Improvement committee X 12 months,	03/27/
				#9 1. The interior and exterior surface of the two hand washing sinks were cleaned thoroughly. 2. The Food Services Director completed a review of the two hand washing sinks to	03/27/
				ensure the sinks were cleaned appropriately. 3. Food Services staff shall be reeducated on the cleaning schedule and cleaning procedures. Food Services Director, or designee, will Olymonitor daily X 2 weeks, then weekly for	03/27/0
				completion of cleaning schedule. 4. Findings will be reported to the Risk Management/Quality Improvement committee X 12 months.	03/27/0

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED			
	!	095019		B: WING		02/1	1/2008		
NAME OF PE	ROVIDER OR SUPPLIER		STREET ADD	DRESS, CITY, STA	ATE, ZIP CODE		77877		
GRANT F	PARK CARE CENTER	·		00 BURROUGHS AVE. NE ASHINGTON, DC 20019					
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REC ENTIFYING INFORMATION)		ORY PREFIX (EACH CORRECTIVE ACTION SHOULD TAG REFERENCED TO THE APPROPRIATE D			(X5) COMPLETE DATE		
L 410	Continued From pag	je 65 H		L 410	#10 1. The ceiling tile near the door labe will be replaced with a properly fitted prevent the exposure of cable wires. 2. The Food Services Director has a review of ceiling tiles throughout to ensure tiles are properly fitted. 3. The Food Services staff will be in on completing maintenance repair rehave damaged, soiled or ill-fitted cel replaced. Food Services Director, or will QI monitor monthly. 4. Findings will be reported to the Ri Management/Quality Improvement of monthly X 12 months.	d plece to completed the kitchen serviced equests to illing tiles r designee, isk	03/27/08 03/27/08 03/27/08		
					1. The ice scoop holders have been on the ice machines to store the ice 2. The Food Services Director has it the ice machine and validated the ich holder is properly affixed to the machine ice scoop is placed in the holder. 3. The Food Services staff will be in on the importance of placing the ice inside the ice scoop holder when not Food Services Director, or designee, monitor daily X 2 weeks, then weekly placement of the ice scoop. 4. Findings will be reported each monitor Risk Management/Quality Improvem committee X 12 months.	scoops. inspected se scoop thine and n-serviced scoop it in use. will QI y for proper	03/27/08 03/27/08 03/27/08		
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STATE FORM

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUMB		(XX) MULTIPLE CONSTRUCTION A BUILDING		(X3) DATE SURVEY COMPLETED	
		D95019		B. WING			1/2008
NAME OF PE	ROVIDER OR SUPPLIER			• • • • • • • •	TATE, ZIP CODE	_	
GRANT P	PARK CARE CENTER		5000 BURI WASHING	ROUGHS AV		<u> </u>	
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY TAG OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX TAG TAG			PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD B REFERENCED TO THE APPROPRIATE DE	(X8) COMPLETE DATE			
L 410	Continued From pag	ge 65 I		L 410	#12 1. Marred and scarred kitchen door repaired/replaced. 2. The Food Services staff will be in on completing maintenance repair remarred and scarred doors. 3. The Maintenance Director has on review throughout the facility to ensure adequate or repaired/replaced a Maintenance Director, or designee, monitor weekly X 4 weeks, then weekly X 12 months. #13 1. The Maintenance Director has repaired both leaks on the dish machine. 2. The Maintenance director has repaired both leaks on the dish machine. 3. The Maintenance director has coinspection of the dish machine and preventative maintenance as scheding prevent further leaks or malfunction in the dish machine and preventative maintenance department. Food Sen Director, or designee, will QI weekly maintenance is contacted with dish machine malfunctions. The Mainten Director or designee will inspect the machine monthly and immediately unotification of service problems/dish ensure optimal functioning. 4. Findings will be reported to the R Management/Quality Improvement canch month X 12 months.	on-serviced equests for conducted a ure doors as needed, will QI ekly. Risk committee	03/27/08 03/27/08 03/27/08 03/27/08 03/27/08 03/27/08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED
	095019	B. WING	02/11/2008

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

GRANT P	ARK CARE CENTER		Roughs a' Ton, DC 20		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGU OR USC IDENTIFYING INFORMATION)	ULATORY	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS- REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETE DATE
L 410	Continued From page 65 J		L 410	#14 1. Eight (8) food carts will be repaired/ replaced. 2. Eight (8) food carts will be repaired/ replaced. 3. The Food Services Director will QI monitor the condition of the new food carts weekly to ensure equipment is serviced and maintained as needed. Kitchen Staff will be educated on the new or repaired food carts care and maintenance. 4. Findings will be reported to the Risk	03/27/08 03/27/08
				Management/Quality Improvement committee X 12 months, #15 1. Employee #6 has been reeducated that he/she cannot light burners on the stove and must notify the Maintenance Director and the	03/27/08
-				Food Services Director when burners on the stove are not working. Employee #6 understands that he/she may not attempt to make any repairs to the kitchen equipment. 2. The Food Services Director has completed a review throughout the kitchen to identify any other equipment that is not functioning and his/her findings have been forwarded to the Maintenance Department for appropriate	03/27/08
				action/resolution. 3. The Food Services staff will be in-serviced that they cannot light burners on the stove and they must notify the Maintenance Director and Food Services Director whenever major equipment fails to operate/function property. Food Services Director, or designee, will QI monitor weekly X 4 weeks, then monthly X 12 months to ensure maintenance is contacted when kitchen equipment fails to function	03/27/08
alth Constant	tion Administration			properly.	03/27/08

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	DIPLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIF	IULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED			
1		095019		B. WING		9 2/11	/2008		
NAME OF PE	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE					
GRANT F	PARK CARE CENTER			0 BURROUGHS AVE. NE 9HINGTON, DC 20019					
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATOR			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD B REFERENCED TO THE APPROPRIATE DE	(X5) COMPLETE DATE			
L 410	Continued From pag	ge 65 K		L 410	#16 1. The cabinet door under the stear been repaired. 2. The Food Services Director has a review on cabinet doors throughout kitchen to identify other damaged/br	conducted ut the	03/27/08		
					equipment. Maintenance repair requipment. Maintenance repair requipmented to repair any broken equipmented to repair any broken and damaged kitchen equipmented to requipmented to repair requipmented to repair any broken equipmented to repair any broken equipme	ipment, eeducated equests for	03/27/08		
					Services Director, or designee, will weekly. 4. Findings will be reported to the R Management/Quality Improvement of	QI mon i tor Iisk	03/27/08		
					X 12 months. #17 1. The pest control vendor was noti		03/27/08		
					immediately of the sightings. All are been treated to control/eliminate per 2. The pest control vendor complete inspection of the kitchen to identify in need of treatment. Areas have b	es have sts. ed a full other areas	03/27/08		
				·	addressed to control/eliminate pests 3. The pest control vendor has been scheduled to inspect areas of the kill weekly and treat areas as needed, be in-serviced on reporting pest confirmediately to the Food Services Didesignee for appropriate follow-up with pest control vendor. Food Services I designee, will QI monitor daily X 2 will provide the pest control vendor.	chen Staff will cerns irector or ith the Director, or reeks, then	03/27/08		
		, ·		÷	to ensure communication of pest iss occurred. 4. A summary of the inspections will reported to the Risk Management/Q Improvement committee monthly X	l be uality	03/27/08 03/27/08		
							;		

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	OF DEFICIENCIES. F CORRECTION	(X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUMB		A. BUILDING B. WING		(X3) DATE SUF COMPLET				
		095019		<u> </u>		02/11	1/2008			
NAME OF PR	KÖVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE						
GRANT P	PARK CARE CENTER			ROUGHS AN		- 1 1-27° - 141	A			
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL RE		GULATORY	JLATORY PREFIX (EACH CORRECTION SHOULD BE CROSS TAG REFERENCED TO THE APPROPRIATE DEFICIENCY			OMPLETE DATE			
E 410	Continued From pag	ge 65 L		L 410	#18 1. The unused detergent box was dimmediately. 2. The Food Services Director has a review in the kitchen to ensure an items are appropriately discarded. 3. The Food Services Director will the Food Services staff on how and properly discarding unused items. Services Director, or designee, will	completed by unused reeducate when to Food QI monitor	03/27/08			
			·		daily X 2 weeks, then weekly X 4 weensure unused items have been dis 4. Findings will be reported to the Findings will be reported t	scarded. Risk	03/27/08			
,				·	#19 1. The sink has been repaired. 2. Pots and pans were rewashed a sanitized. 3. Food Services staff shall be reed the proper sanitation of cooking year.	Jucated on	02/03/08			
					Food Services Director or his/her de shall conduct reviews daily X 2 week weekly, of the three (3) compartmer station to verify staff compliance wit guidelines. 4. Copies of the review shall be sub the Risk Management/Quality Impro Committee each month for review X	esignee eks, then nts sink th sanitation mitted to	03/21/08			

	TEMENT OF DEFICIENCIES PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER			A. BUILDING	PLE CONSTRUCTIO	(X3) DATE SURVEY COMPLETED		
		095019		B. WING_		.1	02/11	/2008
•	OVIDER OR SUPPLIER		5000 BURI	DORESS, CITY, STATE, ZIP CODE PRROUGHS AVE. NE IGTON, DC 20019				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	RTEMENT OF DEFICIENCIES BE PRECEDED BY FULL REC INTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS- REFERENCED TO THE APPROPRIATE DEFICIENCY)			(XS) COMPLETE DATE
L 426	Continued From pag pot and pan wash as PM.	ge 65 rea on February 3, 20	08 at 3:00	L 426			·	
L 442	electrical, and patier operating condition. This Statute is not r Based on observation determined that the laundry equipment in residents personal laundry ensure that preventifor oxygen concentration. The findings include During a tour of the 2008, it was observe personal laundry dry (4) personal laundry dry (4) personal laundry dry of four (4) large drye working and two (2) for facility laundry working and two (3) for facility laundry working and two (4) for facility laundry working and two (5) for facility laundry working and two (6) for facility laundry working and two (7) for facility laundry working and two (8) for facility laundry working and two (9) for facility laundry department facility have enough not have a par level. When it arrives we working and that the laundry department is a par level.	intain all essential ment care equipment in somet as evidenced by: on and staff interview, facility staff failed to: receded to wash and distundry and facility lause maintenance was cators. Identify area on February and that one (1) of four rers was working; two washers were working used for facility lause of four (4) large washers working. In the working of the working of the working. It is that one (1) took of the working of the working. It is that the par level of the ensure that prever working of the w	it was maintain ry ndry and completed uary 5, (4) (2) of four ng; two (2) ndry were ers used ith the 30 AM. m for a over the We [the We do ered. needed. "	L 442	#1 Laundry Equi 1. Facility wi washers and 2. Non-worki repaired or re 3. Maintenar monitor wash are maintaine Maintenance 2 weeks, ther 4. Maintenar facility Risk N committee m Linen Par Lee 1. The Facility ordered enous inventory up facility contine 2. The facility will complete there is amply requirements residents. 3. The House reeducated or is maintained The Houseke Monitor week months linen PAR levels. 4. Findings fi presented to	if repair or replace non- dryers. ing washers and dryers eplaced. nce Director or Designeners and dryers to ensure d in good working order director will QI monitor n weekly. Management/Quality Importhly X 12 months. It Housekeeping/Launch a linen to bring the fatto the required par levenues to place monthly ling y Housekeeping/Launch a linen inventory to ensure enough linen to meet as well as the needs of ekeeping/Laundry Director as well as the needs of ekeeping/Laundry Director as required by 22 DCR eeping/Laundry Director as well as the needs of ekeeping/Laundry Director as well as the needs of ekeeping/Laundry Director as well as the needs of ekeeping/Laundry Director as well as the needs of exercises to ensure reform the linen inventory Facility Risk Management	s will be se will ire that they er. daily X port to the provement dry Director cility's linen el. The nen orders, ry Director sure that the state of our ctor will be n inventory VIR 3254. will QI nthly X 12 equired will be ent/Quality	03/27/08 03/27/08 03/27/08 03/27/08 03/17/08
		•			miprovement	committee monthly X	ı∠ mon(ns,	03/27/08

STATEMENT OF DEFICIENCIES. AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(XCI) DATE SURVEY COMPLETED	
095019		B, WING			D2/11/2008		
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY. STATE, ZIP COUE 5000 BURROUGHS AVE. NE MASHINGTON, DC. 20018				
GRANT PARK CARE CENTER			WASHINGTON, DC 20018				
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY MUST OR LSC IDE	GULATORY	ID PROVIDER'S PLANCE CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE OR TAG REFERENCED TO THE APPROPRIATE DEFICIT		SE CROSS-	(X5) COMPLETE DATE	
L 442	Oxygen concentrators were observed in the following areas: There was no documented evidence of preventive maintenance provided for the above listed oxygen concentrators. a face-to-face interview was conducted with Employee #3 on February 11, 2008 at 1:00 PM. He/she stated, "We don't own the concentrators. The [company] who owns them does the maintenance. They deep the records. We don't have any records about the concentrators here at			i d	#2 1. Facility has replaced the oxygen concentrators in Rooms 508, 525, 52. Facility has requested paperwor the preventative maintenance that it performed on oxygen concentrators	530 and 533. k to show nas been	03/21/08
					Concentrators are current in their many of the Maintenance staff will maint book consisting of the vendor's premaintenance record for oxygen conbeing used in the building. The Madepartment will conduct weekly revioxygen concentrator to ensure that preventative maintenance records a	raintenance, rain a log ventative neentrators intenance iew of the	03/27/08
	The facility]."	iout the concentrators	nere at		available. 4. The Maintenance department witheir findings to the facility Risk Mai Quality Improvement committee mo 12 months.	nagement/	03/27/08
				·			
foolth Poort	tion Administration						