	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A BUILDIN	PLE CONSTRUCTION G	(X3) DATE SU COMPLET		
		095024	8. WING_		02/02	2/2006	
ME OF PI	ROVIDER OR SUPPLIER		STR	REET ADDRESS, CITY, STATE, ZIP CO		22000	
ADLEY	HOSP SKILLED N	JRS UNIT		601 ML KING AVE SW VASHINGTON, DC 20032			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAQ	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION SH REFERENCED TO THE APPROPR	OULD BE CROSS-	(XS) COMPLETION DATE	
F 000		NTS	F 000		· · _		
	on January 31 thr following deficien review observation residents. The satisfiesd on a censul	fication survey was conducted ough February 2, 2006. The cles were based on record ins and interviews with staff and imple included 15 residents is of 59 residents on the first and one (1) supplemental					
F 221 SS=D	483.13(a) PHYS	CAL RESTRAINTS	F 221				
	physical restraints discipline or conv	the right to be free from any s imposed for purposes of enlence, and not required to s medical symptoms.	for in A corr	y on Restraints was reviewed mediate implementation for responding care plan address	resident # 11	2/2/00	
	by: Based on observa review, facility sta	ENT is not met as evidenced ation, interview and record aff falled to identify a geri-chair one (1) of 15 sampled residents.	<ul> <li>also developed. (attachment A)</li> <li>Inservice Informing staff that use of genichairs wind secured table top on residents who are unable to remove the table top is now considered to be a form of restraint and requires implementation of the Restraint Policy SNS.61. (attachment B)</li> </ul>				
	The findings inclu	de: ·	top an table t	sidents using gerichairs with d the residents are unable to op will be monitored if the nu	remove the ursing staff	2/2/0	
	at 9:30 AM and a	observed on January 31, 2006 t 11:45 AM sitting in his/her air with the lap table secured in ent.	the car 4. Monite	plementing the Restraint Pol re of the resident oring outcomes will be report mance Improvement monthh	ted to the	2/19	
0	the resident was a November 1, 200 Minimum Data Se	sident's record revealed that admitted to the facility on 5. According to the quarterly at completed January 27, 2006, goded with long and short-term	:				

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

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CENTER		E & MEDICAID SERVICES				FORM APPROVED OMB NO. 0938-0391					
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(22) N A BU		TIPLE CONSTRUCTION	(X3) DATE S COMPLE	URVEY				
		095024	B. Wi	NG		02/0	2/2006				
NAME OF PI	F PROVIDER OR SUPPLIER			5	TREET ADDRESS, CITY, STATE, ZIP CODE						
HADLEY	LEY HOSP SKILLED NURS UNIT				4601 ML KING AVE SW WASHINGTON, DC 20032						
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEEDED BY FULL				(EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOUL						
F 221	cognitive decision- and mental functio course of the day. being restless up to Section B- Cognitiv Functional Limitati- resident was coded motion of both legs movement. A face-to-face inter was conducted on He stated, " [Resid wheelchair before the table top [Resid him/her] get up and	everely impaired skills for making and for restlessness ning that varied over the The resident was coded as o five (5) days per week ( ve Function). In Section G4d ( ons in Range of Motion), the d with limitations in range of s with no voluntary loss of rview with the resident's son February 1, 2006 at 2:30 PM. dent #11] was always in a coming here. The chair with dent 11] is in now, doesn't let [ d I think it's safer. It's better because [Resident #11] could	F	22			· · · · · · · · · · · · · · · · · · ·				
	November 2 throug According to the pi November 15, 200 with contact guard Ambulated about 1 rolling walker and c walker. Static stan guard assist. Patie endurance with gal A face-to-face inte Director of Rehabil , 2006 at 11:30 AM Resident #11 was table top secured a The geni-chalr was	ved physical therapy from gh December 8, 2005. hysical therapist's note dated 5 at 11:45 AM, " Sit to stand assist/minimum assist. 50' x3 (three times) with contact guard assist for guiding iding balance with contact ent appears to have increased at " rview was conducted with the litation Services on February 2 I. He/she was asked why seated in a geri-chair with the and replied, " I don't know. not recommended by physical	•			4					
	therapy. "					• •					

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Event ID: SV0N11 Facility ID: HADLEY

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If continuation sheet Page 2 of 33

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		AND HUMAN SERVICES			FORM	02/14/2006 APPROVED 0938-0391
TATEMENT	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		(X3) DATE SI COMPLE	JRVEY
		095024	B. WING		02/0	2/2006
	ROVIDER OR SUPPLIER HOSP SKILLED NUF			TREET ADDRESS, CITY, STATE, ZIP CODE 4601 ML, KING AVE SW WASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFUX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION SHOU REFERENCED TO THE APPROPRIAT	ILD BE CROSS-	(25) COMPLETION DATE
F 221	Continued From pa		F 22	1		
	Certified Nurse Aid 25 AM, who had ca admission to the fa	rview was conducted with a le on February 2, 2006 at 11: ared for Resident #11 since acility. He/she stated, "We a gen-chair with the table for				
	Resident Care Coo at 2:30 PM. The c Resident #11 was	rview was conducted with the ordinator on January 31, 2006 harge nurse was asked why seated in a geri-chair and not he charge nurse replied, " It is				
	resident for the use	to identify and assess the e of a geri-chair with the table estraint. The record was 2, 2006.				
F 241 SS=D	The facility must part manner and in an e enhances each res	romote care for residents in a environment that maintains or sident's dignity and respect in his or her individuality.	F 241	<ol> <li>The Resident Care Coordinate the involved nursing assists standard practice of feeding</li> <li>The standard practice of feeding was reviewed with the nurs unit staff meeting 2/15/06.</li> <li>The RCC/designee will content of the standard practice will be standard practice.</li> </ol>	ant about the g residents. eeding resider ing staff at the (attachment C	nts 2/13
	by: Based on observat (1) supplemental re a Certified Nurse A an environment tha dignity as evidence	NT is not met as evidenced tion and staff interview for one esident, it was determined that Alde (CNA) failed to maintain at enhanced Resident A1's ed by failing to verbally be seated while assisting him/ fast meal.		<ul> <li>3. The RCC/designee will conducting mealtimes to ensure protocol for feeding resider</li> <li>4. Monitoring outcomes will to the Performance Improvem meeting monthly</li> </ul>	e that the prop nts is being prop pe reported to	acticed 3/19

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		AND HUMAN SERVICES				FORM	02/14/2006 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SU COMPLE	URVEY
		095024	B. WR	ю		02/0	2/2006
NAME OF P	ROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE		
HADLEY	HOSP SKILLED NUP	RS UNIT		-	501 ML KING AVE SW (ASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE	BE CROSS-	(X5) COMPLETION DATE
F 241	Continued From pa	-	F	241			
	The findings includ						
	at 8:45 AM, the sur	st meal on January 31, 2006 veyor observed a CNA A1 to eat breakfast, The CNA					
	stood beside the re	sident throughout the entire					
	with the resident.	I failed to verbally converse					
	Coordinator was co	view with the Resident Care anducted on January 31, 2006					
	usual process by w	nveyor inquired about the hich residents are assisted to			•		
	have been sitting b	vedged that the CNA should eside the resident, interacting,					
	he/she assisted the	unicating with the resident as resident to eat. The					
	between 8:45 AM a	ade on January 31, 2006 and 9:30 AM.			F 253 1. Identified marred doors w	vill have a	2/10/06
F 253	483.15(h)(2) HOUS	EKEEPING/MAINTENANCE	F	253	protective material called installed on them.		//
SS≂B	The facility must p	ovide housekeeping and			<ol> <li>All entrance doors to room</li> </ol>	ms and	3/19/00
	maintenance service	ces necessary to maintain a nd comfortable interior.			bathroom doors are being by a protective material c Kydex. This will keep th	alled	
	This REQUIREME	NT is not met as evidenced			from being damaged by wheelchairs and beds.		
	Based on observat	ions during the survey period,			3. Doors will be monitored		3/19/06
	were not adequate	hat maintenance services to ensure that the facility was			safety rounds and doors i being covered will be giv		3/19/06
	scarred, married an	e manner as evidenced by d splintered edges on			order to complete.	the	3/19/020
	entrance and bathr were observed in th	oom doors. These findings			4. Outcomes monitoring of entrance and bathroom de		7.7-2
	maintenance direct				be reported to the Perform	nance	
L					Improvement Team.		

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Fecliky ID: HADLEY

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If continuation sheet Page 4 of 33

		& MEDICAID SERVICES				•		APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROMDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL			01	(X3) DATE SI COMPLE	RVEY
		095024	B. WIN	G			02/0	2/2006
	RONDER OR SUPPLIER HOSP SKILLED NUF	RS UNIT		4601	TADDRESS, C		22006	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFD TAG	×	(EACH CORRE		DRRECTION HOULD BE CROSS- RIATE DEFICIENCY)	(XS) COMPLETION DATE
F 253	bathroom doors we rooms 312, 331, 33 of 17 observations	•	F 2	53		-		
F 278 SS=D	and 3:00 PM on Fe 483.20(g) - (j) RES The assessment m resident's status. A registered nurse each assessment w participation of hea	DENT ASSESSMENT UDENT ASSESSMENT ust accurately reflect the must conduct or coordinate with the appropriate lith professionals.	F 2	78			· ·	
	assessment is com Each individual wh assessment must a that portion of the a Under Medicare an willfully and knowin	o completes a portion of the ign and certify the accuracy of assessment. Id Medicaid, an individual who igly certifies a material and				•		
	subject to a civil m \$1,000 for each as who willfully and kr individual to certify statement in a resk a civil money pena each assessment.	a resident assessment is oney penalty of not more than sessment; or an individual nowingly causes another a material and false dent assessment is subject to lify of not more than \$5,000 for ant does not constitute a statement	· .					
FORM CMS-2	567(02-99) Previous Vension	·	1 Fac	alitity LD:	HADLEY		If continuation sheet	at Page 5 of 33

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CENTER		RE & MEDICAID SERVICES				FORM	APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		IPLE CONSTRUCTION	(X3) DATE SI COMPLE	JRVEY
_/		095024	B. WI	VG_		02/0	2/2006
NAME OF P	ROVIDER OR SUPPLIER			sπ	REET ADDRESS, CITY, STATE, ZIP CODE		
HADLEY	HOSP SKILLED NU	JRS UNIT		I	601 ML KING AVE SW VASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES IY MUST BE PRECEEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIVE ACTION SHOUL (EACH CORRECTIVE ACTION SHOUL REFERENCED TO THE APPROPRIATE	D BE CROSS-	(XS) COMPLETION DATE
F 278	by: Based on observa review for three ( facility staff failed Minimum Data Se with a fail; two (2) events; and one ( nursing care. Res The findings inclu 1. Facility staff fa having a fail when	ENT is not met as evidenced ation, Interview and record 3) of 15 sampled residents, I to accurately code the et (MDS) for one (1) resident residents for behavioral 1) resident for restorative idents # 3, 4, and 7.	F 278	1	<ol> <li>MDS of resident #3 was com fall that occurred 8/25/05 (att 2. MDS offesidents who had fa last 3 months were reviewed documentation in the MDS</li> <li>Accuracy of coding MDS for be monitored weekly by the II the weekly care plan meeting be made available for review</li> <li>Monitoring outcomes will be the Performance Improvement monthly by the RCC/designed</li> </ol>	achment D) Is during the for proper falls will DT during (MDS will at <i>H</i> c <i>mTG</i> reported to at Committee	2/20 2/20
	the resident fell o	ent #3's record revealed that n August 25, 2005 and are of the right femur.	F 278		 		
	was blank in Sect days." The reside	completed January 19, 2006, ion J4b - "Fell in past 31-180 ant's fail of August 25, 2005 fell ment period. The record was 31, 2006.		2	<ul> <li>A 1. Quarterly MDS of resident at &amp; 11/7/05 were corrected to administered to the resident E)</li> <li>2. MDS of residents receiving reviewed for accurate coding</li> </ul>	include resto in section P. restorative n	orative nursing (attachment ursing were 2
	<ul> <li>2. Facility staff failed to code Resident #4 as receiving restorative nursing care and inaccurately coded the resident for behavioral symptoms.</li> <li>A. A review of Resident #4's quarterly MDS completed October 13, 2005 and significant change MDS completed November 7, 2005, coded in Section P3 (Nursing Rehabilitation/</li> </ul>				<ul> <li>received.</li> <li>3. Accuracy of coding in MDS will be monitored by the IDT meeting weekly. (completed available to the IDT for review care plan meeting</li> <li>4. Monitoring outcomes will be Performance Improvement Completed available to the IDT for review care plan meeting</li> </ul>	for restorativ during the ca MDS will be w during the reported to t	e nursing 2/2 are plan made weekly he 2/,

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		E & MEDICAID SERVICES				FORM APPROVE		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE S COMPLE	URVEY		
			A, BUILDI	¥G		-160		
		095024	B. WING		02/0	2/2006		
NAME OF P	ROVIDER OR SUPPLIER			REET ADORESS, CITY, STATE		2/2000		
HADLEY	HOSP SKILLED NU	RS UNIT		4801 ML KING AVE SW				
				WASHINGTON, DC 2003	12			
(X4) ID		ATEMENT OF DEFICIENCIES	D		OF CORRECTION	CONPLETION		
PREFX TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	PREFIX TAG	REFERENCED TO THE AF	NON SHOULD BE CROSS-			
			·					
F 278	Continued From p	age 6	F 278					
	receive restorative nursing care. A review of the * Restorative Nursing Log Sheet * revealed that			<ul> <li>e</li> <li>at or 2B 1. Quarterly MDS of resident #4 completed 10/13/05</li> <li>&amp; 11/7/07 were connected. Section E4 was corrected (6 to code no verbal abusive behavior was exhibited by the resident w/in the past 7 days, since there were no documentation in the nurses progress notes nor in the behavior monitoring flow sheet that the resident had exhibited abusive behavior (attachment E)</li> <li>2. MDS of residents with documented abusive behavior were reviewed for accuracy in coding of abusive behavior and behavior symptoms</li> <li>3. Accuracy of coding in MDS for behavioral symptoms will be reviewed by the IDT during the weekly care plan meeting. (completed MDS will be made available to the IDT for review during the meeting)</li> </ul>				
	The nurses' notes were reviewed from September 1 through November 30, 2005. There were no documented episodes of the behaviors listed above. The resident was being monitored on each shift for the following behaviors: outburst, agitation and restlessness. A review of the October and November 2005 behavior monitoring sheets noted no episodes of the monitored behaviors. Facility staff incorrectly coded the MDS for behavioral symptoms. The record was reviewed January 31, 2006.		•		· .			
			- -					
•	3. Facility staff fall behavorial sympto	ed to accurately code ms for Resident #7 on the						
-ORM CMS-2	567(02-99) Prévious Version	s Obsolete Event ID; SV0N1	l Fecilit	YID: HADLEY	If continuation she	et Page 7 of 3		
		•	•					
			7 <del>4</del>	- '				
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		THE HOWARDER VERVER				FORM	APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			•	OMB NO	0938-0391
	Í OF DEFICIENCIES >F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUL			(X3) DATE SU COMPLE	RVEY
		095024	B. WIN	IG		02/0	2/2006
NAME OF P	ROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
HADLEY	HOSP SKILLED NU	RS UNIT		46	91 ML KING AVE SW ASHINGTON, DC 20032		
				***			
(X4) HD PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SCIDENTIFYING INFORMATION)	id Prefi Tag	-	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE	DIBE CROSS	(AS) COMPLETION DATE
F 278	Continued From pa	ige 7	F 278				┝╾╴┨
	quarterly MDS.			2B -	1. Quarterly MDS of resident #7 corrected to include verbal abu	dated 1/6/	Suma alus
	January 5, 2006, d had no behavioral last seven (7) or 30				In section E4 as documented i progress notes to have occurre 7days. (attachment F) 2. MDS of residents with docume	n the nurses ed within the	a past
	2005 at 8:30 AM, ' Charge Nurse's ] c	se note's dated December 29, 'I saw [Resident] wheel to [ office [Resident] was angry are nothing "and cursing "		3	abusive behavior and behavior abusive behavior and behavior Accuracy in coding MDS for be will be monitored by the IDT du meeting weekly. (completed MI	Aracy in coo al symptoms shavioral syn ring the care DS will be care	ding 2/16/06 s mptoms_2/23/g e plan
	7 as having behavi quarterly MDS con	to accurately code Resident # oral symptoms on the opleted January 5, 2006. The od February 1, 2006.		4.	available to the IDT for review of Monitoring outcomes will be re Committee monthly	luring the m	
F 279 SS=D		k)(1) COMPREHENSIVE	- F 2	279			
		the results of the assessment and revise the resident's n of care.	•				
	plan for each resid objectives and time medical, nursing, a	evelop a comprehensive care ent that includes measurable stables to meet a resident's nd mental and psychosocial tiffied in the comprehensive					
	are to be furnished resident's highest p and psychosocial w 483.25; and any se	t describe the services that to attain or maintain the practicable physical, mental, vell-being as required under § prvices that would otherwise be 3.25 but are not provided due				- -	· ·

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Event ID: SV0N11

Fecility ID: HADLEY

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If continuation sheet Page 8 of \$3

## DEPARTMENT OF HEALTH AND HUMAN SERVICES.

DEPARTMENT OF HEALTH AND HUMAN SERVIC CENTERS FOR MEDICARE & MEDICAID SERVICE	-			FORM	02/14/2006 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER	č. 1	WULTIPLE C MLDING	ONSTRUCTION .	(X3) DATE SU COMPLE	RVEY
095024	B.W	NG		02/02	2/2006
		1	NDORESS, CITY, STATE, ZIP-CO IL KING AVE SW		
HADLEY HOSP SKILLED NURS UNIT		WASH	IINGTON, DC 20032		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEEDED BY FUL TAG REGULATORY OR LSC IDENTIFYING INFORMATION	,	FIX 🔤 代 🖻	PROVIDER'S PLAN OF COL ACH CORRECTIVE ACTION SHO FERENCED TO THE APPROPRI	OULD BE CROSS-	(25) Completion Date
F 279 Continued From page 8	F	279			
to the resident's exercise of rights under §4 including the right to refuse treatment under .10(b)(4).		.	:	•	
This REQUIREMENT is not met as eviden by:			· · · · ·		
Based on observation, interview and record review for one (1) of 15 sampled residents, facility staff falled to develop a care plan w goals and approaches for one (1) resident receiving oxygen. Resident #2.			I. Nursing care plan addressing was developed on resident #2 2. Medical records of residents n Therapy were reviewed for the a care plan addressing oxygen	(attachment) (- eceiving Oxygen presence of therapy.	02/22/06 02/22/06
The findings include: Resident #2 was observed on January 31, at 10:00 AM and February 1 and 2, 2006 at AM on both days, receiving oxygen via nas cannula at 2 liters/minute.	t 11:30		Care plans were updated as n 3. When residents are started or a care plan will be developed to Therapy. 4. Records of residents receiving will be reviewed during weekly Review outcomes will be repor Performance improvement coordinates and the second Performance improvement coordinates and the second se	n Oxygen therapy by Respiratory g Oxygen therapy care plan meetings. ried to the	02/22/06
A review of Resident #2's record revealed physician's telephone order dated January 2006, "O2 @ 2L/NC PRN (Oxygen at 2 lit per nasal canhula as needed)."	10,				
The care plan did not include goals and approaches for the use of oxygen.	h tha			•	
A face-to-face interview was conducted wit charge nurse on January 31, 2006 at 3:45 He/she acknowledged that there was no ca plan for oxygen and that the care plan coul updated at any time. The record was revier January 31, 2006.	PM. are id be	-			
F 280 483.20(d)(3), 483.10(k)(2) COMPREHENS SS=D CARE PLANS	IVE F	280			
FORM CMS-2567(02-99) Previous Versions Obsolute Event I	D: SV0N11	Facility ID: 1	HADLEY	If continuation she	at Page 9 of 33

STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA       (X2) MULTIPLE CONSTRUCTION       (X3) DATE SURVICE         AND PLAN OF CORRECTION       095024       A. BUILDING       (X2) MULTIPLE CONSTRUCTION       (X3) DATE SURVICE         NAME OF PROVIDER OR SUPPLIER       095024       B. WING       02/02/21         NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE       4601 MARTIN LUTHER KING JR AVENUE SW         SPECIALTY HOSPITAL OF WASHINGTON - HADLEY SNF       STREET ADDRESS, CITY, STATE, ZIP CODE       4601 MARTIN LUTHER KING JR AVENUE SW         (X4) ID       SUMMARY STATEMENT OF DEFICIENCIES       ID       PROVIDER'S PLAN OF CORRECTION       CORRECTION         (X4) ID       SUMMARY STATEMENT OF DEFICIENCIES       ID       PROVIDER'S PLAN OF CORRECTION       CORRECTION         (X4) ID       SUMMARY STATEMENT OF DEFICIENCIES       ID       PROVIDER'S PLAN OF CORRECTION       CORRECTION         (X4) ID       SUMMARY OR LSC IDENTIFYING INFORMATION)       TAG       CROSS-REFERENCED TO THE APPROPRIATE       CO         F 280       Continued From page 9       F 280       F 280       F 280       ID			I AND HUMAN SERVICES			FORM	: 06/09/2008 APPROVED : 0938-0391
Ogsold     Ogsold       NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE       SPECIALTY HOSPITAL OF WASHINGTON - HADLEY SNF     4601 MARTIN LUTHER KING JR AVENUE SW       (X4) ID     SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG     ID     PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG     ID     PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)     CC							
SPECIALTY HOSPITAL OF WASHINGTON - HADLEY SNF       4601 MARTIN LUTHER KING JR AVENUE SW         (X4) ID       SUMMARY STATEMENT OF DEFICIENCIES       ID         PREFIX       (EACH DEFICIENCY MUST BE PRECEDED BY FULL       PREFIX         TAG       REGULATORY OR LSC IDENTIFYING INFORMATION)       ID       PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE       CC			095024	B. WING	· · · · -	02/0	2/2006
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			ASHINGTON - HADLEY SNF	460	01 MARTIN LUTHER KING JR AV		
F 280 Continued From page 9 F 280	PREFIX	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE	(X5) COMPLETION OATE
	F 280	Continued From pa	ige 9	F 280			
This REQUIREMENT is not met as evidenced by:         Based on observation, interview and record review for two (2) of 15 sampled residents, facility staff failed to update care plans for one (1) resident with multiple pressure sores and one (1) resident with two (2) falls. Residents #2 and 7.         The findings include:         1. Facility staff failed to update Resident #2's care plan for multiple pressure sores.         The resident was observed on January 31, 2006 at 11:20 AM during a wound treatment with one (1) pressure sore on the right heel, one (1) pressure sore on the hight heel, one (1) pressure sore on the hight heel, one (1) pressure sore on the back of the right heel.         A review of Resident #2's care plan included problem #3, "Potential for skin breakdown related to limited mobility and incontinence." The care plan was evaluated and updated on December 29, 2005 and included, " Healed for now - repositioning done."         The quarterly Minimum Data Set completed January 19, 2006, was coded in Section M1c (Ucers that the resident thad three (3) Stage III pressure sores.         A face-to-face interview was conducted with the charge nurse on January 31, 2006 at 3:45 PM. He/she acknowledged that there was no update for the pressure sore care plan and that the care		by: Based on observat review for two (2) o staff failed to updat resident with multip resident with two (2) The findings include 1. Facility staff faile plan for multiple pre The resident was o at 11:20 AM during (1) pressure sore on pressure sore on th (1) pressure sore on problem #3, "Poten to limited mobility a plan was evaluated 29, 2005 and include repositioning done. The quarterly Minin January 19, 2006, N (Ulcers) that the res pressure sores. A face-to-face inter charge nurse on Ja He/she acknowledge	ion, interview and record f 15 sampled residents, facility e care plans for one (1) le pressure sores and one (1) falls. Residents #2 and 7. e: d to update Resident #2's care essure sores. bserved on January 31, 2006 a wound treatment with one n the right heel, one (1) he back of the right leg and one necrotic area) on the left heel. ht #2's care plan included tial for skin breakdown related nd incontinence." The care and updated on December ded, "Healed for now - " hum Data Set completed was coded in Section M1c cause) and M2a (Types of ident had three (3) Stage III view was conducted with the inuary 31, 2006 at 3:45 PM. ged that there was no update				

03/03/2008 F	'R1	12:32	FAX	202	373	5906	HADLEY	ADMINISTRATION
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		AND HUMAN SERVICES		Q	un 3/3/0 b		APPROVE
		& MEDICAID SERVICES	_	_		<u>OMB NO.</u>	0938-03
	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(x2) N A. BUI		PLE CONSTRUCTION G	(X3) DATE SU COMPLE	
		095024	B. Wit	wa	·	02/0	2/2006
NAME OF P	ROVIDER OR SUPPLIER			STR	EET ADORESS, CITY, STATE, ZIP CODE		!
HADLEY	HOSP SKILLED NUP	RS UNIT			601 ML KING AVE SW VASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	XF	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE	BE CROSS-	COMPLENC DATE
F 280	Continued From pa	ige 10	F 280	1	1. Nursing Care Plan was upda	ted for resid	ient
	heel.	-		,	# 2 to include multiple pressure		
•				,	previously submitted) Physicia	n notified.	2/2/06
	A review of Reside	nt #2's care plan included			Orders carried out.		1-1-0
		rtial for skin breakdown related			•		
		and incontinence." The care			<ol><li>Medical records of residents</li></ol>		ez/z/n
		and updated on December			pressure ulcers were reviewed		
		led, "Healed for now -			multiple pressure ulcers in their		-link
	repositioning done.				3. Residents admitted with mul		
	The quarterly Minin	num Data Set completed			ulcers will have a nursing care		ped
		was coded in Section M1c (			within 7 days of admission to th		
		ause) and M2a (Types of			addressing multiple pressure u		
	-	Ident had three (3) Stage III			a resident developed multiple p		ers
	pressure sores.	· i			while in the facility a care plan to		maliat
	A foos to foos inter	a forwards conducted with the			<ul> <li>developed within 7 days from the that multiple pressure ulcers had</li> </ul>		
	1	view was conducted with the nuary 31, 2006 at 3:45 PM,			4. Monitoring and evaluation of	•	eu .
		jed that there was no update			care plan addressing multiple p		į
		e care plan and that the care			ulcers will be conducted month		
		ted at any time. The record			monitorinbg outcomes will be n	•	
	was reviewed Janu	ary 31, 2006.	l		to the Performance committee.		
	There was no evide	ence that the care plan was			: I	-	I
		goals and approaches for the	1				
•		pressure sores identified on					
		The record was reviewed					
	January 31, 2008.						
	O Deville staff fails	d to vindeto and intituto popula		Í			
		ed to update and initiate goals Resident #7 who had two (2)				•	
	falls without injury.						
	· · · · · · · · · · · · · · · · · · ·		•				-
	A review of Reside	nt #7's record revealed that					
		December 25, 2005 and					
	January 9, 2006.						
		e plan, last updated on duded problem #5, " Potential					
	Vanualy 5, 2000 100	added provient #5, PO(ential					
FORM CMS-25	567(02-99) Previous Versione	Obsolete Event ID: SVDN11	Fa	cility )	ID: HADLEY If con	linuation sheet	Page 11 or

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		H AND HUMAN SERVICES				FORM APPROVED OMB NO. 0938-0391		
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUAL		1 E CONSTRUCTION	(X3) DATE SU COMPLE	IRVEY	
		095024	B. WIN	G		02/02	2/2006	
NAME OF PI	ROVIDER OR SUPPLIER			STR	ET ADDRESS, CITY, STATE, ZIP CODE			
HADLEY	HOSP SKILLED NU	RS UNIT			01 ML KING AVE SW ASHINGTON, DC 20032			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES (MUST BE PRECEEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	FIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-			(X5) COMPLETION DATE	
F 280	Continued From p	age 10	F 2	280				
	heel.							
	problem #3, "Pote to limited mobility plan was evaluated	ent #2's care plan included ntial for skin breakdown related and incontinence." The care d and updated on December ded, "Heated for now -						
-	January 19, 2006, Ulcers due to any	erly Minimum Data Set completed 9, 2006, was coded in Section M1c ( to any cause) and M2a (Types of at the resident had three (3) Stage III ores.						
	charge nurse on Ja He/she acknowled for the pressure so	rvlew was conducted with the anuary 31, 2006 at 3:45 PM. ged that there was no update ore care plan and that the care ated at any time. The record uary 31, 2006.						
	updated to include three (3) Stage III	ence that the care plan was goals and approaches for the pressure sores identified on The record was reviewed	F 280	2	<ol> <li>Nursing Care Plan was upd # 7 to include approaches to subsequent to the 2 fails, 12</li> </ol>	) be impleme	ildent 2/3 ented	
		ed to update and initiate goals or Resident #7 who had two (2)			(attachment H) 2. Medical records of residents were reviewed and updated goals and approaches after ( 3. Number Osciellation Control of the second	with multiple	Idditional '	
	A review of Resident #7's record revealed that the resident fell on December 25, 2005 and January 9, 2006.				<ol> <li>Nursing Care Plan will be up resident's fall. Care plan will goals and approaches after et</li> <li>Monitoring for compliance w</li> </ol>	dated after ( include addit ach fall reco	each 3/19 tional	
		re plan, last updated on icluded problem #5, * Potential			monthly. Outcomes will be re Performance Improvement C	ported to the	· ·///	

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					FORM	APPROVED
		& MEDICAID SERVICES			<u>OMB NO</u>	0938-0391
	FOR DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILLE	LTIPLE CONSTRUCTION	(X3) DATE S COMPLE	URVEY
		095024	B. WING	· · · · · · · · · · · · · · · · · · ·	02/0	2/2006
NAME OF P	RÖVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP COD		<u> </u>
HADLEY	HOSP SKILLED NUP	RS UNIT		4601 ML KING AVE SW WASHINGTON, DC 20032		
((0))	SI IMMARY STA			PROVIDER'S PLAN OF COR		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX		JLD BE CROSS-	(XS) COMPLETION DATE
F 280	Continued From pa	ige 11	F 28	30		
	unsteady galt." Th	condary to weakness and here was no evidence that the litional approaches to prevent urther falls.				
	charge nurse on Ja He/she acknowledg for the fails care pl	view was conducted with the nuary 31, 2006 at 3:45 PM. ged that there was no update an and that the care plan it any time. The record was 31, 2006.		F 284 1. Social Work will send po plan of care form certified ma responsible party.	st discharge . il to	3/19/05
F 284 SS=D	When the facility a must have a discha post-discharge plan with the participation her family, which w to his or her new in	· ·	F 28	<ul> <li>Any resident that is slated discharge planning will particle in the discharge planning pro- which will include his/her response party and the IDT team. At the discharge, resident or response will sign the post discharge p care or will be sent certified in self addressed postage paid e</li> </ul>	ipate cess ponsible he time of sible party lan of nail with	3/9/06
· ·	by: Based on the record closed records, it will staff falled to includ family in the develop plan of care. The findings includ Resident #15 was of home) accompanie 2006. Diagnoses in Accident (CVA) Le	NT is not met as evidenced d review for one (1) of two (2) vas determined that facility de Resident #15 and his/her opment of a post discharge e: discharged to the community ( ed by his/her son on June 21, included Cerebrovascular ft Hemipiegia, Gastrostomy betes Mellitus, Hypertension,	· .	<ol> <li>Discharge plan of care w viewed in the discharge plan meeting which will include s worker, IDT team, as well as and responsible party to ensu and proper discharge. Signa responsible party will be obt post discharge plan of care o sent certified mail with a sel postage paid envelope.</li> <li>Discharged charts will be tored and reported in Perform Improvement meeting to ensu compliance.</li> </ol>	vill be re- aing ocial resident ure a safe ture of ained on r will be f addressed oc moni- mance	3/19/06.
FORM CMS-2	567(02-99) Previous Version	s Obsolete Event ID; SV0N11	Faoi	By ID: HADLEY	continuation shee	t Page 12 of 33

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Feolity ID: HADLEY

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		& MEDICAID SERVICES				FORM	APPROVED 0938-0391	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		PLE CONSTRUCTION G	(X3) DATE SU COMPLE	IRVEY	
	:	095024	8. WING			62/02/2020		
NAME OF P	ROMDER OR SUPPLIER		- ·	STR	EET ADDRESS, CITY, STATE, ZIP CODE	02/02/2006		
HADLEY	HOSP SKILLED NUP	RSUNIT			601 ML KING AVE SW (ASHINGTON, DC 20032			
(X4) ID PREFIX YAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	id Prei Tac	-DX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE	BE CROSS-	(X5) COMPLETION DATE	
F 284	Continued From pa	age 12	۴	284				
	Physician's orders signed and dated June 2, 2005, included, "Insulin Human N (NPH) 8 Units subcutaneously every moming for IDDM (Insulin Dependent Diabetes Mellitus), Insulin Human R ( Regular) 3 Units subcutaneously for BS (Blood Sugar) greater than 250."							
	On June 15, a physician's order indicated, " Enteral Feeding via G-Tube 6:00 AM - 12:00 AM 65 mi/hour via pump, water 30 mls before and after medication, water bolus 250mls via G-Tube three (3) time a day, Check residual and patency every day for placement every shift and elevate head of bed 30 degrees."				· · ·			
	15, 2005 dki not inv was instructed in the injections and G-Tr the "Discharge- PI was documented to medications." The approximately 14 m for the medicine and documentation to its were discussed with Post-Discharge Pia the resident's son t instructions were re	ndicate that the medications h the resident's son. The " an of Care" was not signed by o indicate that the discharge eviewed and understood.						
	However, the care indicate that the re- instructions and de administration of in	g was held on June 8, 2005. plan progress note did not sident's son received monstrations for the isulin and G-Tube feeding with ion of a return demonstration.						

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Event ID: SV0N11

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Facility (D: HADLEY .

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CENTER		& MEDICAID SERVICES				FORM, OMB NO.	APPROVED 0938-0391	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1.1	IUL THP		(X3) DATE SU COMPLE	RVEY	
		095024	B. Wi	VG		02/02	2/2006	
NAME OF P	ROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE			
HADLEY	HOSP SKILLED NU	RS UNIT			01 ML KING AVE SW ASHINGTON, DC 20032			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOUL REFERENCED TO THE APPROPRIAT	D BE CROSS-	(XS) COMPLETION DATE	
F 284	Continued From pa	age 13	F	284				
	nurse manager on approximately 9:20 the resident's medi discussed in the ca resident's son did r the insulin and tube	rview was conducted with the February 2, 2006 at 0 AM and he/she indicated that ical and physical status was are plan meeting, however, the not have a demonstration for e feeding prior to the resident's cord was reviewed on						
F 309 SS=G	provide the necess or maintain the hig mental, and psycho	DF CARE t receive and the facility must ary care and services to attain hest practicable physical, osocial well-being, in e comprehensive assessment	F	309	· ·	•		
	by: Based on observat and resident interv sampled residents, staff failed to: follo gait training for one readmission to the subsequent fractur blood pressure me physician's orders. The findings includ 1. Rehabilitative S physician's order for after his/her return	NT is not met as evidenced ion, record review, and staff iews, for two (2) of 15 it was determined that facility w-up on a physician's order for e (1) resident upon facility after a fail and e and hold one (1) resident's dications according to the Residents #3 and 6. le: ervices failed to follow-up on a or gait training for Resident #3 from the hospital for a fail and e. The resident was walking	· ·	•				
FORM CMS-2	67(02-99) Previous Version		F	ility M	D: HADLEY If a		Page 14 of 33	

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		AND HUMAN SERVICES				FORM /	02/14/2006 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SU COMPLET	RVEY	
		095024	B. Wil	₩G		02/02/2006		
	ROVIDER OR SUPPLIER HOSP SKILLED NUP	RS UNIT		4	REET ADDRESS, CITY, STATE, ZIP CODE 601 ML KING AVE SW VASHINGTON, DC 20032			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREF		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETION DATE	
F 309	using a walker with with fracture. The his/her return from 2005). A review of Reside /she fell and sustain distal femur and wa , 2005 to Septembe ambulating during p assistive device (w fracture. Following hospital for treatme not been assessed According to a nurs	assistance prior to the fall resident has not walked since the hospital (September 3, nt #3's record revealed that he ned a fracture of the right as hospitalized from August 26 er 3, 2005. Resident #3 was obysical therapy with an alker) prior to the right femoral his/her return from the ent of the fracture, he/she has for the ability to walk.	F		<ul> <li>F 309</li> <li>#1</li> <li>1. Reassessment for rehab set performed by the Clinical Sup of the Rehab Dept. on Residet</li> <li>2. A review of all residents reduring the last quarter 2005 the January 2006, will be perform reassessments will be done as indicated. (see attached form)</li> </ul>	xervisor nt #3. cadmitted uru ued and	2/2/06	
	room where I obser the door lying face X-ray report of Aug fractures of the dist the mid and distal t condyle * . Residen on August 26, 2005 treatment. Resident #3 was re September 3, 2005 orders dated Septe Physical Therapy of Wednesday & Frid A review of the Phy July 1, 2005 reveal physical therapy pr July 28, 2005 docu ) with standard walt	"Writer called to resident's ved resident on the floor near down ". According to the ust 26, 2005, " Impression: al right femur extending from hird of the lateral femoral it was admitted to the hospital of further assessment and admitted to the facility on . Physician readmission mber 3, 2005 included " rder gait training for Monday, ay 9/3/05." ysical Therapy (PT) note dated ed that the resident received ior to the fall. A PT note dated mented, " amb.(ambulating ker with minimal assist at 30 ft There was no evidence in			<ol> <li>The Admitting Coordinato notify the Clinical Supervisor Rehab Dept. via e-mail of all returning to the facility.</li> <li>A request form for screening admits, readmits and change of will be submitted to the Rehal by the SNF nursing staff. (see form)</li> <li>Records of residents readmin facility will be reviewed for of with the reassessment protocol outcomes will be reported to a Performance Improvement con monthly.</li> </ol>	of the residents of new of status b. Dept. attached nitted to the compliance ol. Review the	• / / ·	

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FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: SV0N11 Fecility ID: HADLEY .

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		AND HUMAN SERVICES			•.	FORM	02/14/2006 APPROVED 0938-0391
	F OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1. 1	IULTI ILDINK	PLE CONSTRUCTION G	COMPLETED	
		095024	B. WI	VG_		02/0	2/2006
	ROVIDER OR SUPPLIER	RS UNIT		4	REET ADDRESS, CITY, STATE, ZIP CODE 601 MLI KING AVE SW		
				L	ASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	TX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE	BE CROSS-	(XS) COMPLETION DATE
F 309	Continued From pa	age 15	F	309	· · ·		
		ident #3 was assessed by PT ion to the facility on				-	
		-					
	Screening," policy 1 "Residents in th	cility's policy, "Rehabilitative number PT 05-018, page 1 of e SNF (Skilled Nursing					
	Services departme	reened by Rehabilitative ant within 5 days of admission vill be done annually and when					
	physician."	is reported by nursing or					
	Director of Rehabil	rview was conducted with the Itation Services on February 1					
	aware that Resider	He/she stated that he/she was it #3 was admitted to the he/she was not aware that the					
	director acknowled been seen in the re	nitted to the facility. The ged that the resident had not shabilitation department for the					
	last several months						
	Coordinator was co at 1:00 PM. The su	rview with the Resident Care onducted on February 1, 2006 inveyor Inquired about the PT is notified of evaluation					
	orders. He/She sta	ted " PT is notified by elephone log is kept in					
	January 19, 2006, short term memory	inimum Data Set, dated Resident #3 had no tong or problems and was philive daily decision making					
	A face-to-face inte	rview with Resident #3 was			. 		

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Facility ID: HADLEY

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		AND HUMAN SERVICES	-1			FORM	02/14/2006 APPROVED 0938-0391
	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU			(X3) DATE SU COMPLE	
		095024	B. WI	NG		02/0	2/2006
	ROVIDER OR SUPPLIER	RS UNIT		S	TREET ADDRESS, CITY, STATE, ZIP CODE 4801 ML KING AVE SW WASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	id Pref Tac	FIX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOUL REFERENCED TO THE APPROPRIATI	D BE CROSS-	(XS) COMPLETION DATE
F 309	conducted on Febr resident stated that but does not remer resident also stated a walker prior to the he/she returned fro walked with hls/her After the surveyor i physical therapy as Rehabilitation Serv February 2, 2006 a Occupational thera pathology evaluation the Impression of The record was rev 2. Facility staff falle to hold Resident #6 when the systolic p A review of Reside physician's order w 1, 2003 which read medications if patie 120 or less." The following medi Hypertension on th Lasix 40 mg via G- mg via G-tube eve HR Patch to skin e PM. A review of the MA Records) revealed	uary 1, 2006 at 11:30 AM. The he/she remembered the fall nber the exact date. The d that he/she was walking with e fall. He/she added that when in the hospital he/she had not walker again. identified the lack of a sessment, the Director of frices assessed Resident #3 on t 11:00 AM. Physical therapy, py and Speech language ons were recommended with "potential for rehab - fair."	F 5 309	30	· · ·	ensed staff ent Care Coo ed of the error nsive meds y ure. (attachm cords of all n dications with s were review eviewed with ration was re aff meeting 2	2//5/0 prdinator. pr. vere vere vent I) esidents 2//5/0 ved for involved viewed 2//5/06

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If continuation sheet Page 17 of 33

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		AND HUMAN SERVICES				FORM	02/14/2006 APPROVED 0938-0391
STATEMENT	F OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUN		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		095024	B. WAN	ю	·	02/0:	2/2006
	ROVIDER OR SUPPLIER	RS UNIT	STREET ADDRESS, CITY, STATE, ZIP CODE 4601 ML KING AVE SW WASHINGTON, DC 20032				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SCIDENTIFYING INFORMATION)	ID PRÉFI TAG	x	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETION DATE
F 309	Continued From pa	age 17	F	309			
.   .   .	December 11, 23, 3 January 3, 5, 7, 8, Lisinopril - Novemi December 1, 23, 2 , 5, 7, 8, 15 and 24	ber 7, 9, 11 and 12, 2005; 4 and 26, 2005; and January 3 , 2006. ember 4 and 5, 2005; and			· · · · · · · · · · · · · · · · · · ·	· .	
	medication as per t	to hold blood pressure the physician's order. viewed on February 1, 2006.	<b>,</b>				1
F 314 SS=D	resident, the facility who enters the facility does not develop p individual's clinical they were unavoid pressure sores reco services to promot	URE SORES prehensive assessment of a y must ensure that a resident lifty without pressure sores pressure sores unless the condition demonstrates that able; and a resident having eives necessary treatment and e healing, prevent infection ores from developing.	F	314	· · ·		· · · · · · · · · · · · · · · · · · ·
	by: Based on observat review for one (1)	NT is not met as evidenced tion, interview and record of 15 sampled residents, d to assess and treat a necrotic f2's left heel.					
		le: ent #2's record revealed that completed January 19, 2006			· · · ·		

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Facility ID: HADLEY .

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STATEMENT OF DEPROERCIES       (x) PROVEERSUPPLEXCUA DENTRYCATION NUMBER:       (x) DWLTELE CONSTRUCTION A BULIONO       (x) DWLTELECATION NUMBER:       (x) DWLTELECATION NUMB	CENTER		& MEDICAID SERVICES				FORM OMB NO	APPROVED 0938-0391
MARE OF PROVIDER OF BUPPLER     02/02/2006       HADLEY HOSP SKILLED NURS UNIT     STREET ADDRESS, CITY, STATE, 2P CODE       GOID     SUMMARY STATEMENT OF DEPOLENCES     PROVIDER OF ADDRESS FLANDE CORRECTION       REPERACTORY OF DEPOLENCES     PROVIDER OF ADDRESS FLANDE CORRECTION     Continued From page 18       Wass coded in Section M with three (3) Stage III     PROVIDER OF MARY BERECEEDED BY FLL     PROVIDER OF MARY BERECEEDED BY FLL       F 314     Continued From page 18     F 314     1. The necrotic ulcer on resident #2's     //3/       Wass coded in Section M with three (3) Stage III     pressure sores.     F 314     1. The necrotic ulcer on resident #2's     //3/       The resident was observed on January 31, 2006     at 11:20 AM during a wound treatment with one (1)     pressure sores on the traft heel, one (1)     pressure sores on the bright heel, one (1)     2/2 bc       A new of the resident's record revealed     physical sore (nortoc area on the left heel, the nurse stated that the resident second revealed     3. Team Leaders were instructed to he include in the monthy report to the included in the facility 3//9/AC       A review of the skin montiong sheets revealed     both right leg wounds had been assessed weekly from January 10. 2006 at 11:30 An (16). The resident's room on January 2, 2006. There was no assessment for the left heel.       A nurse's note dated January 10. 2006 at 11:30							(X3) DATE SI	JRVEY
NAME OF REVIDENCE NOPELER       STREET ADDESS CITY, STATE JP CODE         HADLEY HOSP SKILLED NURS UNIT       STREET ADDESS CITY, STATE JP CODE         COID PREFX TAC       SUMMARY STATEMENT OF DEFICIENCES RECALPRESEDED FULL (EXCHORPORCH MAST REPROSEDED BY FULL RECALPRESEDED TO THE APPROPRIATE DEFICIENCY RECALPRESEDED TO THE APPROPRIATE DEFICIENCY (EXCHORPORCH ACTION SPACED BEFT TAC       D PROVICES FLATOC CORRECTION (EXCHORPORCH ACTION SPACED BEFT (EXCHORPORCH ACTION SPACED BEFT (E			095024	B. WI	NG		02/0	2/2006
PADLEE HOSP SMULED NORS ON1       WASHINGTON, DC 20032         (0) ID PREFIX TAG       SUMMARY STATEMENT OF DEFICIENCIES (EXCHERCISENT MAST DE RECEDED BY FULL REGULTIONY ON LISC DENTFINIX AFORMATION)       PREFIX PREFIX PREFIX TAG       PROMERS PLAND CORRECTION (EXCHERCISENT ACTION SHOLD BE GROSS)       COMPLETON (EXCHERCISENT ACTION SHOLD BE GROSS)         F 314       Continued From page 18 was coded in Section M with three (3) Stage III pressure sores.       F 314       1. The necrotic ulcer on resident #2's left heel was assessed. Physican was notified and prescribed treatment was foldowed. (attachment k) 2. Daily Skin Assessment Protocol at the units staff meeting on 2/15/06 (attachment B) A copy of the Braden Scale tool was given to each nursing staff to review as resource material and assist staff in identifying stage 1's 3. Team Leaders were instructed to include the outcomes of daily skin assessments in their shift report to the incoming shift. This is to be implemented in al shift effective 2/15/06 A review of the resident's record revealed both right leg. No drainage 8 cm x 2 cm. Right heel heel.       3//9/AC         A review of the skident's record revealed both right leg. No drainage 8 cm x 2 cm. Right heel heel.       A rurse's note dated January 10, 2006 at 11:30 PM documented, " Stage II pressure ulcer on ingit outer leg. No drainage 8 cm x 2 cm. Right heel heel and necrotic sres and been assessed.         The Director of Nursing (DON) accompanied the surveyor to the resident's room on January 31, 2006 at 11:30 AM. He/sho observed the left heel necrotic area and acknowledged that the area should heve bjeen assessed.       In the monthy report to the resident's room on January 31, 2006 at 11:30 AM. He/sho observed the left heel necrotic area and acknowledged that	NAME OF P	ROVIDER OR SUPPLIER	·		5	TREET ADDRESS, CITY, STATE, ZIP CODE		
PREFIX TXG       EACH CORRECT MUST BE PRECEDED BY FULL RECULTORY OR LISE DETRY MO NORMATION       PREFIX TXG       PREFIX PREFIX       CALL CORRECTIVE ACTION SHOLL BE CROSS. ACTION TAXANT OF TXG INCOMENTED BETWORN OF TXG TXG       Continued From page 18 was coded in Section M with three (3) Stage III pressure sores.       Continued From page 18 was coded in Section M with three (3) Stage III pressure sores.       F 314       I The necrotic ulcer on resident #2's left heel was assessed. Physican was notified and prescribed treatment (1) pressure sore on the right leg and one (1) pressure sore on the right leg. There was no treatment for the feft heel. When queried about the care of the necrotic area on the left heel, then russ stated that the resident's record revealed physiciaris orders dated January 10, 2006 for the treatment of the two (2) right leg wounds. There were no orders for the treatment of the left heel.       F 314       I The necrotic area on the left heel. The nurse completed treatment for the fer heel. When queried about the care of the necrotic area on the left heel the nurse stated that the resident's record revealed physiciaris orders dated January 10, 2006 for the treatment of the two (2) right leg wounds. There were no orders for the treatment of the left heel.       F 314       I The nurse completed the left heel.         A review of the skin monitoring sheets revealed both right leg wounds had been assessed weekly from January 10 through February 2, 2006 There was no assessment for the necrotic area on the left heel.       I and sits effective 2/1506       I and sits effective 2/1506         A review of the skin monitoring sheets revealed both right leg wounds had been assessed.       The precord that the left heel necrotic area had been assessed.       I and sits ef	HADLEY	HOSP SKILLED NUP	RS UNIT					
<ul> <li>F 314</li> <li>1. The necrotic luker on resident #2's //3// key held held was assessed. Physican was notified and prescribed treatment (7) pressure sores on the right leg and one (1) pressure sore on the right leg. There was no treatment for the left heel. When queried about the care of the necrotic area on the left heel, the nurse stated that the resident's record revealed physician's orders dated January 10, 2006 for the treatment of the left heel.</li> <li>A review of the skin monitoring sheets revealed both right leg wounds had been assessed. Weekly from January 10 through February 2, 2006. There was no assessment for the necrotic area on the left heel.</li> <li>A nurse's note dated January 10, 2006 at 11:30 PM documented, *Stage II pressure ulcer on right outer leg. No drainage 9 cm x 2 cm. Right heel an excrute for Nursing (DON) accompanied the surveyor to the resident's mean assessed.</li> <li>The Director of Nursing (DON) accompanied the surveyor to the resident the resident the reare should have been assessed.</li> <li>The Director of Nursing (DON) accompanied the surveyor to the resident at the end and nearcottic S care and acknowledged that the area as and acknowledged that the area should have been assessed.</li> </ul>	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEEDED BY FULL	PREF	FIX	(EACH CORRECTIVE ACTION SHOULD	BE CROSS-	
should have been assessed and treated. The		Continued From pa was coded in Secti pressure sores. The resident was o at 11:20 AM during 1) pressure sore or pressure sore on the one (1) pressure sore heel. The nurse co wounds on the righ for the left heel. We the necrotic area o stated that the resident A review of the resident A review of the resident treatment of the two were no orders for A review of the skill both right leg wound from January 10 the There was no asse on the left heel. A nurse's note date PM documented, hight outer leg. Not heel hard and nech was no evidence in necrotic area had to The Director of Nur- surveyor to the resident 2006 at 11:30 AM.	age 18 on M with three (3) Stage III bserved on January 31, 2006 a wound treatment with one ( in the right heel, one (1) he back of the right leg and one (necrotic area) on the left ampleted treatments to the t leg. There was no treatment Anen queried about the care of in the left heel, the nurse dent had no treatment for it. ident's record revealed dated January 10, 2006 for the o (2) right leg wounds. There the treatment of the left heel. In monitoring sheets revealed rds had been assessed weekly rough February 2, 2006. ssment for the necrotic area ed January 10, 2006 at 11:30 "Stage II pressure ulcer on drainage 9 cm x 2 cm. Right otic 5 cm x 4 cm " There in the record that the left heel been assessed. rsing (DON) accompanied the ident's room on January 31, He/she observed the left heel		_	<ol> <li>The necrotic ulcer on residuleft heel was assessed. Physical was notified and prescribed was followed. (attachment K</li> <li>Daily Skin Assessment Professional was reviewed with the nursinal the unit staff meeting on 2 (attachment B) A copy of the Scale tool was given to each staff to review as resource in assist staff in identifying stag</li> <li>Team Leaders were instruct include the outcomes of dail assessments in their shift re the incoming shift. This is to in all shifts effective 2/15/06</li> <li>Pressure Ulcers developed will be included in the month</li> </ol>	ent #2's sican treatment ) pocol ng staff /15/06 Braden nursing naterial and pe 1's ted to y skin port to be implement in the facilit ty report	DATE $1/31/06$ 2/2/06 2/15/06 2/15/06 ented by $3/19/06$
	· ·	should have been	assessed and treated. The					

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Facility ID: HADLEY

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	AND HUMAN SERVICES	-	Runz [3] 3	FORM	02/14/2006 APPROVED 0938-0391	
OF DEFICIENCIES P CORRECTION	(X1) PROVIDER/SLIPPL/ER/CLA IDENTIFICATION NUMBER:	1	ULTIPLE CONSTRUCTION	(XC) DATE SI COMPLE		! :
	095024	B, WI	ki	02/0	2/2006	· · ·
ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, & P CODE	5		
HOSP SKILLED NUP	TINUS	•	4501 ML KING AVE SW WASHINGTON, DC 20032	• .		
(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	SD PREF TAG		LD BE CROSS,	DATE CONFLETION DATE	
Continued From pa	E OF MOTION	F 318	<ol> <li>Nursing staff on the unit war for failure to apply the ankle resident # 6. The schedule fo of the splints were reviewed</li> </ol>	splints for or the applicati	2/0 ion	406
vith a limited range oppropriate treatme	vehensive assessment of a y must ensure that a residen a of motion receives ent and services to increase d/or to prevent further		The ankle splints were applie The attending physician was the ankle splints were not co applied.	ed as of 2/2/06 notified that	3. ·	
decrease în range			<ol> <li>All residents with order for a other adaptive devices were nursing staff compliance to ti 3. The schedule was reviewed</li> </ol>	reviewed for he order.	\$/*/	106
This REQUIREME by:	NT is not met as evidenced		Services staff for a revision of and allow time for the resider	of the time sch nt sleep time (	edule /	0/06
interview for one () was determined the Resident #6's ankle	view, observation and staff ) of 15 sampled residents, it at facility staff failed to apply e splints for over five (5)		the night. The attending phys of the revised schedule and implement it and was implem staff. (attachment L)	he gave the or nented by the	rder to nursing'	
months. The findings includ	e:		<ol> <li>Daily rounds by RCC /desig to the schedule of application adaptive devices will be com- adaptive devices will be com-</li> </ol>	on of splints ar ducted and ou	nd other tcomes	2-115702
2005 [origination d	rders dated November 30, ate of September 1, 2005] ing order: "Ankle contracture		reported to the Performance monthly			
of two (2) anide coa	ed an order for the purchase ntracture splints from a npany on August 10, 2005.					
documented the fo Treatment For Out on August 10, 2005 ankle contractures Patient requires tot	pist evaluated the resident and lowing on the "Plan Of patient Rehabilitation " form 5: "Is total dependant with and susceptible to heel ulcers, al assistance Provide			•		
caregiver education schedule for multip	a. Order written for wearing		<u> </u>			

9) Previous Versions Obsolate

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		AND HUMAN SERVICES				FORM	02/14/2006 APPROVED 0938-0391
	FOR DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	1` '	KULTIP ILDING	ALE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		095024	B. Ŵi	NG_		02/0	2/2006
	ROVIDER OR SUPPLIER HOSP SKILLED NUS	RS UNIT	STREET ADDRESS, CITY, STATE, Z 4601 ML KING AVE SW				
~~~~	SI BRANDY STA	TEMENT OF DEFICIENCIES	~	<u> </u>	ASHINGTON, DC 20032 PROVIDER'S PLAN OF CO	PRECTICAL	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEEDED BY FULL SCIDENTIFYING INFORMATION)	id Pret Tag	TX	(EACH CORRECTIVE ACTION SH REFERENCED TO THE APPROPR	OULD BE CROSS-	(XS) COMPLETION DATE
F 318	Continued From pa	age 20	F	318			
	the record, dated A the following writte "Short Range Go wearing schedule) 8 PM - Off; 8 PM -	Rehabilitation Goal" was in august 10, 2005 and included n by the physical therapist: al: Multipodis Boot splints ( 12 PM - 4 PM - On; 4 PM - 12 AM - On; 12 AM - 4 PM - On; and 8 AM - 12 PM - Off."					•
	10, 2005 read as fo	progress note dated August blows: "Nursing staff podls boot Discontinue I therapy)."					
		bserved in his/her room on t 12:20 PM. He/She did not on.	- ,				
	RCC (Resident Car 2006 at 2:35 PM at resident never had stated, "The physi- many things for res	rview was conducted with the re Coordinator) on February 1, nd acknowledged that the ankle splints applied. He/She cal therapist recommended sidents. I don't remember [ lints.* The RCC checked the			F 323		
		d stated, "They are in his/her	)+		<ol> <li>A new water temperat has been created. San attached.</li> </ol>	ture log book nple of log	2/20/04
		iled to apply the ankle splints cord was reviewed on			<ol> <li>Water temperatures to monitored a minimum week with rooms bein selected. No less than</li> </ol>	n of 3 times a grandomly	2/20/06
F 323 \$S=E	-	DENTS nsure that the resident ins as free of accident hazards	F	323	<ol> <li>Boor will be checked.</li> <li>Water temperatures w the faucets in resident: day rooms with a them then recorded in the lo</li> </ol>	ill be taken at s' rooms and mometer and	2/20/00
FORM CMS-2	567(02-99) Previous Version	s Obsolete Event ID; SV0N1	I F	acility i	D: HADLEY	If continuation sheet	Page 21 of 33

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	MENT OF HEALTH						PRINTED: FORM / OMB NO.	02/14/2006 APPROVED 0938-0391	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUF		l` í	iultipu Liding		(X3) DATE SU COMPLET		
	•	095	024	B. Wit	₩G	· · · · · · · · · · · · · · · · · · ·	02/02	/2006	
	ROWDER OR SUPPLIER	RS UNIT			460	ET ADDRESS, CITY, STATE, ZIP CODE 1 ML KING AVE SW ISHINGTON, DC 20032			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIE MUST BE PRECEEDI SCIDENTIFYING INFO	ED BY FULL	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD) REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETION DATE	
F 323	Continued From particular This REQUIREMENDS by: Based on an obserperiod, it was deter was not available to temperatures were This finding was ob- maintenance direct The findings includ Documentation was maintenance staff temperature monitor ensure that hot wat 110 degrees Fahre and common areas December 31, 2005 February 2, 2006.	NT is not met as vation during the mlned that docu o ensure that hot monitored on a served in the pri- tor. e: s not available to conducted rando bring on a consis- ter temperatures nheit (F) in resid s between June 3	e survey mentation t water regular basis, esence of the o show that on hot water stent basis, to were below lents' rooms 30, 2005 and	F	323	temperatures will be mor according to the regulation 4. Results of monitoring wi reported at the Performant Improvement meetings of quarterly basis.	ons 11 be nce	3/19/04	
F 371 \$S=E	PREP & SERVICE The facility must st serve food under s	ore, prepare, dis anitary condition	tribute, and s.	F	371				
	This REQUIREME by: Based on observat it was determined t adequate to ensure safe and sanitary n drippings from a ga soiled dessert bow cutting boards that after washing. The	ions during the s that dietary servi that food was s nanner as evider asket over the po ls; expired cartor were not thorou	survey period, ces were not erved in a nced by: oil otato mixer; ns of milk; and ghly cleaned						
FORM CMS-25	667(02-99) Previous Versions	s Obsolute	Event (D; SVON11	l Fe	cility ID:	HADLEY If conti	inuation sheet i	Page 22 of 33	

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TMENT OF HEALTH AND HUMAN SERVICES	

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	PLE CONSTRUCTION G	(X3) DATE SU COMPLET	RVEY ED
		095024	B. WING_		02/02	/2006
	ROMDER OR SUPPLIER HOSP SKILLED NU	RSUNIT		REET ADDRESS, CITY, STATE, ZP C 601 ML KING AVE SW VASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES (MUST BE PRECEEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION S REFERENCED TO THE APPROF	HOULD BE CROSS-	(X5) COMPLET DATE
F 371	director. The findings includ 1. Oil was observed the bowl of the pol observation at app January 31, 2006. 2. Dessert bowls w stored on top of th reuse by staff duri approximately 12: 17 of 17 observati 3. Cartons of milk walk in refrigerator dated January 26, ) of 20 cartons; ski 2006 in two (2) of dated January 26 cartons between 8 January 31, 2006. 4. Cutting boards a reuse were not the as evidenced by for	e food service supervisor and le: d dripping from a gasket over lato mixer in one (1) of one (1) woximately 8:40 AM on with visible leftover food were e counter and were ready for ng the lunch meal at 10 PM on January 31, 2006 in	•	<ul> <li>#1 1. Identified the oil dri over the mixer bowl tightened to stop dr</li> <li>2. Before and after ea mixer bowl the gasi for drips and wiped</li> <li>3. Monitor and Spot c by the Director and manager of dietary</li> <li>4. Outcomes will be re Performance improv</li> <li>#2 1 Identified all bowls a remove residual food</li> <li>2. Bowls will be include procedures. Dietary s proper washing dishes</li> <li>3. Spot check will be reported mill immediately thrown a</li> <li>2. Checking and Rotation reinforced when stool</li> <li>3. Daily spot checks will by the production ma Supervisor of Dietary</li> <li>4. Outcomes will be reported mill immediately thrown a</li> </ul>	has been ipping. ch use of the ket is checked if needed. hecks conducted production daily. ported to vement committee. and rewashed to 1 particles. ed in the washing taff retrained on is. ed in the washing taff retrained on is. ompleted by the sor of Dietary. orted to performance ttee. k was way. on procedures cing the milk supply l be conducted mager and /.	1/31
F 385 SS=D	:30 PM on Februa 483.40(a) PHYSIC A physician must j recommendation t	ry 1, 2006. CIAN SERVICES personally approve in writing a hat an Individual be admitted in resident must remain under	F 385	<ul> <li>performance improve</li> <li>#4 1. Identified the dirty and cleaned immedia</li> <li>2. Ordered and replace with the dark stains</li> <li>3. Cutting boards will sanitized after every</li> <li>4. Outcomes will be reference of the second state of the second s</li></ul>	cutting boards ately. d the cutting boards be washed and use.	2/1/0 2/1/0 2/1/0

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	Remased us	FORM	02/14/2006 APPROVED 0935-0391_
(X2) MULT	IPLE CONSTRUCTION	(X3) DATE SU	
A BUILDIN	lo	COMPLE	TED
B. WING_		02/0	2/2006
	REET ADDRESS, CITY, STATE, ZIP CODE 1601 ML KING AVE SW WASHINGTON, DC 20032		
	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOUL	•	(XS) COMPLETION

	F OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	•	iultipi. Lding		(X3) DATE S COMPLE	
		095024	B, WI	ю		02/0	2/2006
HADLEY (X4) ID PREFIX	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL	10 PREF	460 WA	ET ADDRESS, CITY, STATE, ZIP CODE M ML KING AVE SW ASHINGTON, DC 20032 PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD	CTION DE CROSS-	(XS) COMPLETION DATE
TAG	REGULATORY OR L	SCIDENTIFYING INFORMATION)	TAG	;	REFERENCED TO THE APPROPRIATE	DEFICIENCY)	CALE
F 385	The facility must ere each resident is su another physician s residents when the unavailable. This REQUIREME by: Based on observat review for two (2) of physician failed to: and physical exam and include a sacra and physical for on and 10. The findings includ 1. A review of Reside last history and physical history and physical A review of Reside last history and physical A faca-to-face inter Coordinator was co at 3:30 PM. After m acknowledged that and physical exam record was reviewe 2. The physician fa a Stage 4 sacral ul Physical (H&P) for	hsure that the medical care of pervised by a physician; and supervises the medical care of in attending physician is NT is not met as evidenced ion, interview and record of 15 sampled residents, the complete an annual history ination for one (1) resident, al pressure sore on the history e (1) resident. Residents # 8 e: ident #8's record revealed that i to complete an annual al examination. Int #8's record revealed the vsical examination was omber 12, 2004. rview with the Resident Care anducted in January 31, 2006 eviewing the record, he/she there was no recent history ination in the record. The od February 1, 2006. illed to include the presence of cer on the History and Resident #10.		385	<ul> <li>F385 #1</li> <li>History and Physic of resident #8 was completed on February 24<sup>th</sup>, 2004 (attachment)</li> <li>Medical Records o both nursing units were reviewed if History and Physic were completed according to the regulation. Non- compliant physicia will be addressed to complete the H and</li> <li>Review of medical records for timeline of History and Physical will be completed by Medi Records monthly.</li> <li>Reviewed outcome will be reported to Performance Improvement committee monthly</li> </ul>	6. n al ns o IP. ess ical s the	2/24/06 3/1/06 3/1/06 3/19/06
TORM CMS-2	557(02-99) Provious Versions	Obsolcto Event ID: SVDN1	1 178	carry ID	: HADLEY If con	TINUETION Shee	Page 24 of 33

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		AND HUMAN SERVICES		Ý	wai 3	14.0	FORM	: 02/14/2006 APPROVED . 0938-0391	
STATEMENT	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(XZ) MI		ONSTRUCTION	QC3) DATE S	(03) DATE SURVEY COMPLETED		
		095024	B. WIN	G	·		02/0	2/2006	
NAME OF P	ROVIDER OR SUPPLIER	, ,		STREET	ADDRESS, CITY,	, STATE, ZIP COD			
HADLEY	HOSP SKILLED NUP	IS UNIT.			IL KING AVE S IINGTON, DO	-			
(X4) ID PREFIX •TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SCIDENTIFYING INFORMATION)	id Prefe Tag		ACH CORRECT	S PLAN OF COR ME ACTION SHO THE APPROPRY		DOMINE THOM	
F 385	Continued From pa		<b>E</b> 2	95				+	
	The following nurse, 2006 at 2:00 PM: Stage IV, also ulcer The admission order revealed the follow cleanse with Microl Silvadene to wound fluffed Mesalt and o QD (dally). " A review of the rec- a history and physic physician on Janua examination, the pl	ge 24 s' note was dated January 10 "Admitted has sacral ulcer is on both heels" ers dated January 10, 2006 ing order: " Sacral wound denz. Apply ¼ inch of d surface. Pack wound with cover with abdominal pads ord for Resident #10 revealed cal signed and dated by the ry 12, 2006. On physical rysician documented the al heel ulcers [no indication of	incl atta 2, M ulco exa 3, F will will rep Dire 4, ( rep	History a lude bot achmen Medical ers were ers sites am repo Residen be revia all be in orts. ector an Compile	th sacral ulce t previously s records of re e reviewed to swere include rts ts admitted v ewed to ensu- ocluded in th Deficiencies of SNF Admit d monthly re	submitted. esidents adm o ensure that led in the hist with pressure ure that the p e history and s will be repo- inistrator view outcom	ral heel uicers itted with pres muitiple press tory and physic	isure 3/3/20 sure cal nission 3/19/20 sites n dical be 3/16/20	
		rsical lacked evidence of the r. The record was reviewed 6.					·		
F 386 SS=D	The physician must program of care, in treatments, at each ) of this section; wrinotes at each visit; with the exception of pneumococcal poly	i review the resident's total cluding medications and visit required by paragraph (c ite, sign, and date progress and sign and date all orders of influenza and saccharide vaccines, which ad per physician-approved	F3		•				
	This REQUIREMEN	NT Is πot met as evidenced		,		••			

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Event ID: \$V0N/11

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Facility ID: HADLEY

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STATEMENT	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	1.1.	LULTIPL	E CONSTRUCTION	(X3) DATE SI COMPLE	JRVFY
		095024	B. Wi	VG	· · · · ·	02/02/2006	
NAME OF P	ROVIDER OR SUPPLIER				ET ADDRESS, CITY, STATE, ZIP CODE		~1000
HADLEY	HOSP SKILLED NU	RS UNIT			1 ML KING AVE SW SHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE D	BE CROSS-	COMPLETION DATE
F 386	Continued From pa Based on record re Interview for three was determined the failed to: sign and identify a necrotic resident; follow up use of ankle splints during resident visi review the total pla Residents #2, 6 and The findings includ 1. The physician faile orders and identify during his/her visits A. The physician f orders during his/h Re-admission telep the nurse as Janua this review (21 day physician signature There were progres physician dated Ja 2006. The physician faile orders during his/h B. The physician f	age 25 eview, observation and staff (3) of 15 sampled residents, it at the attending physician date re-admission orders and area to the left heel for one (1) and re-evaluate the resident's is and sign and date orders its for one (1) resident; and in of care for one (1) resident. d 14. le: alled to sign re-admission a necrotic area to the left heel is with Resident #2. alled to sign re-admission er visits with Resident #2. ohone orders were dated by any 10, 2006. At the time of is later), there was no		$\rightarrow$	<ul> <li>F386 #1A, B</li> <li>1. The Attending Physician of Resident #2 has been informed of the deficiencies and received a copy of the Medical Staff Attending Physician policy outlining the time frame for signing re-admission orders and resident assessment.</li> <li>2. All residents' orders and progress notes will be reviewed by Nursing and Medical Records for compliance to the policy and accuracy of the resident's condition.</li> <li>3. Medical Records will document any non- compliant physicians and outline the needed signatures on each resident's chart. Medical Records will</li> </ul>		3/19/06 3/19/06 3/19/06
	Resident #2. A review of Reside the quarterly MDS	ent #2's record revealed that completed January 19, 2006			also send a copy of the summary report to the Medical Director for follow-up.		
FORM CMS-2	567(02-99) Previous Version	s Obsolete Event ID: SVON1	1, Fe	cility 1D:	: HADLEY If cont	inuation sheel	Page 26 of 33

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CENTER		AND ADIMAN SERVICES				FORM	02/14/2006 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(22) N A. BU		PLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY
		095024	B. Wi	WG_	· · · ·	02/0	2/2006
NAME OF PI	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
HADLEY HOSP SKILLED NURS UNIT					601 ML KING AVE SW VASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	JD PREF TAG	X	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETION DATE
F 386	pressure sores. The resident was o at 11:20 AM during 1) pressure sore on pressure sore on the one (1) pressure so heel. A review of the resident sorters of treatment of the two were no orders for There were progress physician dated Jan 2006. The progress necrotic area to the reviewed January 3 2. The attending pri Resident #6 for the and date orders du A. The attending pri the resident for the The physician signed of two (2) ankle con- medical supply con- The readmission of 2005 [origination di	on M with three (3) Stage III bserved on January 31, 2006 a wound treatment with one ( a the right heel, one (1) the back of the right leg and one (necrotic area) on the left ident's record revealed dated January 10, 2006 for the o (2) right leg wounds. There the treatment of the left heel. is notes written by the nuary 11 and January 16, a notes lacked evidence of a b left heel. The record was 31, 2006. hysician failed to re-evaluate use of ankle splints and sign	F	386	<ul> <li>Non-compliant physicians will be reported to the Administrator.</li> <li>4. Outcomes will be reported to the Performance Improvement Committee.</li> <li>F386 #2A, B</li> <li>The Attending Physician of Resider #6 has been informed of the deficiency and received a copy of th Medical Staff Attending Physician outlining the assessment of residents, timeframe for signing and datin orders and monthly progress notes.</li> <li>All residents' medical records will be reviewed by Nursing and Medical Records for accuracy and physician signature and date of orders.</li> </ul>	d I ie g al	3/19/06 3/19/06 3/19/06
ļ	A face-to-face inter	view was conducted with the					

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\*ORM CMS-2567(02-89) Previous Versions Obsolete

Facility ID: HADLEY

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If continuation sheet Page 27 of 33

TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA NO PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MÜLTI	PLE CONSTRUCTION	COMPLETED	
		095024	B. WING	· · · · ·	02/02/2006
AME OF PE	ROVIDER OR SUPPLIER		STR	EET ADDRESS, CITY, STATE, ZIP CODE	
ADLEY	HOSP SKILLED NUP	IS UNIT		501 ML KING AVE SW (ASHINGTON, DC 20032	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL BC IDENTIFYING INFORMATION)	id Prefix Tag	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHOU REFERENCED TO THE APPROPRIAT	LD BE CROSS- COMPLETION
F 386	2006 at 2:35 PM an resident never had	ge 27 e Coordinator) on February 1, id acknowledged that the ankle splints applied. He/She cal therapist recommended	F 386	<ol> <li>Nursing and/or Medical Records v inform and docum any non-compliant</li> </ol>	ent ('/'
	many things for res resident] having sp	idents. I don't remember [ Ints.* The RCC checked the d stated," They are in his/her	•	physicians. Medic Records will also send a copy of the summary report to	the
0	the order for the an monthly progress n	ed the resident monthly after kle splints was written. The otes failed to include arding the ankle splints.		Medical Director f follow-up. Non-compliant physicians will be reported to the	or
		hysician failed to sign and visits with the resident.		Administrator. 4. Outcomes will be	3/19/00
	following telephone "Transfer resident t GT reinserted" and	nt #6's record revealed the orders: November 25, 2005, o Emergency room to have I November 30, 2005,		reported to the Performance Improvement Tea	m. // *
	readmission orders signed by the atten	These orders were not ding physician.		F386 #3 1. The Attending	
		is notes written by the dated December 28, 2005 06.		Physician of R #14 was notified the deficiency	ed of and a
	orders during his/he	to sign the readmission or visits with the resident. iewed on February 1, 2006.		copy of the rep placed in the N Staff file. 2. In the event, a	
	total plan of care at			resident is four unresponsive,	the
	Resident #14, it wa	of the clinical record for s noted on December 24, at the resident was found	:	attending phys will be notified DNR status of	i of the
M CMS-25	67(02-99) Previous Versions	Obsolete Event ID: SV0N11	Facility	D: HADLEY If c	ontinuation sheet Page 28 of 3

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		AND HUMAN SERVICES					FORM	APPROVED
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) M A. BUR				(X3) DATE SL COMPLE	0938-0391 JRVEY TED
		095024	8.WIN	iG			0.270	2/2222
NAME OF P	ROMDER OR SUPPLIER			STRE	EET ADDRESS, CITY	STATE ZIP CODE	020	2/2006
HADLEY		RS UNIT			01 ML KING AVE S ASHINGTON, DO			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	-	(EACH CORRECT	R'S PLAN OF CORRE TWE ACTION SHOULD THE APPROPRIATE	DBE CROSS.	(XS) COMPLETION DATE
F 456	unresponsive. Acc December 24, 200 full code and there Do Not Resuscitate The physician's pro 24, 2005 at 4:30 Pi see patient who wa paramedics have to pronounced her de Cardiac Life Suppo patient was a DNR The review of facili information Sheet" "1. Is this resident i directive been exe ". The form was si worker on August 1 There was no DNR physician's plan of dated by the physic On February 1, 200 face-to-face Intervi Director of Nurses resident was not a resident did not ha The physician faile plan of care at the reviewed on Febru	cording to a nurse's note dated 5 at 4:30 PM, "Resident was was no prior order for DNR ( b)." ogress note dated December Mindicated, "I was called to is found unresponsive. The eeen called in and they had ad. No ACLS (Advanced ort) was initiated because Pt. ( " ty's "Advance Directive indicated: competent to make decisions are"; "No" was coded. s competent, has an advance cuted"; "DNR" was coded "No gned and dated by the social 8, 2005. corder observed on the care that was signed and clan on December 24, 2005. D6 at approximately 1:00 PM a ew was conducted with the who acknowledged that the DNR. She/he indicated, " The ve a DNR order." d to review the resident's total time of death. The record was		456	3. The do Ma rel to Ph 4. Ou rep Per	sident. the nurse will cument in the edical Record t ay of informati the Attending ysician. the comes will be ported to rformance provement.	on	3/19/04
SS=E								
Form CMS-2	 557(02-99) Previous Version: ; ;	s Obsolete Event ID: SV0N11	Fa , ,	icitity X	D: HADLEY	if co	ntinuation sheet	Page 29 of 33

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	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING			OMB NO. (X3) DATE SL COMPLE	RVEY
		095024	B. WING			02/0;	2/2006
NAME OF P	ROVIDER OR SUPPLIER		S.		ADDRESS, CITY, STATE, ZIP CODE		
HADLEY	HOSP SKILLED NU	RS UNIT			IL KING AVE SW HINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SCIDENTIFYING INFORMATION)	ið Prefix Tag		PROVIDER'S PLAN OF CORRECTIVE ACTION SHOUL ACH CORRECTIVE ACTION SHOUL SPERENCED TO THE APPROPRIATI	D BE CROSS-	(XS) COMPLE DATI
F 456	The facility must m mechanical, electri equipment in safe This REQUIREME by: Based on observat determined that do and temperatures in pumps, chilled and the air handler unit log books to show monitored and ope These findings was the maintenance d The findings includ 1. Temperatures a booster water pum books on a regular between May 25 th through July 7, 200 2005 and August 1 of 12 observations approximately 1:00 2. Chilled and hot handler units were regular basis from between May 10 th through July 7, 200 14, 2005 and Octo 2005 in four (4) of February 2, 2006.	haintain all essential lical, and patient care operating condition. NT is not met as evidenced tions during the survey, it was becomentation of the pressures of domestic water booster is hot water temperatures for is and exhaust fans were not in that equipment was serviced, erating in a safe manner. Is observed in the presence of lirector. It is were not entered in log basis in the east boiler rooms mough May 31, 2005, July 1 05, July 29 through July 31, 1 through 14, 2005, In five (5) is on February 2, 2006 at 0 PM. water temperatures from air not entered in log books on a the east and west penthouses mough May 16, 2005, July 1 05, August 1 through August ber 28 through October 30, 12 observations at 1:20 PM on	F 45	F <sup>2</sup> 1. 2. 3.	<ul> <li>456 #1, 2, and 3 Temperatures and press domestic water pumps, hot water temperatures handlers and supply air temperatures of exhaust be constantly monitored documented in logs to b order to ensure their con All temperatures will be on a regular basis. Pers reprimands (according t will be taken when emp to or falsify the informat log books. A user friendly log bool developed to make equi rounds easier to identify complete. During weekly Plant sh the log books will be ch discussed. Each log bool signed off at the end of for completeness by the</li> </ul>	chilled and from air and fans will l and e done in npleteness. e monitored onnel o policy) doyees fail tion in the k will be pment y and op meetings lecked and ok will be	3/19/ 3/19/

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		HAND HUMAN SERVICES					FORM	APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			· _		OMB NO.	<u>093</u> 8-0391
	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		RULTIP REDING		_	(X3) DATE SU COMPLE	RVEY
		095024	B. WING			_		
NAME OF P				enpe	ET ADDRESS, CITY, STATE, ZIP		02/02	2/2006
HADLEY	HOSP SKILLED NUP	rs unit		464	ASHINGTON, DC 20032			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ю	·	PROVIDER'S PLAN OF	CORRECT	TION	
PREFIX	(EACH DEFICIENCY	MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION REFERENCED TO THE APPRO	SHOULD	BE CROSS-	(XS) COMPLETION DATE
F 456	Continued From pa	uge 30	F	456		•		
	from the east and y 10 through May 16 2005, August 1 thr October 7 through	a log books on a regular basis west penthouses between-May , 2005, July 1 through July 14, bugh August 14, 2005 and October 10, 2005 in four (4) of approximately 1:40 PM on						
F 514	483.75(i)(1) CLINIC	CAL RECORDS	F	514				
SS=D	The facility must m each resident in ac professional standa complete; accurate	aintain clinical records on cordance with accepted ards and practices that are by documented; readily stematically organized.						
	Information to Iden the resident's asses services provided;	ening conducted by the State;						
	i		-					
	This REQUIREME	NT is not met as evidenced						
	review for two (2) of staff failed to consi- restorative log she accurately docume	ion, interview and record of 15 sampled records, facility stently document on the et for one (1) resident and ont on the behavioral for one (1) resident. Residents						
	The findings includ	•						
	_	1						
	care provided to Re	ed to document the restorative esident #3.					·	
FORM CMS-2	567(02-99) Previous Versions	s Obsolete Event ID: SV0N11	F	cility IC	THADLEY	If cont	inuation sheet	Page 31 of 33
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		AND HUMAN SERVICES			uner 3/3/005	FORM	02/14/2006 APPROVED 0938-0391	
ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA ID PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 095024			(X2) MULTIPLE CONSTRUCTION A BUILDING B. WING			(X3) DATE SURVEY COMPLETED		
						02/02/2006		
AME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZP CODE			
TADLEY	HOSP SKILLED NUP	IS UNIT		1	WASHINGTON, DC 20032			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LEC IDENTIFYING INFORMATION)		ID PREF TAG	ЯX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE D	BE CROSS-	(23) COMPLETION DATE	
F 514	Resident #3's physi 1, 2004, and subse , directed, "Restoral A review of Reside Log Sheet" on Janu the restorative nursi document the resto Resident #3 as ord June 2005: 9, 13, 1 A face-to-face inter Coordinator was co at 3:00 PM. He/she #3 had received re- past year and the k The record was rev 2. Facility staff fails the behavior monit A raview of Reside the January 2006 in sheet indicated that monitored for, "Ou and " Agitation." incidents occurred January 2006. A nurse's note date PM documented, " window, [resident] I the CNA (Certified On January 24, 200	ician orders dated December quently renewed April 1, 2005 tive care every day ". Int #3's "Restorative Nursing Jary 31, 2006 revealed that sing assistants did not reative care provided to ered for the following days: 4, 16, 17, 28, 29 and 30. View with the Resident Care inducted on January 31, 2006 acknowledged that Resident storative care daily during the og sheet was not accurate, riewed on January 31, 2006. Ad to accurately document on oring sheets for Resident #7. Int #4's record revealed that nonthly behavlor monitoring the resident was being thurst," "Restlessness," Staff recorded that no under any behavior for ad January 14, 2006 at 3:10 When told not to open the became verbally abusive to Nurse Aide)."	F 514	1	<ol> <li>Restorative Log record of reside was reviewed with the nursing st unit. Nursing staff involved were</li> <li>All residents records receiving re- nursing services were reviewed f in documentation</li> <li>Licensed staff were instructed to compliance to the restorative nur- by the resident from team member team. Licensed staff are to check log record of residents assigned to documentation compliance. Repe- will be reported to the RCC to be performance appraissals.</li> <li>Monthly record review of docum nursing services in the restorative will be included in the Performance Committee report</li> </ol>	aff of the counselled. astorative or complian include do sing service ers during it s assigned to their team eated non of included in entation of a nursing fic	ace 2/15/c cumentation is received in their prative in for compliance the employee restorative w sheet	a 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2
	documented, * Re	sident was walking out of						

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Event ID: SVON11 Fedility ID: HADLEY

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CENTER		E & MEDICAID SERVICES			FORM	APPROVED	
STATEMENT OF DEPICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING		OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED		
			B. WINK	3	02/02/2006		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO			
HADLEY	HOSP SKILLED NU	RS UNIT		4601 ML KING AVE SW WASHINGTON, DC 20032			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SCIDENTIFYING INFORMATION)	D PREFD TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION SHK REFERENCED TO THE APPROPRI	OULD BE CROSS-	(X5) COMPLETION DATE	
F 514	<ul> <li>4 Continued From page 31</li> <li>A review of Resident #3's "Restorative Nursing Log Sheet" on January 31, 2006 revealed that the restorative nursing assistants did not document the restorative care provided to Resident #3 as ordered for the following days:</li> <li>June 2005: 9, 13, 14, 16, 17, 28, 29 and 30.</li> <li>A face-to-face interview with the Resident Care Coordinator was conducted on January 31, 2006 at 3:00 PM. He/she acknowledged that Resident #3 had received restorative care daily during the past year and the log sheet was not accurate. The record was reviewed on January 31, 2006.</li> <li>F 514</li> <li>F 514</li> <li>I. Restorative Log record of resident #3 was reviewed with the nursing staff of the unit. Nursing staff involved were counselled.</li> <li>A in residents records receiving restorative nursing services were reviewed for compliance in documentation</li> <li>Licensed staff were instructed to include docu- compliance to the restorative nursing services by the resident from team members during the of shift report from team members assigned in team. Repeated non compliance will be report to the RCC to be included in the employee's performance appraissals.</li> <li>Monthly record review of documentation of re nursing services in the restorative hursing flow will be included in the Performance Improvement Committee report</li> </ul>			ance 2/15/06 locumentation ces received the end 2/15/ of in their ported s of restorative low sheet			
	<ul> <li>2. Facility staff failed to accurately document on the behavior monitoring sheets for Resident #7.</li> <li>A review of Resident #4's record revealed that the January 2006 monthly behavior monitoring sheet indicated that the resident was being monitored for, "Outburst," "Restlessness," and " Agitation." Staff recorded that no incidents occurred under any behavior for January 2006.</li> <li>A nurse's note dated January 14, 2006 at 3:10 PM documented, "When told not to open the window, [resident] became verbally abusive to the CNA (Certified Nurse Alde)."</li> <li>On January 24, 2006 at 7:10 AM, a nurse's note documented, " Resident was walking out of</li> </ul>		F 614	<ul> <li>14 2 1. Behavior monitoring sheet for resident #7 2/2/06 was reviewed with the nursing staff on the unit. Nursing staff involved were counselled</li> <li>2. All residents records receiving medications 2/15/06 for behavioral symptoms were reviewed for appropriate documentation in the behavior monitoring sheet.</li> <li>3. License staff were instructed to include asking 2/15/06 the team members working with them whether any outburst in behavior, verbal abuse, agitation, outburst of any nature were exhibited by the residents in their care to be included and documented in the behavior monitoring sheet each shift</li> <li>4. Record review of the behavior monitoring sheets for appropriate and accurate documentation will be 1006 reported to the Performance Improvement Committee monthly</li> </ul>			

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CENTERS FOR MEDICARE & MEDICAID SERVICES							FORM APPROVED OMB NO. 0938-0391			
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				(A2) MULTIPLE CONSTRUCTION				(X3) DATE SURVEY		
095024				A BUILDING				COMPLETED		
		095024	B. WING				12/0	2/2006		
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		02/02/2006					
HADLEY HOSP SKILLED NURS UNIT			,	4601 ML KING AVE SW WASHINGTON, DC 20032						
(X4) ID		TEMENT OF DEFICIENCIES	ID.	J	PROVIDER'S PI			~~~~		
PRÉFIX TAG		MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE / REFERENCED TO THE			(X5) COMPLETION DATE		
F 514	Continued From pa	ge 32	F:	514						
	rounds, refused to	ff was making morning move out of the way for the ent] started cursing the staff ason"						. ·		
	2006 at 7:10 AM, ' attempted to trip [C are you trying to do	e's note dated January 26, ' CNAreported that residen :NA]nurse asked " What i? Are you trying to trip me? " " Yes, now tie my shoe. "	t							
	2006 at 7:15 AM, 1	e's note dated January 26, 'Housekeeping employee fused to move and started no reason "	-		·					
	reflected on the be	cited incidents were not havior monitoring sheet for record was reviewed					·			
	1							· ·		
		•								
							•			
						•	, <sup>1</sup>			
ORM CMS-25	67(02-89) Previous Version	Cobsolele Event ID: SVON	11 Fa	acility (D	HADLEY	lf a	ntinuation sheel	Page 33 of 33		
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