POC accepted 3/7/06

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING _____ B. WING _____	02/02/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HADLEY HOSP SKILLED NURS UNIT	4601 ML KING AVE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 000	Initial Comments An annual licensure survey was conducted on January 31 through February 2, 2006. The following deficiencies were based on record review, observations and interviews with staff and residents. The sample included 15 residents based on a census of 59 residents on the first day of the survey and one (1) supplemental resident.	L 000		
L 001	3200.1 Nursing Facilities Each nursing facility shall comply with the Act, these rules and the requirements of 42 CFR Part 483, Subpart B, Sections 483.1 to 483.75; Subpart D, Sections 483.150 to 483.158; and Subpart E, section 483.200 to 483.206, all of which shall constitute licensing standards for nursing facilities in the District of Columbia. This Statute is not met as evidenced by: Based on observation, interview and record review, facility staff failed to comply with CFR 483.25, F309 by failing to follow-up on a physician's order for gait training for one (1) resident upon readmission to the facility after a fall and subsequent fracture The findings include: Rehabilitative Services failed to follow-up on a physician's order for gait training for Resident #3 after his/her return from the hospital for a fall and subsequent fracture. The resident was walking using a walker with assistance prior to the fall with fracture. The resident has not walked since his/her return from the hospital (September 3, 2005). A review of Resident #3's record revealed that he/she fell and sustained a fracture of the right	L 001	1. Reassessment for rehab services was performed by the Clinical Supervisor of the Rehab Dept. on Resident #3. 2/02/06 2. A review of all residents readmitted during the last quarter 2005 thru January 2006, will be performed and reassessments will be done as indicated. (see attached form) 2/20/06 3. The Admitting Coordinator will notify the Clinical Supervisor of the Rehab Dept. via e-mail of all residents returning to the facility. A request form for screening of new admits, readmits and change of status will be submitted to the Rehab. Dept. by the SNF nursing staff. (see attached form) 2/10/06 4. Records of residents readmitted to the facility will be reviewed for compliance with the reassessment protocol. Review outcomes will be reported to the Performance Improvement committee monthly. 3/9/06	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: CEO — (X6) DATE: 2/22/06

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING _____ B. WING _____	02/02/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HADLEY HOSP SKILLED NURS UNIT	4601 ML KING AVE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 001	Continued From page 1 distal femur and was hospitalized from August 26 , 2005 to September 3, 2005. Resident #3 was ambulating during physical therapy with an assistive device (walker) prior to the right femoral fracture. Following his/her return from the hospital for treatment of the fracture, he/she has not been assessed for the ability to walk. According to a nurse's note dated August 25, 2005 at 11:00 PM, "Writer called to resident's room where I observed resident on the floor near the door lying face down ... " . According to the X-ray report of August 26, 2005, " Impression: fractures of the distal right femur extending from the mid and distal third of the lateral femoral condyle " . Resident was admitted to the hospital on August 26, 2005 for further assessment and treatment. Resident #3 was readmitted to the facility on September 3, 2005. Physician readmission orders dated September 3, 2005 included " Physical Therapy order gait training for Monday, Wednesday & Friday 9/3/05." A review of the Physical Therapy (PT) note dated July 1, 2005 revealed that the resident received physical therapy prior to the fall. A PT note dated July 28, 2005 documented, " ... amb. (ambulating) with standard walker with minimal assist at 30 ft x 2 (times two) ... " There was no evidence in the record that Resident #3 was assessed by PT following readmission to the facility on September 3, 2005. According to the facility's policy, "Rehabilitative Screening," policy number PT 05-018, page 1 of 1 " Residents in the SNF (Skilled Nursing Facility) will be screened by Rehabilitative Services department within 5 days of admission	L 001		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING _____ B. WING _____	02/02/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HADLEY HOSP SKILLED NURS UNIT	4601 ML KING AVE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 001	Continued From page 2 ... Reassessment will be done annually and when a change in status is reported by nursing or physician." A face-to-face interview was conducted with the Director of Rehabilitation Services on February 1 , 2006 at 2:30 PM. He/she stated that he/she was aware that Resident #3 was admitted to the hospital. However, he/she was not aware that the resident was readmitted to the facility. The director acknowledged that the resident had not been seen in the rehabilitation department for the last several months. A face-to-face interview with the Resident Care Coordinator was conducted on February 1, 2006 at 1:00 PM. The surveyor inquired about the process by which PT is notified of evaluation orders. He/She stated " PT is notified by telephone, but no telephone log is kept in reference to these calls." According to the Minimum Data Set dated January 19, 2006 Resident #3 had no long or short term memory problems and was independent of cognitive daily decision making skills (Section-B). A face-to-face interview with Resident #3 was conducted on February 1, 2006 at 11:30 AM. The resident stated that he/she remembered the fall but does not remember the exact date. The resident also stated that he/she was walking with a walker prior to the fall. He/she added that when he/she returned from the hospital he/she has not walked with his/her walker again. After the surveyor identified the lack of a physical therapy assessment, the Director of Rehabilitation Services assessed Resident #3 on	L 001		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING _____ B. WING _____	02/02/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HADLEY HOSP SKILLED NURS UNIT	4601 ML KING AVE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 001	Continued From page 3 February 2, 2006 at 11:00 AM. Physical therapy, Occupational therapy and Speech language pathology evaluations were recommended with the impression of "potential for rehab - fair." The record was reviewed January 31, 2006.	L 001		
L 051	3210.4 Nursing Facilities A charge nurse shall be responsible for the following: (a)Making daily resident visits to assess physical and emotional status and implementing any required nursing intervention; (b)Reviewing medication records for completeness, accuracy in the transcription of physician orders, and adherences to stop-order policies; (c)Reviewing residents' plans of care for appropriate goals and approaches, and revising them as needed; (d)Delegating responsibility to the nursing staff for direct resident nursing care of specific residents; (e)Supervising and evaluating each nursing employee on the unit; and (f)Keeping the Director of Nursing Services or his or her designee informed about the status of residents. This Statute 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	L 051		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING _____ B. WING _____	02/02/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HADLEY HOSP SKILLED NURS UNIT	4601 ML KING AVE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 4 oxygen use 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 and the use of oxygen. A. Resident #2's care plan was not updated to include 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 back of the right leg and one (1) pressure sore (necrotic area) on the left 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 (Ulcers due to any cause) and M2a (Types of Ulcers) that the resident had 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 plan could be updated at any time. The record was reviewed January 31, 2006. There was no evidence that the care plan was	L 051	#1A 1. Nursing Care Plan was updated for resident #2 to include multiple pressure ulcers (attachment G) 1/31/06 2. Medical records of residents with multiple pressure ulcers were reviewed to include multiple pressure ulcers in their care plan 3/19/06 3. Residents admitted with multiple pressure ulcers will have a nursing care plan developed within 7 days of admission to the facility addressing multiple pressure ulcers. When a resident develops multiple pressure ulcers while in the facility, a care plan will be developed within 7 days from the assessment that multiple pressure ulcers have developed. 3/19/06 4. Monitoring and evaluation of resident's care plan addressing multiple pressure ulcers will be conducted monthly and monitoring outcomes reported to the Performance Improvement Committee. 3/19/06 5. 3/16/06	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING _____ B. WING _____	02/02/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HADLEY HOSP SKILLED NURS UNIT	4601 ML KING AVE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 5 updated to include goals and approaches for the three (3) Stage III pressure sores identified on January 10, 2006. The record was reviewed January 31, 2006. B. Facility staff failed to develop a care plan with goals and approaches for the use of oxygen for Resident #2. Resident #2 was observed on January 31, 2006 at 10:00 AM and February 1 and 2, 2006 at 11: 30 AM on both days, receiving oxygen via nasal cannula at 2 liters/minute. A review of Resident #2's record revealed a physician's telephone order dated January 10, 2006, "O2 @ 2L/NC PRN (Oxygen at 2 liters per nasal cannula as needed)." The care plan did not include goals and approaches for the use of oxygen. 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 care plan for oxygen and that the care plan could be updated at any time. The record was reviewed January 31, 2006. 2. Facility staff failed to update and initiate goals and approaches for Resident #7 who had two (2) falls without injury. A review of Resident #7's record revealed that the resident fell on December 25, 2005 and January 9, 2006. A review of the care plan, last updated on January 5, 2006 included problem #5, " Potential for falls/injuries secondary to weakness	L 051	#1B. 1. Nursing care plan addressing Oxygen Therapy was developed on resident #2 (attachment) 2. Medical records of residents receiving Oxygen Therapy were reviewed for the presence of a care plan addressing oxygen therapy. Care plans were updated as needed 3. When residents are started on Oxygen therapy a care plan will be developed by Respiratory Therapy. 4. Records of residents receiving Oxygen therapy will be reviewed during weekly care plan meetings. Review outcomes will be reported to the Performance Improvement committee monthly #2 1. Nursing Care Plan was updated for Resident # 7 to include approaches to be implemented subsequent to the 2 falls, 12/05 & 1/06 (attachment H) 2. Medical records of residents with multiple falls were reviewed and updated to include addditional goals and approaches after each fall reoccurring. 3. Nursing Care Plan will be updated after each resident's fall. Care plan will include additional goals and approaches after each fall reoccurring. 4. Monitoring for compliance will be conducted monthly. Outcomes will be reported to the Performance Improvement Committee monthly 5. 3/16/06	02/22/06 02/22/06 02/22/06 02/22/06 2/2/06 2/2/06 3/19/06 3/19/06

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING _____ B. WING _____	02/02/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HADLEY HOSP SKILLED NURS UNIT	4601 ML KING AVE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 6 and unsteady gait." There was no evidence that the facility initiated additional approaches to prevent the resident from further falls. 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 falls care plan and that the care plan could be updated at any time. The record was reviewed January 31, 2006.	L 051		
L 052	3211.1 Nursing Facilities Sufficient nursing time shall be given to each resident to ensure that the resident receives the following: (a)Treatment, medications, diet and nutritional supplements and fluids as prescribed, and rehabilitative nursing care as needed; (b)Proper care to minimize pressure ulcers and contractures and to promote the healing of ulcers : (c)Assistants in daily personal grooming so that the resident is comfortable, clean, and neat as evidenced by freedom from body odor, cleaned and trimmed nails, and clean, neat and well-groomed hair; (d) Protection from accident, injury, and infection; (e)Encouragement, assistance, and training in self-care and group activities; (f)Encouragement and assistance to:	L 052		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING _____ B. WING _____	02/02/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HADLEY HOSP SKILLED NURS UNIT	4601 ML KING AVE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 7 (1)Get out of the bed and dress or be dressed in his or her own clothing; and shoes or slippers, which shall be clean and in good repair; (2)Use the dining room if he or she is able; and (3)Participate in meaningful social and recreational activities; with eating; (g)Prompt, unhurried assistance if he or she requires or request help with eating; (h)Prescribed adaptive self-help devices to assist him or her in eating independently; (i)Assistance, if needed, with daily hygiene, including oral acre; and j)Prompt response to an activated call bell or call for help. This Statute is not met as evidenced by: Based on observation, interview and record review for three (3) of 15 sampled residents, sufficient nursing time was not given to ensure that : a pressure sore was assessed and treated for one (1) resident and blood pressure medication was administered per physician's order and splints applied for one (1) resident. Residents #2 and 6. The findings include: 1. Sufficient nursing time was not given to Resident #2 to ensure that a necrotic left heel was assessed and treated. A review of Resident #2 ' s record revealed that the quarterly MDS completed January 19, 2006	L 052		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING _____ B. WING _____	02/02/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HADLEY HOSP SKILLED NURS UNIT	4601 ML KING AVE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 8 was coded in Section M with three (3) Stage III 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 back of the right leg and one (1) pressure sore (necrotic area) on the left heel. The nurse completed treatments to the wounds 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 had no treatment for it. A review of the resident's record revealed physician's 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. 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. 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 hard and necrotic 5 cm x 4 cm ..." There was no evidence in the record that the left heel necrotic area had been assessed. The Director of Nursing (DON) accompanied the surveyor to the resident's room on January 31, 2006 at 11:30 AM. He/she observed the left heel necrotic area and acknowledged that the area should have been assessed and treated. He/she record was reviewed January 31, 2006. 2. Sufficient nursing time was not given to	L 052	#1 1. The necrotic ulcer on resident #2's left heel was assessed. Physican was notified and prescribed treatment was followed. (attachment K) 2/2/06 2. Daily Skin Assessment Protocol was reviewed with the nursing staff at the unit 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 2/15/06 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 all shifts effective 2/15/06 2/15/06 4. Pressure Ulcers developed in the facility will be included in the monthly report to the Performance Improvement Committee 3/1/06	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING _____ B. WING _____	02/02/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HADLEY HOSP SKILLED NURS UNIT	4601 ML KING AVE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 9 Resident #6 to ensure that blood pressure medication was held as per physician orders and splints were applied. A. Sufficient nursing time was not given to Resident #6 to ensure that blood pressure medication was held as per physician's orders. A review of Resident #6's record revealed a physician's order with an origination date of July 1, 2003 which read: "Hold blood pressure medications if patient's systolic blood pressure is 120 or less." The following medications were indicated for Hypertension on the physician's orders: Lasix 40 mg via G-tube every day; Lisinopril 2.5 mg via G-tube every day; and Nitrek 0.2 mg/1 HR Patch to skin every day on at 6 AM off at 6 PM. A review of the MARs (Medication Administration Records) revealed the following medications were given when the systolic blood pressure was 120 or below: Lasix - November 9, 11 and 12, 2005; December 11, 23, 24, 25 and 26, 2005; and January 3, 5, 7, 8, 15 and 24, 2006 Lisinopril - November 7, 9, 11 and 12, 2005; December 1, 23, 24 and 26, 2005; and January 3 , 5, 7, 8, 15 and 24, 2006. Nitrek patch - November 4 and 5, 2005; and January 1, 10, 21, 23 and 24, 2006. Facility staff failed to hold blood pressure medication as per the physician's order. The record was reviewed on February 1, 2006. B. Sufficient nursing time was not given to	L 052	#2A 1. Occurrence reports were completed on the discovered errors. Involved licensed staff were counselled by the Resident Care Coordinator. Attending Physician was notified of the error. Parameter to hold antihypertensive meds were changed to 110 systolic pressure. (attachment I) 2/15/06 2. Medication Administration Records of all residents receiving antihypertensive medications with orders of parameters when to hold meds were reviewed for compliance. Outcomes were reviewed with involved staff. 2/15/06 3. Policy on Medication Administration was reviewed with Nursing Staff at the unit staff meeting 2/15/06. (attachment J) 2/15/06 4. Monitoring outcomes will be reported to the Performance Improvement Committee monthly 3/19/06	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING _____ B. WING _____	02/02/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HADLEY HOSP SKILLED NURS UNIT	4601 ML KING AVE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 10 ensure that Resident #6's splints were applied as ordered by the physician. The readmission orders dated November 30, 2005 [origination date of September 1, 2005] included the following order: "Ankle contracture splints". The physician signed an order for the purchase of two (2) ankle contracture splints from a medical supply company on August 10, 2005. The physical therapist evaluated the resident and documented the following on the "Plan Of Treatment For Outpatient Rehabilitation " form on August 10, 2005: "...is total dependant with ankle contractures and susceptible to heel ulcers . Patient requires total assistance ... Provide caregiver education. Order written for wearing schedule for multipodis boots." The form "Medical Rehabilitation Goal" was in the record, dated August 10, 2005 and included the following written by the physical therapist: "...Short Range Goal: Multipodis Boot splints (wearing schedule) ... 12 PM - 4 PM - On; 4 PM - 8 PM - Off; 8 PM - 12 AM - On; 12 AM - 4 PM - Off; 4 AM - 8 AM - On; and 8 AM - 12 PM - Off." A physical therapy progress note dated August 10, 2005 read as follows: "Nursing staff education on multipodis boot ... Discontinue skilled PT (physical therapy)." The resident was observed in his/her room on February 1, 2006 at 12:20 PM. He/She did not have ankle splints on. A face-to-face interview was conducted with the RCC (Resident Care Coordinator) on February 1,	L 052 2B	1. Nursing staff on the unit were counselled for failure to apply the ankle splints for resident # 6. The schedule for the application of the splints were reviewed with the staff. The ankle splints were applied as of 2/2/06. 2/02/06 2. All residents with order for ankle splints and other adaptive devices were reviewed for nursing staff compliance to the order. 2/2/06 3. The schedule was reviewed with Rehabilitative Services staff for a revision of the time schedule and allow time for the resident sleep time during the night. The revised schedule was implemented. (attachment (L) 2/3/06 4. Daily rounds by RCC /designee to ensure compliance to the schedule of application of splints and other adaptive devices will be conducted and outcomes reported to the Performance Improvement Committee monthly 2/15/06	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING _____ B. WING _____	02/02/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HADLEY HOSP SKILLED NURS UNIT	4601 ML KING AVE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 11 2006 at 2:35 PM and acknowledged that the resident never had ankle splints applied. He/She stated, "The physical therapist recommended many things for residents. I don't remember [resident] having splints." The RCC checked the resident's closet and stated, "They are in his/her closet." The facility staff failed to apply the ankle splints as ordered. The record was reviewed on February 1, 2006.	L 052		
L 080	3216.1 Nursing Facilities Each resident has the right to be free from physical and chemical restraints. This Statute is not met as evidenced by: Based on observation, interview and record review, facility staff failed to identify a geri-chair as a restraint for one (1) of 15 sampled residents . Resident #11. The findings include: The resident was observed on January 31, 2006 at 9:30 AM and at 11:45 AM sitting in his/her room in a geri-chair with the lap table secured in front of the resident. A review of the resident's record revealed that the resident was admitted to the facility on November 1, 2005. According to the quarterly Minimum Data Set completed January 27, 2006, the resident was coded with long and short-term memory loss and severely impaired skills for cognitive decision-making and for restlessness and mental functioning that varied over the course of the day. The resident was coded as being restless up to five (5) days per week (	L 080		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING _____ B. WING _____	02/02/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HADLEY HOSP SKILLED NURS UNIT	4601 ML KING AVE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 080	Continued From page 12 Section B- Cognitive Function). In Section G4d (Functional Limitations in Range of Motion), the resident was coded with limitations in range of motion of both legs with no voluntary loss of movement. A face-to-face interview with the resident's son was conducted on February 1, 2006 at 2:30 PM. He stated, " [Resident #11] was always in a wheelchair before coming here. The chair with the table top [Resident 11] is in now, doesn't let [him/her] get up and I think it's safer. It's better than a wheelchair, because [Resident #11] could get up from the wheelchair." Resident #11 received physical therapy from November 2 through December 8, 2005. According to the physical therapist's note dated November 15, 2005 at 11:45 AM, " Sit to stand with contact guard assist/minimum assist. Ambulated about 150' x3 (three times) with rolling walker and contact guard assist for guiding walker. Static standing balance with contact guard assist. Patient appears to have increased endurance with gait ... " A face-to-face interview was conducted with the Director of Rehabilitation Services on February 2 , 2006 at 11:30 AM. He/she was asked why Resident #11 was seated in a geri-chair with the table top secured and replied, " I don't know. The geri-chair was not recommended by physical therapy. " A face-to-face interview was conducted with a Certified Nurse Aide on February 2, 2006 at 11: 25 AM, who had cared for Resident #11 since admission to the facility. He/she stated, "We have always used a geri-chair with the table for his/her safety."	L 080	1. Policy on Restraints was reviewed with the staff for immediate implementation for resident # 11 A corresponding care plan addressing restraints also developed. (attachment A) 2/2/06 2. Inservice informing staff that use of gerichairs with 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) 2/2/06 3. All residents using gerichairs with secured table top and the residents are unable to remove the table top will be monitored if the nursing staff are implementing the Restraint Policy during the care of the resident 2/2/06 4. Monitoring outcomes will be reported to the Performance Improvement monthly 3/15/06	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING _____ B. WING _____	02/02/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HADLEY HOSP SKILLED NURS UNIT	4601 ML KING AVE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 080	Continued From page 13 A face-to-face interview was conducted with the Resident Care Coordinator on January 31, 2006 at 2:30 PM. The charge nurse was asked why Resident #11 was seated in a geri-chair and not in a wheelchair. The charge nurse replied, " It is for his/her safety." Facility staff failed to identify and assess the resident for the use of a geri-chair with the table top secured as a restraint. The record was reviewed February 2, 2006.	L 080		
L 099	3219.1 Nursing Facilities Food and drink shall be clean, wholesome, free from spoilage, safe for human consumption, and served in accordance with the requirements set forth in Title 23, Subtitle B, D. C. Municipal Regulations (DCMR), Chapter 24 through 40. This Statute is not met as evidenced by: Based on observations during the survey period, it was determined that dietary services were not adequate to ensure that food was served in a safe and sanitary manner evidenced by: oil drippings from a gasket over the potato mixer; soiled dessert bowls; expired cartons of milk; and cutting boards that were not thoroughly cleaned after washing. These findings were observed in the presence of the food service supervisor and director. The findings include: 1. Oil was observed dripping from a gasket over the bowl of the potato mixer in one (1) of one (1) observation at approximately 8:40 AM on January 31, 2006.	L 099	#1 1. Identified the oil dripping gasket over the mixer bowl has been tightened to stop dripping. 1/31/06 2. Before and after each use of the mixer bowl the gasket is checked for drips and wiped if needed. 1/31/06 3. Monitor and Spot checks conducted by the Director and production manager of dietary daily. 1/31/06 4. Outcomes will be reported to Performance improvement committee. 3/19/06	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING _____ B. WING _____	02/02/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HADLEY HOSP SKILLED NURS UNIT	4601 ML KING AVE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 099	Continued From page 14 2. Dessert bowls with visible leftover food were stored on top of the counter and were ready for reuse by staff during the lunch meal at approximately 12:10 PM on January 31, 2006 in 17 of 17 observations. 3. Cartons of milk were observed stored in the walk in refrigerator with expired dates: super milk dated January 26, 27 and 30, 2006 in seven of (7) of 20 cartons; skim milk dated January 30, 2006 in two (2) of 20 cartons; and regular milk dated January 26 and 27, 2006 in two (2) of 10 cartons between 8:35 AM and 8:45 AM on January 31, 2006. 4. Cutting boards stored on a rack and ready for reuse were not thoroughly cleaned after washing as evidenced by food and dark stains on board surfaces in two (2) of seven (7) observations at 2 :30 PM on February 1, 2006.	L 099	#2 1 Identified all bowls and rewashed to remove residual food particles. 2. Bowls will be included in the washing procedures. Dietary staff retrained on proper washing dishes. 3. Spot check will be completed by the Director and Supervisor of Dietary. 4. Outcome will be reported to performance improvement committee. #3 1. Identified expired milk was immediately thrown away. 2. Checking and Rotation procedures reinforced when stocking the milk supply. 3. Daily spot checks will be conducted by the production manager and Supervisor of Dietary. 4. Outcomes will be reported to performance improvement committee. #4 1. Identified the dirty cutting boards and cleaned immediately. 2. Ordered and replaced the cutting boards with the dark stains. 3. Cutting boards will be washed and sanitized after every use. 4. Outcomes will be reported to PI.	1/31/06 2/6/06 1/31/06 3/9/06 1/31/06 1/31/06 1/31/06 3/9/06 2/1/06 2/6/06 2/1/06 3/9/06
L 135	3225.2 Nursing Facilities Medication may be ordered by telephone if: (a)The order is given by a physician or licensed advanced registered nurse; (b)The order is reduced to writing immediately in the resident's medical record by the person taking the order; and (c)The order is taken by a licensed registered or practical nurse and countersigned by a physician within ten (10) days . This Statute is not met as evidenced by: Based on record review and staff interview for three (3) of 15 sampled residents, it was	L 135		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING _____ B. WING _____	02/02/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HADLEY HOSP SKILLED NURS UNIT	4601 ML KING AVE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 099	Continued From page 14 2. Dessert bowls with visible leftover food were stored on top of the counter and were ready for reuse by staff during the lunch meal at approximately 12:10 PM on January 31, 2006 in 17 of 17 observations. 3. Cartons of milk were observed stored in the walk in refrigerator with expired dates: super milk dated January 26, 27 and 30, 2006 in seven of (7) of 20 cartons; skim milk dated January 30, 2006 in two (2) of 20 cartons; and regular milk dated January 26 and 27, 2006 in two (2) of 10 cartons between 8:35 AM and 8:45 AM on January 31, 2006. 4. Cutting boards stored on a rack and ready for reuse were not thoroughly cleaned after washing as evidenced by food and dark stains on board surfaces in two (2) of seven (7) observations at 2 :30 PM on February 1, 2006.	L 099		
L 135	3225.2 Nursing Facilities Medication may be ordered by telephone if: (a)The order is given by a physician or licensed advanced registered nurse; (b)The order is reduced to writing immediately in the resident's medical record by the person taking the order; and (c)The order is taken by a licensed registered or practical nurse and countersigned by a physician within ten (10) days . This Statute is not met as evidenced by: Based on record review and staff interview for three (3) of 15 sampled residents, it was	L 135	L 135 #1, 2, 3 1. The Attending Physicians of Residents #2, #6 and #10 have been informed of the deficiency and the regulation to countersign the telephone with in ten (10) days. 2. All residents' telephone orders will be reviewed by Nursing and/or Medical Records for compliance to the regulation	3/19/06 3/19/06

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING _____ B. WING _____	02/02/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HADLEY HOSP SKILLED NURS UNIT	4601 ML KING AVE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 135	Continued From page 15 determined that the physician failed to countersign the telephone orders within ten days for three (3) residents. Residents # 2, 6 and 10. The findings include: 1. The physician failed to countersign telephone orders for Resident #2 within ten days. Re-admission telephone orders were dated by the nurse on January 10, 2006. At the time of this review (21 days later), there was no physician signature. The record was reviewed January 31, 2006. 2. The physician failed to countersign telephone orders for Resident #6 within ten days. A review of Resident #6's record revealed the following telephone orders: November 25, 2005, " Transfer resident to Emergency room to have GT reinserted " and November 30, 2005, readmission orders. The above orders were not signed. The record was reviewed on February 1, 2006. 3. The physician failed to countersign telephone orders for Resident #10 within ten days. A review of Resident #10's record revealed the following telephone orders: January 10, 2006, new admission orders; January 11, 2006, " Transfer to ER for management of Pneumonia"; and January 19, 2006, readmission orders. The above orders were not signed. The record was reviewed on February 1, 2006.	L 135	3. Medical Records and/or Nursing will document any non-compliant physicians and outline the needed signatures on each resident's chart. Medical Records will also send a copy of the summary report to the Medical Director for follow-up. Non-compliant physicians will be reported to the Administrator. 4. Outcomes will be reported to the Performance Improvement Committee.	3/19/06 3/19/06

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING _____ B. WING _____	02/02/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HADLEY HOSP SKILLED NURS UNIT	4601 ML KING AVE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 442	Continued From page 16	L 442		
L 442	3258.13 Nursing Facilities The facility shall maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This Statute is not met as evidenced by: Based on observations during the survey, it was determined that documentation of the pressures and temperatures of domestic water booster pumps, chilled and hot water temperatures for the air handler units and exhaust fans were not in log books to show that equipment was serviced, monitored and operating in a safe manner. These findings was observed in the presence of the maintenance director. The findings include: 1. Temperatures and pressures of domestic booster water pumps were not entered in log books on a regular basis in the east boiler rooms between May 25 through May 31, 2005, July 1 through July 7, 2005, July 29 through July 31, 2005 and August 1 through 14, 2005, in five (5) of 12 observations on February 2, 2006 at approximately 1:00 PM. 2. Chilled and hot water temperatures from air handler units were not entered in log books on a regular basis from the east and west penthouses between May 10 through May 16, 2005, July 1 through July 7, 2005, August 1 through August 14, 2005 and October 28 through October 30, 2005 in four (4) of 12 observations at 1:20 PM on February 2, 2006. 3. Supply air and temperatures of exhaust fans were not entered in log books on a regular basis from the east and west penthouses between May 10 through May 16, 2005, July 1 through July 14,	L 442	1. Temperatures and pressure of domestic water pumps, chilled and hot water temperatures from air handlers and supply air and temperatures of exhaust fans will be constantly monitored and documented in logs to be done in order to ensure their completeness. 2/20/06 2. All temperatures will be monitored on a regular basis. Personnel reprimands (according to policy) will be taken when employees fail to or falsify the information in the log books. 2/20/06 3. A user friendly log book will be developed to make equipment rounds easier to identify and complete. 3/19/06 4. During weekly Plant shop meetings the log books will be checked and discussed. Each log book will be signed off at the end of the month for completeness by the Director. 3/19/06	

FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING _____ B. WING _____	02/02/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HADLEY HOSP SKILLED NURS UNIT	4601 ML KING AVE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 442	Continued From page 17 2005, August 1 through August 14, 2005 and October 7 through October 10, 2005 in four (4) of 12 observations at approximately 1:40 PM on February 2, 2006.	L 442		