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PRINTED. 06/05/2007 FORM APPROVED

05/25/2007

Haalth	Deculation	Administration
пеаші	Requiation	Administration

095026

(X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED IDENTIFICATION NUMBER A BUILDING 8 WING

NAME OF PROVIDER OR SUPPLIER

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

STREET ADDRESS, CITY, STATE, ZIP CODE

KNOLLWOOD HSC

6200 OREGON AVE NW

KNOLLWOOD HSC		WASHINGTON, DC 20015				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY REGULATORY OR LSC IDENTIFYING INFORMA	FULL PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE		
L 000	An annual licensure survey was conduct 24 through 25, 2007. The following defic were based on record review, observation interviews with facility staff. The sample 13 residents based on a census of 44 through of survey and five (5) supplemental in the conduction of the conduction o	ciencies ins and included e first	(1) A. The multivitamin tablet for resident JH3 was administered after staff became aware of the omission. In addition, medication nume #1 was counseled on the proper procedure for documenting when a medication is omitted during the medication pass by encircling her initials on the front of the MAR, indicating that the medication was not given and entering the reason for the omission of the medication on the back side of the MAR.	6/26/07		
	Sufficient nursing time shall be given to a resident to ensure that the resident receives the following: (a)Treatment, medications, diet and nutri supplements and fluids as prescribed, ar rehabilitative nursing care as needed; (b)Proper care to minimize pressure ulce contractures and to promote the healing (c)Assistants in daily personal grooming the resident is comfortable, clean, and neevidenced by freedom from body odor, cland trimmed nails, and clean, neat and well-groomed hair; (d) Protection from accident, injury, and is self-care and group activities; (f)Encouragement and assistance to (1)Get out of the bed and dress or be drein his or her own clothing; and shoes or slip which shall be clean and in good repair; (2)Use the dining room if he or she is able	itional and of ulcers so that eat as leaned in pers,	(1) B. The second drop of Artificial Tears ophthalmic solution was instilled in Resident JH5's eyes (right and left) after staff became aware. Medication nurse #1 was counseled to carefully read the physician's orders regarding the number of drops of Artificial Tears ophthalmic solution. (1) C. Acular eye drop 0.5%, Aspirin 325 mg and Docusate Sodium Liquid 60 mg/5 ml were administered after staff became aware of the omission. Medication nurse #2 was immediately relieved of the responsibility of medication administration and replaced by another licensed nurse. (2) Medication nurse #2 is no longer employed at this facility. Additionally, the Director of Nurses/designee will monitor medication pass with various medication nurses on a weekly basis for the next thirty days, and monthly thereafter. (3) The RN Account Manager with Woodhaven Pharmacy will monitor the medication pass on 6/13/07 and 6/26/07 with all medication nurses and immediately inservice them on the proper procedure for medication pass and documentation. This review will continue on a quarterly basis. (4) The results of the medication pass will be incorporated into the Quality Assurance Program.			

Health Regulation Administration Esterie, LNHA LABORATORY DIRECTOR'S OR PROMOER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Ture Idaniastratur

(X6) DATE

STATE FORM

Heaith F	Regulation Administra	ation			· 		
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPI				•	(X3) DATIE S COMPLI		
		095026		B WING_		05/2	5/2007
NAME OF F	ROVIDER OR SUPPLIER		STREET AD	DRESS, CITY,	STATE, ZIP CODE		
KNOLLV	OOD HSC	:		EGON AVE 1 STON, DC 2			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN O (ILACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	(X5) COMPLETE DATE		
L 052	Continued From pa	 ge 1		L 052			
	(3)Participate in me recreational activities	aningful social and					
ļ	(g)Prompt, unhurrie requires or request	d assistance if he or help with eating;	she				
	(h)Prescribed adap him or her in eating independently;	tive self-help devices	to assist				•
	(i)Assistance, if nee including oral acre;	ded, with daily hygie and	ne,				1
,	j)Prompt response t for help	to an activated call be	ell or call				·
	Based on observation interview for three (sobserved during medetermined that lice that residents were	met as evidenced by on, record review and 3) of eleven residents dication pass, it was used staff failed to e free from medication or rate was 10.5%.	d staff s nsure errors.				
	The findings include	9 : ,					
	medication pass. Tobserved on Thursd approximately 9:00 amount of May 25, 2007 at apprint of the medication pass nurses were observed pass. After the medication pass.	erred during the morn he medication pass value, May 24, 2007 at AM and 4 00 PM on proximately 8:30 AM. hities were observed. Three (3) medication ad during the medication pass, the observed	riday friday during on ition erved				
	1 On May 24, 2007	at approximately 9:4	15 AM,				ł

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Health Regulation Administration

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		A BUILDING		(X3) DATE SURVEY COMPLETED	
		095026		B WING_		05/2	5/2007
NAME OF F	ROVIDER OR SUPPLIER		ļ		TATE, ZIP CODE		_ _ _
KNOLLV	VOOD HSC	·		EGON AVE N STON, DC 20			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		FULL	ID PREFIX TAG	I'ROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
L 052	Continued From pa	ge 2		L 052			
	medications to Res tablet for resident J medication pass. The May 14, 2007 read, every day for supple tablet was document the MAR (Medication was not observed be during the medication The record was review 2. On May 24, 2007 medication nurse # Artificial Tears ophtion JH5's eyes (right a order dated May 9, 14% drops. Instill 2.	1 administered eight ident JH3. The multi H3 was omitted during physician 's order "Multivitamin one (ement "The multivitated as being administration Receing given to the reson passifiewed on May 24, 20 al approximately 1 instilled one (1) dromalmic solution into Find left). The physici 2007 read, "Artificia drops to each eye 3	ivitamin ing the r dated 1) tablet itamin stered on cord), but ident 07 0 00 AM, ip of Resident an 's il Tears				
4	day for dry eyes. " The record was revi	ewed on May 24, 20	07		·		
	3. On May 25, 2007 medication nurse #2 medications to Resil #2 did not sign the M (5) medications were resident.	dent JH6. Medication MAR, indicating that t	n nurse the five				
	The medication nursimedications. Acular 325mg and Docusat The physician 's ord "Acular Eye drops, I 4 times a day for preone (1) tablet every of Docusate Sodium Lic (100mg) po every day A face-to-face intervenedication nurse #3	eye drop 0 5%, Aspi e Sodium Liquid 50n lers dated May 2, 20 nstill on (1) drop to r issure in eye, Aspirin day for clot prevention quid 50mg/5ml Ten (ity for constipation "	rin ng/ 5ml 07 read, ight eye i 325mg on; and (10) mls				

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FORM APPROVED Health Regulation Administration STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER A BUILDING B WING 095026 05/25/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **6200 OREGON AVE NW** KNOLLWOOD HSC WASHINGTON, DC 20015 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) L 052 Continued From page 3 L 052 approximately 9.15 AM He/She stated that the errors were due to the surveyors making him/her nervous. The record was reviewed on May 25, 2007. (1) A. The nine hotel pans were rewashed and L 099 3219 1 Nursing Facilities L 099 6/11/07 all leftover food and greasy residue was removed. Food and drink shall be clean, wholesome, free from spoilage, safe for human consumption, and (1) B. The eight sheet pans were rewashed served in accordance with the requirements set and all leftover food and greasy residue were forth in Title 23, Subtitle B, D. C. Municipal removed. Regulations (DCMR), Chapter 24 through 40. This Statute is not met as evidenced by: (1) C. The floor behind the grill and deep fiver Based on observations during the tour of the and the rear of the steamer and convection main kitchen, it was determined that dietary ovens were deaned of any dirt, debris or services failed to ensure that foods were served greasy residue. and prepared in a safe and sanitary manner as (1) D. The gas lines to the grill were cleaned to evidenced by soiled hotel and sheet pans, floor remove any debris or greasy residue. surfaces, gas lines and shelves. These findings were observed in the presence of the Director of (1) E. The two shelves that stored hotel and Dietary Services on May 24, 2007 at 8:50 AM sheet pans were cleaned to remove rust and debris. The findings include. (2) Management will continue to monitor and spot-check the hotel pans, sheet pans, floors. 1. Nine (9) of 17 hotel pans were soiled with gas lines and shelves on a dally basis. Food leftover food and a greasy residue after being service staff has been inserviced on 6/12/07 washed and ready for reuse. and 6/13/07 regarding the cleaning schedule and proper procedure for cleaning the hotel 2. Eight (8) of 22 sheet pans were soiled with pana, sheet pans, floors, gas lines and leftover food and a greasy residue after being shelves washed and ready for reuse. (3) Food Service Management will monitor the above on a daily basis. The Director of Dining 3 The floor behind the grill and deep fryer and in Services or designee will monitor this on a the rear of the steamer and convection ovens dally basis and the Registered Dietitian and was soiled with dirt, debris and a greasy residue Administrator will monitor this during quarterly

in one (1) of one (1) floor observation

observation of the gas lines.

and a greasy residue in one (1) of one (1)

4: The gas lines to the grill were soiled with debris

grand rounds.

Program.

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(4) The results of management's findings will

be incorporated into the Quality Assurance

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