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

FORM APPROVED
OMB NO. 0938-0391

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 _____	11/08/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPECIALTY HOSPITAL OF WASHINGTON-HADLEY SNF	4601 ML KING AVE SW WASHINGTON, DC 20032

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F 000	INITIAL COMMENTS An annual recertification survey was conducted November 6 through 8, 2007. The following deficiencies were based on record review, observations, and interviews with the facility staff and residents. The sample included 15 residents based on a census of 61 residents on the first day of survey and four (4) supplemental residents.	F 000		
F 221 SS=D	483.13(a) PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview, for one (1) of 15 sampled residents, it was determined that facility staff failed to consistently assess the resident for the least restrictive device and attempt restraint reduction for Resident #8. The findings include: A physician's order initially dated May 31, 2007 and renewed October 10, 2007, directed, "Right and left hand mittens for 24 hours for prevention on pulling G.Tube (gastrostomy tube)." Resident #8 was observed in bed with both hands secured in mittens on the following days: November 6, 2007 at approximately 9:30 AM, 11:30 AM, 1:30 PM, and 2:30 PM. November 7, 2007 at approximately 7:10 AM, 9:10 AM, 11: 10 AM, and 1:10 PM .	F 221	1. Resident #8 was reassessed and it was determined that physical restraints were unnecessary. The interdisciplinary team decided the best intervention was to place an abdominal pad over the G-Tube to prevent the resident from pulling it out of place. Subsequently, the physician order for hand mittens was discontinued and the care plan was updated November 7, 2007. 2.All residents with restraints were audited 11-12-07 to ensure the orders were necessary. These residents were assessed for the least restrictive devices and there was an attempt at restraint reduction (see attachment #1). No other resident have been identified to be affected by this practice. All family representatives of resident's with restraints have been notified. 3.The staff will be in-serviced by our RCC's or designee on our facility's restraint reduction policy by 12-22-07. The in-service will review restraint assessments and reduction protocols. A restraint information and consent form (see attachment #2) has been instituted. 4.Results of the restraints audit tool and the findings from At-Risk meetings will also be shared at the Quality Improvement/Performance Committee meeting, quarterly. 5. 12-22-07	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 11-29-07

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

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F 221	Continued From page 1 November 8, 2007 at approximately 7:15 AM, 9:15 AM, 11:15 AM, and 1:15 PM. A care plan was initiated on May 31, 2007 and reviewed August 30 and October 18, 2007, which directed, "Resident needs to use hand mitts continuously to prevent pulling [out] G-tube." There was no evidence in the record that the interdisciplinary care team assessed the resident in May 2007 for the least restrictive device or that an on-going attempt for restraint reduction was attempted after the hand mitts were applied. There was no evidence in the record that the resident's responsible party was notified that the use of hand mitts was initiated on May 31, 2007 at the time of this review. "Restraint Intervention" sheets were not available at the time of this review. Facility staff located the "Restraint Intervention" sheets after the survey was completed. A sample of the sheets was faxed to the surveyor on November 15, 2007. A review of the "Restraint Intervention" sheets revealed that "Attempted alternative measures" was not consistently checked and no explanation was offered as to the type of alternative restraint attempted if checked. Employee #2 documented on the facsimile message transmittal sheet that there were no "Restraint Intervention" sheets for May or June, 2007. The first sheet initiated was July 2, 2007. A face-to-face interview was conducted on November 7, 2007 at approximately 10:00 AM with Employee # 8. He/she acknowledged that	F 221	**F 221** 1. Resident #8 was reassessed and it was determined that physical restraints were unnecessary. The interdisciplinary team decided the best intervention was to place an abdominal pad over the G-Tube to prevent the resident from pulling it out of place. Subsequently, the physician order for hand mittens was discontinued and the care plan was updated November 7, 2007. 2. All residents with restraints were audited 11-12-07 to ensure the orders were necessary. These residents were assessed for the least restrictive devices and there was an attempt at restraint reduction (see attachment #1). No other resident have been identified to be affected by this practice. All family representatives of resident's with restraints have been notified. 3. The staff will be in-serviced by our RCC's or designee on our facility's restraint reduction policy by 12-22-07. The in-service will review restraint assessments and reduction protocols. A restraint information and consent form (see attachment #2) has been instituted. 4. Results of the restraints audit tool and the findings from At-Risk meetings will also be shared at the Quality Improvement/Performance Committee meeting, quarterly. 5. Completed by 12-22-07	

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F 221	Continued From page 2 facility staff failed to inform the resident or responsible party of the use of hand mitts, consistently assess the resident for least restrictive device and consistently attempt to reduce the restraint. The record was reviewed November 7, 2007.	F 221	F 253 - 1 1. No resident was affected by this practice. The floor surfaces that were soiled with accumulated debris in the rear of convection ovens and deep fryers in four (4) of four (4) convection ovens observed were cleaned immediately 2. No other residents identified were affected by this practice. An audit was done on the kitchen floor to ensure no other areas were soiled or had debris build up. 3. Staff will complete an in-service on cleaning the convection ovens and will be required, to sweep and mop area behind convection ovens daily 4. Foodservice supervisors will monitor the area behind convection ovens 3 times a day and track the findings and report all deficient findings to monthly Quality Improvement / Performance Committee meetings. 5. Completed 12-5-07	
F 253 SS=D	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations during the dietary and environmental tour, it was determined that housekeeping and maintenance services were not adequate to ensure that the facility was maintained in a clean and sanitary manner as evidenced by: soiled floor surfaces in the rear of the convection ovens, deep fryers, drains under the dietary work stations and elevator track; damaged dresser drawers and floor tile; cleaning equipment stored on the floor, and urine odor detected in a resident's room. The dietary and environmental tour observations were made in the presence of Employees # 4, 5, 6, 7 and 9 on November 7, 2007 between 8:00 AM and 11:00 AM and November 8, 2007 at 7:15 AM. The findings include: 1. Floor surfaces were soiled with accumulated debris in the rear of convection ovens and deep fryers in four (4) of four (4) convection ovens observed. 2. The inner surfaces of floor drains under food	F 253	F 253 - 2 1. No resident was affected by this practice. The inner surfaces of floor drains under food preparation area in the main kitchen that were soiled and accumulated with food debris in the main kitchen and dish washer area on three (3) of three (3) drains observed were cleaned immediately 2. No other resident was affected by this practice. The Food Service supervisor on all the drains in the kitchen to ensure they were all clean did an audit. 3. Staff is required to clean drains daily, as an integral part of Foodservices cleaning schedule. 4. Food Service supervisors will monitor drains throughout the kitchen 3 times a day and track the findings and report all deficient findings to monthly Quality Improvement / Performance Committee meetings. 5. Completion by: 12-22-07 + Ongoing	revision requested 12/26/07

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F 253 SS=D	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations during the dietary and environmental tour, it was determined that housekeeping and maintenance services were not adequate to ensure that the facility was maintained in a clean and sanitary manner as evidenced by: soiled floor surfaces in the rear of the convection ovens, deep fryers, drains under the dietary work stations and elevator track; damaged dresser drawers and floor tile; cleaning equipment stored on the floor, and urine odor detected in a resident's room. The dietary and environmental tour observations were made in the presence of Employees # 4, 5, 6, 7 and 9 on November 7, 2007 between 8:00 AM and 11:00 AM and November 8, 2007 at 7:15 AM. The findings include: 1. Floor surfaces were soiled with accumulated debris in the rear of convection ovens and deep fryers in four (4) of four (4) convection ovens observed. 2. The inner surfaces of floor drains under food	F 253	2. No other residents identified were affected by this practice. An audit was done on the kitchen floor to ensure no other areas were soiled or had debris build up. 3. Staff will complete an in-service on cleaning the convection ovens and will be required, to sweep and mop area behind convection ovens daily 4. The Food Service supervisors will monitor the area behind convection ovens 3 times a day and track the findings and report all deficient findings to monthly Quality Improvement / Performance Committee meetings. 5. Completed 12-5-07 **F 253 – 2** 1. No resident was affected by this practice. The inner surfaces of floor drains under food preparation area in the main kitchen that were soiled and accumulated with food debris in the main kitchen and dish washer area on three (3) of three (3) drains observed were cleaned immediately 2. No other resident was affected by this practice. The Food Service supervisor did an audit on all drains in the kitchen, to ensure they were all clean.	

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F 253	Continued From page 3 preparation areas in the main kitchen were soiled with accumulated food and debris in the main kitchen and dishwasher area in three (3) of three (3) floor drains observed. 3. One (1) of three (3) elevator tracks was observed soiled in the 3 West hallway. 4. Dresser drawers in two (2) of 13 rooms were observed damaged in the following areas: Room 324 was missing a front to the first drawer and room 303 the dresser drawer was missing knobs. 5. Floor tile in one (1) of 13 rooms, room 324, was observed cracked near the resident's bathroom. 6. Cleaning equipment such as dust mops were stored on floor surfaces in one (1) of two (2) janitorial closets. 7. A strong urine odor was detected in one (1) of 13 rooms, room 317. A face-to-face interview was conducted on November 8, 2007 at 7:55 AM with Employee #8. He/she acknowledged that room 317 had a strong urine odor at 7:45 AM on November 8, 2007. Employee #4, 5, 6, 7 and 9 acknowledged the above environmental and kitchen findings at the time of the observations.	F 253	3. The staff is required to clean drains daily, as an integral part of Food Services cleaning schedule. A Staff in-service has been scheduled. 4. Food Service supervisors will monitor drains throughout the kitchen 3 times a day and track the findings and report all deficient findings to monthly Quality Improvement / Performance Committee meetings. 5. Completion by: 12-22-07 + Ongoing **F 253 – 3&5** 1. No residents were affected by this practice. Elevator tracks were cleaned immediately November 7, 2007.Elevator tracks were cleaned immediately and floor tiles were repaired immediately on November 7, 2007. 2. No other residents were affected by this practice. The housekeeping supervisor will monitor the elevator tracks to ensure tracks remain free of dirt and other debris. 3. Environmental rounds will include the monitoring of elevator tracks and cleaning of the tracks on a regular weekly schedule. An in-service on elevator track cleaning will be scheduled. 4. Our plan to monitor performance and ensure solutions are sustained includes reporting results from rounds to the EOC and Performance Improvement/ Performance Committee on a quarterly basis. 5. Completion by 12-22-07 + Ongoing	
F 278 SS=D	483.20(g) - (j) RESIDENT ASSESSMENT The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate	F 278		

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F 278	Continued From page 4 each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview for one (1) of 15 sampled residents, it was determined that facility staff failed to accurately code the Minimum Data Set (MDS) for dialysis treatment for Resident #12. The findings include: Facility staff failed to code Resident #12 for dialysis treatment on the quarterly MDS completed May 15 and August 9, 2007.	F 278	**F 253 – 4** 1. No resident was affected by this practice. The residents were made aware that their dressers were damaged and/or required repair, 11-8-07. Families will be removing damaged furniture from the facility. 2. No other residents were affected by the practice. During rounds, personal furniture and equipment will be inspected and a report will be given to the units RCC or Charge Nurse to advise the resident and their families, of the condition of personal belongings. Facility-owned damaged furniture was removed immediately 11-08-07 3. The RCC, Housekeeping and or Maintenance supervisors will do rounding and note furniture not in compliance. Staff will be informed at staff meeting to note and make appropriate person aware of the compliance issue. 4. Our plan to monitor performance and ensure solutions are sustained includes reporting results from rounds to the EOC and Performance Improvement/Performance Committee on a quarterly basis. 5. Completion by 12-22-07 **F 253 – 6&7** 1. No residents were affected by this practice. Cleaning equipment such as dust mops were stored on floor surfaces in janitorial closets Hangers will be installed in the janitor closets for mops. The room was cleansed to remove the odor.	

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F 278	Continued From page 4 each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview for one (1) of 15 sampled residents, it was determined that facility staff failed to accurately code the Minimum Data Set (MDS) for dialysis treatment for Resident #12. The findings include: Facility staff failed to code Resident #12 for dialysis treatment on the quarterly MDS completed May 15 and August 9, 2007.	F 278	F 253 - 6 1. No residents were affected by this practice. Cleaning equipment such as dust mops were stored on floor surfaces in janitorial closets Hangers will be installed in the janitor closets for mops. 2. No other residents have been affected by this practice. Monitoring of the janitors closets for items on floor will be conducted by the Housekeeping supervisor and Housekeeping staff. 3. Environmental rounds will include janitor's closets to ensure items are not stored on the floor 4. Our plan is to monitor performance and ensure solutions are sustained. Includes reporting results from rounds to the EOC and Performance Improvement/Performance Committee. 12/22/07 MD F 278 1. Resident #12's MDS was modified to reflect dialysis treatment. This was noted and transmitted on November 8, 2007 (please see attachment #III). 2. The MDS Coordinator or Designee will audit residents receiving dialysis- this will also included newly admitted residents receiving dialysis. The audit will be completed by December 22, 2007. It will be performed on a quarterly basis to ensure those individuals are coded correctly (please see attachment #IV).	reviewed requested 12/3/07

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F 278	Continued From page 5 According to the admission MDS completed November 28, 2006 and the quarterly MDS completed February 20, 2007, the resident was coded in Section P1(Special Treatments, Procedures and Program) for dialysis. A history and Physical completed November 2, 2006, revealed the resident's diagnosis included ESRD [End Stage Renal Disease] and treatment for dialysis. A face-to-face interview was conducted with Employee # 8 on November 8, 2007 at approximately 7:45 AM. He/she acknowledged that the resident's was not coded for dialysis on the May and August quarterly MDS assessments. The record was reviewed November 8, 2007.	F 278	2. No other residents have been affected by this practice. All SNF janitor closets were inspected by staff immediately 11-08-07. All SNF resident rooms were inspected for odors on the same day. No other resident's room was found to have an odor. 3. Monitoring of the janitors closets for items on floor and urine odor will be conducted by the House keeping Supervisor and House keeping staff. Environmental rounds will include janitor's closets and urine odors daily. 4. Our plan is to monitor performance and ensure solutions are sustained. Includes reporting results from rounds to the EOC and Performance Improvement/Performance Committee on a quarterly basis.	
F 279 SS=D	483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment	F 279	5. Completion date 12-22-07 **F 278** 1. Resident #12's MDS was modified to reflect dialysis treatment. This was noted and transmitted on November 8, 2007 (please see attachment #III). 2. The MDS Coordinator or Designee will audit residents receiving dialysis- this will also included newly admitted residents receiving dialysis. The audit will be completed by December 22, 2007. It will be performed on a quarterly basis to ensure those individuals are coded correctly (please see attachment #IV).	

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F 279	Continued From page 6 under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on staff interview and record review for one (1) supplemental resident, it was determined that facility staff failed to initiate a care plan with appropriate goals and approaches for Resident F1's behaviors of expectorating on the floor and hoarding food items. The findings include: On November 6, 2007 at 9:20 AM and November 8, 2007 at 7:50 AM, during the environmental tour of Resident F1's room, the resident was observed spitting on the floor and flying insects were observed. A face-to-face interview was conducted on November 8, 2007 at 9:55 AM with Employee #8. He/she stated, "[Resident] spits on the floor. The resident puts a towel on the floor and when the CNAs go into the room they take the towel off the floor. The resident is non-compliant with care..." A face-to-face interview was conducted on November 8, 2007 at 10:10 AM with Employee #12. He/she stated, "I assist the resident sometimes. [He/she] has had this problem [expectorating] for years. Even [his/her] family has a concern about this. The resident likes to hold on to fruit and dessert and that's why there are fruit flies in the room. Housekeeping assists. They mop the floor and wash down the bed. When I care for the resident, I encourage [him/her] to take a shower and change clothes, but [he/she] yells and refuses to care."	F 279	3. The MDS Coordinator was notified of the findings and the DON re-educated her on November 8, 2007. The DON or designee will verify the MDS for accuracy. 4. Results of the MDS Dialysis Treatment Audit and compliance monitoring out comes will be reported and discussed at our quarterly QA Meetings. 5. Completion by 12.22.07 **F 279** 1. A care plan and behavioral monitoring flow sheet for resident F1 was instituted on November 8, 2007. The new care plan addresses appropriate goals and approaches. 2. All residents with behavioral issues were identified. These residents will be reviewed in our weekly At-Risk Meetings. The resident behavioral monitoring flow sheet was initiated on November 8, 2007. 3. The facility staff will be in-serviced by Social Service Department Head or Designee. The in-service will reinforce the behavioral monitoring flow sheet. Additionally, the in-service will teach facility staff to identify, report, manage and document behaviors, and update care plans to reflect the appropriate goals and approaches.	

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F 279	Continued From page 7 A review of the care plans last updated on September 7, 2007 revealed that there was no care plan initiated to include appropriate goals and approaches for the resident's aforementioned behaviors. A face-to-face interview was conducted with Employee #8 on November 8, 2007 at 9:58 AM. He/she acknowledged that there was no care plan to address the resident's behaviors. The record was reviewed November 8, 2007.	F 279	4. Results from the behavioral monitoring flow sheet and compliance monitoring outcomes will be discussed by RCC at the QA meetings on a quarterly basis as well as our weekly At-Risk Meetings. 5. Completion by 12/22/07	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by:	F 280	**F 280** 1. The appropriate goals and interventions for fluid restriction for resident #4 were added to the care plan on November 26, 2007. Resident F1's care plan and medications were assessed and evaluated by the IDT during our At-Risk Meeting. New interventions were implemented and the resident's physician and family members were notified. The care plan was also updated. The MDS was modified, noted and transmitted on November 27, 2007. 2. All residents with Dietary Orders for fluid restriction will be audited by the Dietician by December 22, 2007. The RCC or Designee will audit the care plan.	

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F 280	Continued From page 8 Based on observations, staff interview and record review for one (1) of 15 sampled residents and one (1) supplemental resident, it was determined that facility staff failed to amend the care plans with appropriate goals and approaches for one (1) resident on fluid restriction and one (1) resident with incontinence. Resident #4 and F1. The findings include: 1. Facility staff failed to amend Resident #4's care plan with appropriate goals and approaches for fluid restriction. A review of Resident #4's "Physicians Order Sheet" signed and Dated October 1, 2007 revealed, "Dietary Orders: ... Fluid Restriction of 1200 mls per day..." A review of the "Therapeutic Diet" care plan that was last updated on August 31, 2007, lacked evidence that the care plan was amended with goals and approaches for fluid restriction. According to the resident's record, facility staff identified that the resident received 200 ml of fluid during the night shift (11:00 PM to 7:30 AM) and 500 ml of fluid during each of the day (7:00 AM to 3:30 PM) and evening shifts (3:00 PM to 11:30 PM). A face-to-face interview was conducted on November 7, 2007 at approximately 9:35 AM with Employee #3. He/she acknowledged that the "Therapeutic Diet" care plan had not been amended to include fluid restriction. The record was reviewed on November 7, 2007. 2. Facility staff failed to amend Resident F1's care	F 280	For our incontinent residents, the facility has instituted a bowel/bladder evaluation form on November 12, 2007 (please see attachment #V & #VI). A urinary incontinence audit will be performed by the RCC or Designee by December 12, 2007. Feedback from these assessments and evaluations will be discussed at the weekly IDT At-Risk meetings. 3. The Dietician will audit all orders for fluid restriction. The RCC will audit the care plans for fluid restriction. The facility has instituted a bowel/bladder evaluation form. The information received from the evaluation will be used to revise and create a plan of care that addresses incontinence. 4. Results from the bowel/bladder evaluation form, urinary incontinence audit, dietary fluid restriction audit, nursing care plan audit and any other compliance monitoring outcomes will be presented by the RCC and Dietician at the QA meetings on a quarterly basis. 5. Completion by 12.22.07	

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F 280	Continued From page 9 plan with appropriate goals and approaches for urinary incontinence. On November 6, 2007 at 9:20 AM and November 8, 2007 at 7:50 AM, during the environmental tour of Resident F1's room, strong urine odors were detected. A face-to-face interview was conducted on November 8, 2007 at 9:55 AM with Employee #8. He/she stated, "...[Resident] has urinary incontinence at times and does not want to wear incontinent pads. When I started working here [at the facility in the beginning of the year] it was a concern. The staff cleans after the resident and within one hour the room smells again. The resident is on Lasix and doesn't want us to assist [him/her]..." A face-to-face interview was conducted on November 8, 2007 at 10:10 AM with Employee #12. He/she stated, "I assist the resident sometimes... Housekeeping assists. They mop the floor and wash down the bed. When I care for the resident I encourage [him/her] to take a shower and change clothes, but [he/she] yells and refuses to care." The most recent quarterly MDS (Minimum Data Set) dated September 6, 2007 for Section H1b (Bladder Continence) coded the resident as continent. A review of the care plan with the identified problem, "Requires assistance with ADL care", was last updated on September 7, 2007 and revealed "Resident is using the bathroom freely" and "Resident is continent".	F 280		

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F 280	Continued From page 10 A face-to-face interview was conducted with Employee #8 on November 8, 2007 at 9:58 AM. He/she acknowledged that there was no care plan to address the resident's incontinence. The record was reviewed November 8, 2007.	F 280		
F 312 SS=D	483.25(a)(3) ACTIVITIES OF DAILY LIVING A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview for one (1) of 15 sampled residents, it was determined that facility staff failed to provide the necessary services to maintain good grooming and personal hygiene for Resident # 8 as evidenced by strong body odor and soiled hand mittens. Resident #8's The findings include: On November 8, 2007 at approximately 7:50 AM, Resident # 8 was observed in bed awake. The resident emitted a strong body odor. The resident had soiled hand mittens on both hand and two additional soiled pairs of mittens at the resident ' s bedside. According to the quarterly Minimum Data Set (MDS) completed October 25, 2007, he/she is bedfast most of the time and totally dependent on staff for all of his/her activities of daily living: ambulation, dressing, personal hygiene, toileting and bathing. (Section G). He/she presents with	F 312		

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F 312	Continued From page 11 bowel and bladder incontinence (Section H1). Diseases listed in Section I included: Diabetes Mellitus, Hypertension, Congestive Heart failure and Alzheimer ' s, Dementia other than Alzheimer ' s disease. A review of an Interdisciplinary Care Plan with the last entry dated August 3, 2007 revealed the following " Problem: Resident is totally dependent on nursing for all aspects of care ... Goals: Resident will be well groomed, free of odors... Approaches: Provide daily care for resident. " According to the daily shower list revised 2007, the resident was scheduled for a shower on Mondays and Tuesdays. According to the " Resident Care Flow Record " for October and November 2007, the resident received a bed bath daily. There was no evidence that the resident received a shower for October and November 2007. A face-to-face interview was conducted with Employee # 8 on November 8, 2007 at approximately 7:55 AM. He/she acknowledged that the resident had a strong body odor, and soiled hand mittens. Additionally He/she could not explain why the resident had not received a shower in October and November 2007.	F 312	F 312 1. Resident #8's hand mittens were discontinued on November 8, 2007. The shower schedule has been revised to reflect the actual shower days. The care plan for resident #8 was updated on November 12, 2007 and resident #8 received a shower. 2. The RCCs reviewed all resident shower schedules and will continue to monitor for compliance with shower schedule and ensure that ADL flow sheets accurately reflects the bathing modality i.e. shower, bed bath etc. 3. The RCC or Designee will perform daily rounds to monitor personal hygiene and care. The Rehab Director or Designee will conduct an in-service on transferring, body mechanics, and showering residents who may be difficult to maneuver. In addition, the IDT determined that some residents have a history of refusing showers. Social Services and resident family representatives will assist the facility staff with encouraging those residents to shower. Residents who are non-compliant with showers will be documented and care planned. 4. Compliance monitoring outcomes related to resident showers will be presented by the RCCs at the QA meetings on a quarterly basis in efforts to maintain effective grooming and personal hygiene of our residents.	
F 323 SS=D	483.25(h) ACCIDENTS AND SUPERVISION The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323	5. Completion 12.22.07	

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F 323	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on observations during the survey period, it was determined that the facility staff failed to maintain a hazard free environment as evidenced by an unsecured box of laundry detergent in a resident's room. The environmental tour was conducted on November 6, 2007 between 10:30 AM and 11:35 AM in the presence of Employees #4, 5, 6 and 7. The findings include: A box of dish detergent was observed unsecured on a table in a resident's room, #335. Employee #4, 5, 6 and 7 acknowledged the above finding at the time of the observations.	F 323	**F 323** 1. The unsecured box of detergent in resident's room #335 was immediately taken out of the room when it was discovered. This resident was re-educated on the proper placement of detergent on November 6, 2007. The Resident verbalized understanding. 2. The Charge Nurse, Housekeeping, and Maintenance conducted daily room rounds in all rooms- in order to maintain a hazard free environment. 3. The facility staff will be in-serviced by RCCs or Designee on the facility's practice of maintaining a hazard free environment and the need environmental room rounds. 4. Compliance monitoring outcomes related to maintaining a hazard free environment will be presented by the Maintenance Manager at the QA meetings on a quarterly basis. 5. Completion by 12-22-07 + Ongoing	
F 371 SS=E	483.35(i)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT 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 foods were prepared, stored and served in a safe and sanitary manner as evidenced by: expired nutritional supplements and undated and/or unlabeled food stored in the pantry refrigerator, a soiled compressor body and fan covers, deep fryers and dish machine tray	F 371		

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F 371	Continued From page 13 and a large mixer with an oil leak. The observations were made in the presence of Employee #4, 5, 6, 7 and 9 on November 7, 2007 between 8:45 AM and 11:00 AM. The findings include: 1. One (1) case of great shake plus nutrient and one (1) case of great shake supplement nutrient were observed in the walk in refrigerator with expiration dates of September 11, 2007 in two (2) of two (2) cases of nutritional supplement observed. 2. One (1) undated and unlabeled zip lock bag containing chicken and a biscuit and one (1) undated hot pocket were observed in one (1) of two (2) pantries on the nursing units. 3. The exterior surfaces of the compressor body and fan covers in the walk in refrigerator were soiled with accumulated dust and debris in one (1) of one (1) compressor fan observed. 4. The exterior panels, inner panels, valves and burner surfaces of deep fryers were soiled with food deposits and grease in two (2) of two (2) deep fryers observed. 5. A mechanical mixer located adjacent to cooking hoods in the main kitchen was observed to have an oil drip around a bolt near the metal shaft which was directly over the bowl when the mixer was in operation in one (1) of one (1) mixer observed. 6. Food was allowed to collect on the clean side of the dishwasher tray as dishes were washed after the breakfast meal in one (1) of one (1) dish	F 371	**F 371 – 1&2** 1. No residents were affected by this practice. All other areas in the kitchen were inspected to ensure no other expired foods are present. Expired foods were removed immediately 11-08-07. The chicken and biscuit were removed immediately. 2. There were no residents affected by this practice. All areas of the kitchen were checked to ensure that no foods were expired. The (1) case of great shake plus nutrient and one (1) case of great shake supplement nutrient were observed in the walk in refrigerator with expiration dates of September 11, 2007 was immediately removed from the walk in refrigerator. An audit was done immediately to ensure that no other food items were found. 3. Staff in-service was scheduled by food service manger on proper storage and labeling and dating practices, mostly stressing the importance of rotation of food by understanding the (First In First Out Method). Quarterly staff in-services will be conducted to educate new staff and reinforce standard policy practice. 4. Food service supervisors will monitor walk in boxes 3 times a day and track the findings and report all deficient findings to monthly Quality Improvement / Performance Committee meetings. 5. Completion: 12-22-07	

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F 371	Continued From page 14 washer observed. Employees #4, 5, 6, 7 and 9 acknowledged the above findings at the time of the observations.	F 371	**F 371- 3** 1. No resident was affected by this practice. The exterior surfaces of the compressor body and fan covers in the walk in refrigerator that were soiled with accumulated dust and debris will be cleaned by maintenance. 2. No other residents were found affected by this practice. An audit was done immediately to ensure that no other fans or vents were soiled. An in-service has been scheduled by the food service manager to address the cleanliness of the compressor body and fan cover. 3. Maintenance will be requested to clean compressor body and fan covers monthly to ensure that the practice does not recur. 4. The Food Service supervisor will monitor compressor body and fans covers in walk in boxes 3 times a day and track the findings and report all deficient findings to monthly Quality Improvement / Performance Committee meetings. 5. Completion 12-22-07 + Ongoing	
F 456 SS=D	483.70(c)(2) SPACE AND EQUIPMENT The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observations during the dietary survey, it was determined that electrical outlets near the tray line were damaged; and during the environmental survey, it was determined that Heating Ventilation and Air Conditioning (HVAC) systems were not operating in two (2) residents' rooms. The findings include: 1. During the tour of the dietary department, one (1) electrical outlet installed in the floor near the tray line was damaged and not secured to the floor and one (1) outlet lacked power as evidenced by failure of a cold box to operate when the cord was plugged into the outlet socket in two (2) of three (3) outlets observed at 12:30 PM on November 6, 2007. 2. The environmental tour on 3 West was conducted on November 6, 2007 between 10:30 AM and 11:35 AM in the presence of Employees #4, 5, 6 and 7. During an environmental tour, two (2) of 13 HVAC units failed to operate in resident rooms, 332 and	F 456	**F 371 – 4** 1. No resident was affected by this practice. The exterior panels, inner panels, valves and burner surfaces of deep fryers that were soiled with food deposits and grease were cleaned immediately.	

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F 456	Continued From page 15 338. A face-to-face interview was conducted on November 6, 2007 at 11: 25 AM with Resident F2 in room 338. He/she stated, "I told the staff that the system does not work. I was told that it [the HVAC system] needed a piece. It's cold at night. It [the HVAC system] has not worked since I have been here [in the facility]. I got here in May of this year. The staff will give me another blanket at night when I ask for one." A face-to-face interview was conducted on November 6, 2007 at 11: 28 AM with Resident F3 in room 332. He/she stated, "They [the staff] know that it ' s not working [HVAC] it has not worked since I have been here [in the facility]. I got here in April [2007]. My spouse brought me another blanket to put on my bed because it's cold at night." A face-to-face interview was conducted on November 6, 2007 at 11:30 AM with Employee #6. He/she acknowledged that both HVAC units were not operating. The two (2) HVAC units were replaced on November 6, 2007 at approximately 3:30 PM.	F 456	2. No other resident were identified to be affected by this practice. An audit was done immediately to ensure that all deep fryers weren't soiled with food deposits and grease. 3. The systemic changes put in place will be reinforcing to staff the importance of following cleaning schedule. In addition, quarterly staff in-services will be conducted to educate new staff and reinforce standard policy practice. 4. The Food Service supervisor will monitor cooking equipment 3 times a day and track the findings and report all deficient findings to monthly Quality Improvement / Performance Committee meetings. 5. Completed 12-22-07 + Ongoing F 371-5	
F 469 SS=D	483.70(h)(4) PHYSICAL ENVIRONMENT- PEST CONTROL The facility must maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observations during the environmental	F 469	1. No resident was affected by this practice. The observed mechanical mixer located adjacent to cooking hoods was taken out of operation for repair. 2. No other residents were affected by this practice. An audit was done on the other mechanical mixer to ensure there is no leakage.	

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F 469	Continued From page 16 tour, it was determined that facility staff failed to maintain a pest free environment. This observation was made in the presence of Employees #6 and 7 on November 6, 2007 at 9:30 AM. The findings include: Multiple flying insects were observed in room 317. Employees #6 and 7 acknowledged the above findings at the time of the observation.	F 469	3. Maintenance will be requested to provide preventative maintenance on the mixers as needed once mixer is repaired. 4. The Food Service supervisor will monitor mechanical mixers and report all deficient findings to Maintenance and Quality Improvement / Performance Committee meetings on a monthly basis. 5. Completed by 12.22.07 **F 371-6** 1. No residents were affected.	
F 492 SS=D	483.75(b) ADMINISTRATION The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, it was determined that facility staff failed to ensure that one (1) of six (6) newly hired employees had a current Nurse Aide certification on record upon hire and the physician failed to follow facility policy for signing monthly orders for two (2) residents. Residents #1 and 8. The findings include: 1. Facility staff failed to ensure that a Certified Nurse Aide (CNA) had a certification when hired by the facility. According to 22 DCMR 3203.2, "A list of	F 492	2. Food was removed from the clean side of the dishwasher tray immediately. 3. An in-service has been scheduled, which will center on proper dish washing techniques. 4. The Food Service Supervisor will monitor the dish-washing practices. The results of the in-service will be reported to QA on a monthly basis. 5. Completion date 12-22-07 **F 456** 1. The electrical outlets will be repaired in dietary. The HVAC unit in room 332 was installed on 11/06/07 and the HVAC unit in room 338 was repaired and working on 11/06/07. 2. Environmental rounds will be conducted in each unit and repairs will be issued a work order. The fan coils (HVAC units) are presently on a quarterly PM cycle. See attachments.	

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F 492	Continued From page 17 employees, with the appropriate current license or certification numbers shall be on file at the facility and available to the Director." A Certified Nurse Aide (CNA), Employee #13, was hired at the facility on April 14, 2007. During the review of certifications on November 7, 2007, it was observed that Employee #13's record lacked a current District of Columbia Nurse Aide certificate. The review of the staffing for the week of November 4 through 10, 2007, revealed that Employee #13 worked on November 4 and 6, 2007, day shift (7:00 AM to 3:30 PM). He/she was on duty on November 7, 2007, day shift, and was relieved of his/her duties after it was revealed that a certificate was not on record. Present in the employee's record was a copy of a receipt from the post office that documented that an application for a District of Columbia CNA certification was mailed on March 16, 2007. There was no further information in the employee's record regarding the status of the application for certification. On November 7, 2007, at approximately 10:30 AM, a face-to-face interview was conducted with Employee #2 who indicated that Employee #13 had applied for the DC certification, but had not followed up on the application. 2. The physician failed to sign and date monthly orders for Resident #1. According to 22 DCMR 3207.8, "Each physician shall adhere to the written policies and regulations that govern the health services provided in the	F 492	3. Environmental rounds will include housekeeping, maintenance and the department head or manager. 4. Results from rounds will be reported to the EOC committee and to the Performance Improvement Committee on a quarterly basis. 5. Repairs to outlets to be completed by 11/30/07. **F 469** 1. All rooms were checked for insects. No insects were observed. 2. *No residents were affected by this practice in Room #317, was cleaned creating a flying insects free room.* 3. *Monitoring of the environment for flying and other insects in the facility will be conducted quarterly and as needed. Our pest control services will continue treatment of the facility for insects and provide a staff in-service on "Creating a Insect Free Zone."* 4. *During environmental rounds the evidence of insects will be monitored and reported to the Pest Management Company for immediate elimination treatment.* 5. Our plan to monitor performance and ensure solutions are sustained includes: reporting results from rounds to the EOC and Performance Improvement/Performance Committee by the housekeeping supervisor. 6. Completion by 12-22-07	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 492	Continued From page 18 facility." A review of the facility's policy titled "Medical Staff Attending Physicians" and effective August 10, 1992 in Section V (1): "Resident Care Policies" revealed the following: "Documentation of the medical supervision of each resident shall be evidenced by orders and progress notes in the resident ' s record, written and signed by the Attending Physician at least every 30 days." During the review of the clinical record for Resident #1, it was determined that the physician failed to sign orders for September 1, 2007, October 1, 2007 and November 1, 2007. The last orders signed and dated were noted for August 4, 2007. A nurse practitioner's progress note was present in the record for August 29; 2007. A physician's progress note was present in the record for October 6, 2007. On November 7, 2007 at approximately 8:45 AM a face-to-face interview was conducted with Employee #8 who stated that the physicians are to sign and date orders every 30 days. The record was reviewed on November 6, 2007. 3. The physician failed to sign and date monthly orders for Resident # 8. A review of Resident # 8's record revealed physician's order forms for the months of August, September and October 2007 that failed to include the physician's signature and dates. A face-to-face interview was conducted on November 7, 2007 at approximately 10:00 AM	F 492	**F 492** 1. No resident affected by this practice. On November 7, 2007, Employee #13 was relieved of duty until this employee followed up with the DC C.N.A Certification. 2. The Human Resources Manager, DON or designee will verify all licensed and unlicensed personnel to ensure that all care-givers certifications are valid and up-to-date prior to beginning employment. 3. The Human Resources Manager and all hiring managers will verify all licensed and unlicensed personnel to ensure that all care-givers certifications are valid and up-to-date on a monthly basis. 4. A current list of active licenses/certifications will be provided to the DON and Administrator during Monthly QA Meetings as well as employee orientation. 5. Completion by 12-22-07	

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 _____	11/08/2007

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F 492	Continued From page 19 with Employee # 8. He/she acknowledged that the physician failed to sign and date orders for the months of August, September and October 2007. The record was reviewed November 7, 2007.	F 492		
F 514 SS=D	483.75(l)(1) CLINICAL RECORDS The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) supplemental resident, it was determined that facility staff failed to document Resident F1's behavior of expectorating on the floor, hoarding food and urinary incontinence. The findings include: On November 6, 2007 at 9:20 AM and November 8, 2007 at 7:50 AM, during the environmental tour of Resident F1's room, the resident was observed spitting on the floor and flying insects were observed . On November 8, 2007 at approximately 7:50 AM, strong urine odors were detected. A face-to-face interview was conducted on	F 514	F 514 1. The care plans for resident F1 were updated and instituted on November 8, 2007. The updated care plans addresses appropriate goals and approaches for resident behaviors. Resident F1's Physician and family was notified. 2. Residents identified with behavioral issues are reviewed in our weekly At-Risk Meetings. The recently instituted behavioral monitoring flow sheet will capture the resident's behaviors. The RCCs will monitor for compliance with shower schedule, hoarding and personal hygiene practices. 3. What measure will be put in place or what systemic changes you will make to ensure the deficient practice does not recur? The Charge Nurse or Designee will perform daily room rounds in order to maintain a sanitary environment. 4. Results from the behavioral monitoring flow sheet, ADL Flow sheet and other compliance monitoring outcomes will be discussed at the QA meetings on a quarterly basis as well as our weekly At-Risk Meetings. 5. Completion 12.22.07	

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F 514	Continued From page 20 November 8, 2007 at 10:10 AM with Employee #12. He/she stated, " I assist the resident sometimes. He/she has had this problem [expectorating and incontinence] for years. Even his/her family has a concern about this. The resident likes to hold on to fruit and dessert and that's why he/she has the fruit flies. Housekeeping assists. They mop the floor and wash down the bed. When I care for the resident I encourage him/her to take a shower and change clothes, but he/she yells and refuses to care." A face-to-face interview was conducted on November 8, 2007 at 9:55 AM with Employee #8. He/she stated, " [He/she] spits on the floor. The resident puts a towel on the floor and when the CNAs go into the room they take the towel off the floor. The resident is non-compliant with care. He/she has urinary incontinence at times and he/she does not want to wear incontinent pads. When I started working here [at the facility in the beginning of the year] it was a concern. The staff cleans after the resident and within one hour the room smells again. The resident is on Lasix and he/she doesn't want us to assist him/her. When we see trash we remove it." A review of the nursing notes for Resident F1 lacked evidence of documentation regarding the resident's aforementioned behaviors. A face-to-face interview was conducted with Employee #3 on November 8, 2007 at 10:30 AM. He/she acknowledged that there was no documentation in the resident's record regarding his/her behaviors. The record was reviewed November 8, 2007.	F 514		