		HAND HUMAN SERVICES		7		M APPROVEL
CENTER	S FOR MEDICARE	& MEDICAID SERVICES). 0 <mark>93</mark> 8-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	PLE CONSTRUCTION G	(X3) DATE SI COMPLE	
		095024	B. WING_		11/	08/2007
NAME OF PR	OVIDER OR SUPPLIER	÷	STE	REET ADDRESS, CITY, STATE, ZIP GODE		
SPECIAL	TY HOSPITAL OF W	ASHINGTON-HADLEY SNF	1	#601 ML KING AVE SW WASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MU	STATEMENT OF DEFICIENCIES ST BE PRECEDED BY FULL REGULATORY DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHOU REFERENCED TO THE APPROPRIAT	LD BE CROSS-	(X6) COMPLETION DATE
F 000	INITIAL COMMEN	ITS	F 000			
F 2014	November 6 throu deficiencies were observations, and and residents. The based on a censurof survey and four	ication survey was conducted gh 8, 2007. The following based on record review, interviews with the facility staff the sample included 15 residents s of 61 residents on the first day (4) supplemental residents.	F 2014	·		
F 221 SS=D	The resident has to physical restraints discipline or converted the resident's med. This REQUIREME Based on observation interview, for one determined that fat assess the resider and attempt restraint attempt restraint and mittens for 2 G. Tube (gastrosto Resident #8 was a secured in mittens November 6, 2007 AM, 1:30 PM, and	entrions, record review and staff (1) of 15 sampled residents, it was staff failed to consistently not for the least restrictive device aint reduction for Resident #8. de: er initially dated May 31, 2007 and 10, 2007, directed, "Right and left 4 hours for prevention on pulling my tube)." observed in bed with both hands on the following days: of at approximately 9:30 AM, 11:30, 2:30 PM. of at approximately 7:10 AM, 9:10	F 221	1. Resident till was reassessed and it was distorminitation frostränkt were unnecessary. The interdisciplinary has intervention was to place an attendinal paid over the the resident from pulling it out of place. Subsequently order for hand mittens was discontinued and fin care November 7, 2007. 2. All residents with resistants were audited 11-12-07 (were necessary. These residents were assessed for disvlops and throw was an attempt at restraint reducibit.) No other resident have been identified to be allepractice. All tentily representatives of resident's with been notified. 3. The staff will be in-serviced by our RCC's or design resistant reducible notified. 4. Results of the materialists audit tool and the findings if meetings will also be shared at the Questy Improven Committee meeting, quarterly. 5. 12-22-07	in depicted the best GTube to prevent the physician plan was updated of ensure the orders the forat methicities in specifically and specifically and popular have been on our facility's will review restraint marion and	
LABORATORY	DIRECTOR'S OR PROVIDE	ER/SUPPLIER REPRESENTATIVE SIGNATURE	•	Administrator>	11.	(X8) DATE -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 c survey whether or not a plan of correction is provided. For nursing homes, the poove 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 regulsite to continued program participation.

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

Event (D: 34MU11

Facility ID: HADLEY

If continuation sheet Page 1 of 2

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 095024 11/08/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4601 ML KING AVE SW SPECIALTY HOSPITAL OF WASHINGTON-HADLEY SNF WASHINGTON, DC 20032 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-PRÉFIX OR LSC IDENTIFYING INFORMATION) REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG TAG F 221 Continued From page 1 F 221 F 221 November 8, 2007 at approximately 7:15 AM, 9:15 AM, 11:15 AM, and 1:15 PM. Resident #8 was reassessed and it was determined that physical restraints were A care plan was initiated on May 31, 2007 and unnecessary. The interdisciplinary team decided reviewed August 30 and October 18, 2007, which the best intervention was to place an abdominal directed, "Resident needs to use hand mitts pad over the G-Tube to prevent the resident continuously to prevent pulling [out] G-tube." from pulling it out of place. Subsequently, the physician order for hand mittens was There was no evidence in the record that the discontinued and the care plan was updated interdisciplinary care team assessed the resident in November 7, 2007. May 2007 for the least restrictive device or that an on-going attempt for restraint reduction was 2. All residents with restraints were audited 11-12attempted after the hand mitts were applied. 07 to ensure the orders were necessary. These residents were assessed for the least restrictive There was no evidence in the record that the devices and there was an attempt at restraint resident's responsible party was notified that the reduction (see attachment #1). No other use of hand mitts was initiated on May 31, 2007 at resident have been identified to be affected by the time of this review. this practice. All family representatives of resident's with restraints have been notified. "Restraint Intervention" sheets were not available at the time of this review. Facility staff located the The staff will be in-serviced by our RCC's or "Restraint Intervention" sheets after the survey was designee on our facility's restraint reduction completed. A sample of the sheets was faxed to policy by 12-22-07. The in-service will review the surveyor on November 15, 2007. restraint assessments and reduction protocols. A restraint information and consent form (see A review of the "Restraint Intervention" sheets attachment #2) has been instituted. revealed that "Attempted alternative measures" was not consistently checked and no explanation was 4. Results of the restraints audit tool and the offered as to the type of alternative restraint findings from At-Risk meetings will also be attempted if checked. shared at the Quality Improvement/Performance Committee Employee #2 documented on the facsimile meeting, quarterly. message transmittal sheet that there were no "Restraint Intervention" sheets for May or June.

2007. The first sheet initiated was July 2, 2007.

November 7, 2007 at approximately 10:00 AM with

A face-to-face interview was conducted on

Employee # 8. He/she acknowledged that

5. Completed by 12-22-07

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		2	A. BUII	DING			
		095024	B. WiN	G		11/0	8/2007
	OVIDER OR SUPPLIER TY HOSPITAL OF WAS	SHINGTON-HADLEY SNF		46	EET ADDRESS, CITY, STATE, ZIP CODE 601 ML KING AVE SW VASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD B REFERENCED TO THE APPROPRIATE DE	E CROSS-	(X5) COMPLETION DATE
F 221	responsible party of consistently assess device and consiste restraint. The record 2007.	ge 2 inform the resident or the use of hand mitts, the resident for least restrictive nilly attempt to reduce the d was reviewed November 7, EKEEPING/MAINTENANCE		221	F 253 - 1 1. No resident was affected by this practifloor surfaces that were soiled with accumulated debris in the rear of convovens and deep fryers in four (4) of for convection ovens observed were clear immediately 2. No other residents identified were affer this practice. An audit was done on the kitchen floor to ensure no other areas.	ection ur (4) ned cted by e	
SS=D	The facility must promaintenance service	ovide housekeeping and es necessary to maintain a d comfortable intenor.			soiled or had debris build up. 3. Staff will complete an in-service on cle the convection ovens and will be requi sweep and mop area behind convection daily	red, to on ovens	reguests
	Based on observation environmental tour, housekeeping and adequate to ensure in a clean and sanit soiled floor surfaces ovens, deep fryers, stations and elevated drawers and floor tithe floor, and urine room. The dietary a observations were a Employees # 4, 5, 6 between 8:00 AM a 2007 at 7:15 AM. The findings include 1. Floor surfaces we debris in the rear of fryers in four (4) of to observed.	ons during the dietary and it was determined that maintenance services were not that the facility was maintained ary manner as evidenced by: in the rear of the convection drains under the dietary work or track; damaged dresser le; cleaning equipment stored on odor detected in a resident's and environmental tour made in the presence of 3, 7 and 9 on November 7, 2007 and 11:00 AM and November 8, escene soiled with accumulated convection ovens and deep four (4) convection ovens			 Foodservice supervisors will monitor the behind convection ovens 3 times a day track the findings and report all deficient findings to monthly Quality Improvement Performance Committee meetings. Completed 12-5-07 F 253 - 2 No resident was affected by this praction inner surfaces of floor drains under for preparation area in the main kitchen the soiled and accumulated with food debinant kitchen and dish washer area on (3) of three (3) drains observed were commediately No other resident was affected by this. The Food Service-supervisor on all the in the kitchen to ensure they were all can audit. Staff is required to clean drains daily, a integral part of Foodservices cleaning schedule. Food Service supervisors will monitor throughout the kitchen 3 times a day at the findings and report all deficient find monthly Quality Improvement / Perford Committee meetings. Completion by: 12-22-07 + Ongoing 	y and nt	regard sky

· - 12/2/07

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		095024	B. WING		11/08	3/2007
	ROVIDER OR SUPPLIER	SHINGTON-HADLEY SNF	STREET ADDRESS, CITY, STATE, ZIP CODE 4601 ML KING AVE SW WASHINGTON, DC 20032			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES F BE PRECEDED BY FULL REGULATORY INTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETION DATE
F 253 SS=D	facility staff failed to responsible party of consistently assess device and consister restraint. The record 2007. 483.15(h)(2) HOUS The facility must promaintenance service sanitary, orderly, and the responsibility of the facility must promaintenance service sanitary, orderly, and the responsibility of the facility must promaintenance service sanitary, orderly, and the responsibility of the facility of the floor surfaces ovens, deep fryers, stations and elevated drawers and floor tilthe floor, and urine room. The dietary a observations were remployees # 4, 5, 6 between 8:00 AM at 2007 at 7:15 AM. The findings included the findings included the floor surfaces we debris in the rear of fryers in four (4) of for observed.	inform the resident or the use of hand mitts, the resident for least restrictive ently attempt to reduce the display and attempt to maintain and comfortable interior. It is not met as evidenced by: It	F 253	No resident was affected by this pr The floor surfaces that were soiled accumulated debris in the rear of covens and deep fryers in four (4) of convection ovens observed were commediately	with convection of four (4) cleaned affected e on the eas were a cleaning equired, to ection monitor 3 times a ort all cy nittee aractice. Under food en that food a washer is ly this isor did an aractice and an aractice.	

FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU	JLTIPL	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		Jā	A. BUILDING				
_		095024	B. WING	B. WING		11/08/2007	
	OVIDER OR SUPPLIER TY HOSPITAL OF WAS	SHINGTON-HADLEY SNF		46	EET ADDRESS, CITY, STATE, ZIP CODE 101 ML KING AVE SW ASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD B REFERENCED TO THE APPROPRIATE DE	E CROSS-	(X5) COMPLETION DATE
F 278 SS=D	with accumulated for kitchen and dishwas floor drains observed. 3. One (1) of three (soiled in the 3 West. 4. Dresser drawers observed damaged. 324 was missing a fraction of the disher drawers observed damaged. 5. Floor tile in one (cobserved cracked not observed cracked not observed on floor surfationitionitionitionitionitionitionition	the main kitchen were soiled od and debris in the main sher area in three (3) of three (3) d. 3) elevator tracks was observed hallway. In two (2) of 13 rooms were in the following areas: Room ront to the first drawer and room wer was missing knobs. I) of 13 rooms, room 324, was ear the resident's bathroom. ent such as dust mops were ces in one (1) of two (2) for was detected in one (1) of 13 riew was conducted on at 7:55 AM with Employee #8. ed that room 317 had a strong M on November 8, 2007. 7 and 9 acknowledged the all and kitchen findings at the		253	 The staff is required to clean drains dintegral part of Food Services cleaning schedule. A Staff in-service has been scheduled. Food Service supervisors will monitor throughout the kitchen 3 times a day the findings and report all deficient fin monthly Quality Improvement / Perfor Committee meetings. Completion by: 12-22-07 + Ongoing F 253 – 3&5 No residents were affected by this prace Elevator tracks were cleaned immedia. November 7, 2007. Elevator tracks we cleaned immediately and floor tiles were paired immediately on November 7 No other residents were affected by the practice. The housekeeping supervismonitor the elevator tracks to ensure remain free of dirt and other debris. Environmental rounds will include the monitoring of elevator tracks and cleate tracks on a regular weekly scheduservice on elevator track cleaning will scheduled. Our plan to monitor performance and solutions are sustained includes reporesults from rounds to the EOC and Performance Improvement/ Performa Committee on a quarterly basis. Completion by 12-22-07 + Ongoing 	actice. actice. actely ere ere , 2007. his sor will tracks aning of ule. An in-	
		nust conduct or coordinate			o. Completion by 12-22-01. Ongoing		

FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION	1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUIL		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	095024	B. WING	S		11/0	8/2007
NAME OF PROVIDER OR SUPPLIER SPECIALTY HOSPITAL OF WASH	INGTON-HADLEY SNF		46	EET ADDRESS, CITY, STATE, ZIP CODE 601 ML KING AVE SW (ASHINGTON, DC 20032		
PREFIX (EACH DEFICIENCY MUST BE	EMENT OF DEFICIENCIES E PRECEDED BY FULL REGULATORY IFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETION DATE
A registered nurse muses assessment is completed. Each individual who consider a season assessment must signs that portion of the assessment must signs that portion of the assessment in a resident civil money penalty of each assessment; or a knowingly causes and material and false state assessment is subject not more than \$5,000. Clinical disagreement and false statement. This REQUIREMENT Based on observation, interview for one (1) of determined that facility code the Minimum Dattreatment for Resident. The findings include: Facility staff failed to complete the minimum of the statement.	at the appropriate participation is. Ist sign and certify that the sted. Ist sign and certify the accuracy of each assessment. Ist sign and certify the accuracy of the sted and certify the accuracy of easiers. Ist sign and certify that the sted and certify the accuracy of each assessment is subject to a not more than \$1,000 for an individual who willfully and other individual who willfully and other individual to certify a tement in a resident in a civil money penalty of for each assessment. Is not met as evidenced by: It is not met as evidenced by: It is not met as evidenced by: It is sampled residents, it was a staff failed to accurately the set (MDS) for dialysis	F2	278	 No resident was affected by this pracresidents were made aware that their were damaged and/or required reparamilies will be removing damaged from the facility. No other residents were affected by During rounds, personal furniture an will be inspected and a report will be units RCC or Charge Nurse to advisive resident and their families, of the corpersonal belongings. Facility-owned furniture was removed immediately as The RCC, Housekeeping and or Mai supervisors will do rounding and not not in compliance. Staff will be informeeting to note and make appropriate aware of the compliance issue. Our plan to monitor performance and solutions are sustained includes represults from rounds to the EOC and Performance Improvement/Performate Committee on a quarterly basis. Completion by 12-22-07 F 253 – 6&7 No residents were affected by this instored on floor surfaces in janitonal of Hangers will be installed in the janitomops. The room was cleansed to recodor. 	r dressers ir, 11-8-07. furniture the practice. d equipment given to the e the ndition of damaged 11-08-07 intenance e furniture med at staff te person d ensure orting ence practice. ops were closets or closets for	

12/2/27

FREFIX (EACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY TAG) 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 to certify a material and false statement in a resident assessment. Clinical disagreement does not constitute a material and false statement. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Tag F 278 I Resident #12's MDS was modified to reflect dialysis treatment. This was noted and transmitted on November 8, 2007 (please see attachment #III). This REQUIREMENT is not met as evidenced by: This REQUIREMENT is not met as e	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MU A. BUILI	DITIPLE CONSTRUCTION DING	(X3) DATE SU COMPLET	
STREET ADDRESS, CITY, STATE, 2IP CODE 460 ML, KING AVE SW WASHINGTON, DC 20032 FROM CACH DESTICIENCY MUST BE PERCESSED BY TAIL PROJUCE SOLD IN CORRECTION TAG 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 is completed. Each individual who completes a portion of the assessment in a resident portion of the assessment of the desident seasement is coincidual 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. 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.			095024	B. WING	3	11/0	8/2007
F 278 Continued From page 4 each assessment with the appropriate participation of health professionals. A registered nurse mūsī 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 not more than \$1,000 for each assessment or individual who willfully and knowingly causes another individual to certify a material and false statement. Clinical disagreement does not constitute a material and false statement. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Tag F 278 F 28 F 29 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 items on floor willfully and knowingly causes another 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: The MDS Coordinator or Designee will au		TY HOSPITAL OF W			4601 ML KING AVE SW WASHINGTON, DC 20032	CODE	
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, or an individual who willfully and knowingly couses another individual to certify a material and false statement in a resident assessment. Clinical disagreement does not constitute a material and false statement. 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.	PREFIX	(EACH DEFICIENCY MU	ST BE PRECEDED BY FULL REGULATORY	PREFI)	X (EACH CORRECTIVE ACTIO	ON SHOULD BE CROSS-	(X5) COMPLETION DATE
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	each assessment of health profession. A registered nurse assessment is contact that portion of the Under Medicare a willfully and knowing statement in a rescivil money penalte each assessment; knowingly causes material and false assessment is submot more than \$5,000 Clinical disagreement false statement. This REQUIREMENTED Based on observation in the following including the findings included t	with the appropriate participation onals. It must sign and certify that the impleted. In completes a portion of the sign and certify the accuracy of assessment. Ind Medicaid, an individual who ingly certifies a material and false ident assessment is subject to a yof not more than \$1,000 for or an individual who willfully and another individual to certify a statement in a resident oject to a civil money penalty of 000 for each assessment. In the third participation is not met as evidenced by: It is not met as evidenced by:	F2	F 253 - 6 1. No residents were affect Cleaning equipment suct stored on floor surfaces: Hangers will be installed for mops. 2. No other residents have practice. Monitoring of the items on floor will be con Housekeeping supervisor staff. 3. Environmental rounds we closets to ensure items a floor 4. Our plan is to monitor posolutions are sustained. Independent of the EOC and Improvement/Performance 12 /2 2 100 pm F 278 1. Resident #12's MDS was dialysis treatment. This we transmitted on November attachment #III). 2. The MDS Coordinator of residents receiving dialysincluded newly admitted dialysis. The audit will be December 22, 2007. It we quarterly basis to ensure	th as dust mops were in janitorial closets in the janitor closets been affected by this he janitors closets for nducted by the or and Housekeeping will include janitor's are not stored on the erformance and ensure cludes reporting results and Performance Committee. It is modified to reflect was noted and er 8, 2007 (please see or Designee will audit sis- this will also residents receiving we completed by will be performed on a er those individuals are	neguetals,

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		095024	B. WING _	·	11/08/2007	
	OVIDER OR SUPPLIER TY HOSPITAL OF WAS	SHINGTON-HADLEY SNF	} .	REET ADDRESS, CITY, STATE, ZIP CODE 4601 ML KING AVE SW WASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE D	BE CROSS- COMPLÉTION	N
F 278	November 28, 2006 completed February coded in Section P1 Procedures and Pro A history and Physic 2006, revealed the re	mission MDS completed and the quarterly MDS 20, 2007, the resident was (Special Treatments, gram) for dialysis.	F 278	practice. All SNF janitor closets were by staff immediately 11-08-07. All SN rooms were inspected for odors on t day. No other resident's room was for an odor. 3 Monitoring of the janitors closets for floor and urine odor will be conducted.	e inspected NF resident he same ound to have items on d by the	
	ESRD [End Stage F dialysis.	Renal Disease] and treatment for		House keeping Supervisor and Hous staff. Environmental rounds will include closets and urine odors daily.		
	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.			 Our plan is to monitor performance a solutions are sustained. Includes rep from rounds to the EOC and Perform Improvement/Performance Committee quarterly basis. 	porting results nance	
F 279 SS=D)(1) COMPREHENSIVE CARE	F 279	s. Completion date 12-22-07		
	develop, review and comprehensive plan for each reside objectives and timel medical, nursing, an needs that are ident assessment. The care plan must be furnished to attain highest practicable psychosocial well-be and any services that under §483.25 but as	velop a comprehensive care nt that includes measurable ables to meet a resident's ad mental and psychosocial ified in the comprehensive describe the services that are to n or maintain the resident's ohysical, mental, and eing as required under §483.25; at would otherwise be required are not provided due to the of rights under §483.10,		1. Resident #12's MDS was modified to dialysis treatment. This was noted at transmitted on November 8, 2007 (p attachment #III). 2. The MDS Coordinator or Designee residents receiving dialysis- this will included newly admitted residents redialysis. The audit will be completed December 22, 2007. It will be perfor quarterly basis to ensure those individed correctly (please see attachment).	will audit also acciving I by med on a iduals are	

· Museu /47/03 PRINTED: 11/19/2007 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 095024 11/08/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4601 ML KING AVE SW SPECIALTY HOSPITAL OF WASHINGTON-HADLEY SNF WASHINGTON, DC 20032 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE CROSS-PREFIX OR LSC IDENTIFYING INFORMATION) DATE REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG TAG F 279 Continued From page 6 F 279 The MDS Coordinator was notified of the under §483.10(b)(4). findings and the DON re-educated her on November 8, 2007. The DON or designee will verify the MDS for accuracy. This REQUIREMENT_is not met as evidenced by: 4. Results of the MDS Dialysis Treatment Audit Based on staff interview and record review for one and compliance monitoring out comes will be (1) supplemental resident, it was determined that reported and discussed at our quarterly QA facility staff failed to initiate a care plan with Meetings. appropriate goals and approaches for Resident F1's behaviors of expectorating on the floor and hoarding Completion by 12.22.07 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 F 279 Resident F1's room, the resident was observed spitting on the floor and flying insects were 1. A care plan and behavioral monitoring flow sheet observed. for resident F1 was instituted on November 8, 2007. The new care plan addresses appropriate A face-to-face interview was conducted on goals and approaches. 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 2. All residents with behavioral issues were CNAs go into the room they take the towel off the identified. These residents will be reviewed in floor. The resident is non-compliant with care...' our weekly At-Risk Meetings. The resident behavioral monitoring flow sheet was initiated on A face-to-face interview was conducted on

care."

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

dessert and that's why there are fruit flies in the

room. Housekeeping assists. They mop the floor

change clothes, but [he/she] yells and refuses to

resident, I encourage [him/her] to take a shower and

this. The resident likes to hold on to fruit and

and wash down the bed. When I care for the

November 8, 2007.

3. The facility staff will be in-serviced by Social

facility staff to identify, report, manage and

Service Department Head or Designee. The in-

service will reinforce the behavioral monitoring

flow sheet. Additionally, the in-service will teach

document behaviors, and update care plans to

reflect the appropriate goals and approaches.

77/01 PRINTED: 11/19/2007 DEPARTMENT OF HEALTH AND HUMAN SERVICES **FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER-COMPLETED A. BUILDING B. WING 095024 11/08/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4601 ML KING AVE SW SPECIALTY HOSPITAL OF WASHINGTON-HADLEY SNF WASHINGTON, DC 20032 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (EACH CORRECTIVE ACTION SHOULD BE CROSS-PREFIX OR LSC IDENTIFYING INFORMATION) REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE TAG TAG F 279 Continued From page 7 Results from the behavioral monitoring flow F 279 sheet and compliance monitoring outcomes will be discussed by RCC at the QA meetings on a A review of the care plans last updated on September 7, 2007 revealed that there was no care quarterly basis as well as our weekly At-Risk plan initiated to include appropriate goals and Meetings. approaches for the resident's aforementioned behaviors. 5. Completion by 12/22/07 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 280 483.20(d)(3), 483.10(k)(2) COMPREHENSIVE F 280 F 280 **CARE PLANS** SS=D 1. The appropriate goals and interventions for The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated fluid restriction for resident #4 were added to under the laws of the State, to participate in the care plan on November 26, 2007. planning care and treatment or changes in care and treatment. Resident F1's care plan and medications were A comprehensive care plan must be developed assessed and evaluated by the IDT during our Atwithin 7 days after the completion of the comprehensive assessment; prepared by an Risk Meeting. New interventions were implemented interdisciplinary team, that includes the attending and the resident's physician and family members physician, a registered nurse with responsibility for were notified. The care plan was also updated. The the resident, and other appropriate staff in MDS was modified, noted and transmitted on disciplines as determined by the resident's needs.

assessment.

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

This REQUIREMENT is not met as evidenced by:

November 27, 2007.

audit the care plan.

2. All residents with Dietary Orders for fluid

restriction will be audited by the Dietician by December 22, 2007. The RCC or Designee will

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES LYAL PROMISE OF DESIGNATION OF DESIGNATION

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		LE CONSTRUCTION	COMPLET	
		095024	B. WIN	IG		11/0	8/2007
	OVIDER OR SUPPLIER	ASHINGTON-HADLEY SNF		46	EET ADDRESS, CITY, STATE, ZIP CODE 601 ML KING AVE SW VASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	STATEMENT OF DEFICIENCIES ST BE PRECEDED BY FULL REGULATORY DENTIFYING INFORMATION) -	ID PREF TAG	ıx	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD F REFERENCED TO THE APPROPRIATE DI	BE CROSS-	(X5) COMPLETION DATE
F 280	Based on observar review for one (1) (1) supplemental refacility staff failed that appropriate goals are sident on fluid reincontinence. Resident on fluid reincontinence. Resident on fluid reincontinence. Resident failed in the findings included. 1. Facility staff failed that the signed and Dated "Dietary Orders:	tions, staff interview and record of 15 sampled residents and one esident, it was determined that to amend the care plans with and approaches for one (1) estriction and one (1) resident with ident #4 and F1. de: led to amend Resident #4's care ate goals and approaches for fluid ent #4's "Physicians Order Sheet" October 1, 2007 revealed, Fluid Restriction of 1200 mls per herapeutic Diet" care plan that on August 31, 2007, lacked care plan was amended with ches for fluid restriction. esident's record, facility staff resident received 200 ml of fluid hift (11:00 PM to 7:30 AM) and ing each of the day (7:00 AM to ning shifts (3:00 PM to 11:30 PM). erview was conducted on at approximately 9:35 AM with she acknowledged that the care plan had not been amended striction. The record was reviewed	F	280	For our incontinent residents, the facility instituted a bowel/bladder evaluation for November 12, 2007 (please see attach #VI). A urinary incontinence audit will be by the RCC or Designee by December Feedback from these assessments and will be discussed at the weekly IDT At-I meetings. 3. The Dietician will audit all orders for restriction. The RCC will audit the confort fluid restriction. The facility has it bowel/bladder evaluation form. The received from the evaluation will be revise and create a plan of care that incontinence. 4. Results from the bowel/bladder evaluation audit, nursing care plan at any other compliance monitoring or be presented by the RCC and Dieti QA meetings on a quarterly basis. 5. Completion by 12.22.07	rm on ment #V & e performed 12, 2007. If evaluations Risk r fluid care plans instituted a e information e used to eat addresses aluation etary fluid audit and utcomes will	

PRINTED: 11/19/2007 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 095024 11/08/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4601 MŁ KING AVE SW SPECIALTY HOSPITAL OF WASHINGTON-HADLEY SNF WASHINGTON, DC 20032 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (EACH CORRECTIVE ACTION SHOULD BE CROSS-PRÉFIX PREFIX OR LSC IDENTIFYING INFORMATION) DATE REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG TAG F 280 Continued From page 9 F 280 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)

"Resident is continent".

dated September 6, 2007 for Section H1b (Bladder Continence) coded the resident as continent.

problem, "Requires assistance with ADL care", was last updated on September 7, 2007 and revealed "Resident is using the bathroom freely" and

A review of the care plan with the identified

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPL	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		\$	A. BUILDING		[
		095024	B. WING	<u> </u>	11/08/2007	
	OVIDER OR SUPPLIER	SHINGTON-HADLEY SNF	46	EET ADDRESS, CITY, STATE, ZIP CODE 01 ML KING AVE SW VASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES I BE PRECEDED BY FULL REGULATORY INTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD B REFERENCED TO THE APPROPRIATE DI	BE CROSS-	(X5) COMPLETION DATE
F 280	, ,	ge 10 view was conducted with	F 280			
	He/she acknowledg	vember 8, 2007 at 9:58 AM. ed that there was no care plan ent's incontinence. The record mber 8, 2007.				
F 312 SS=D	483.25(a)(3) ACTIV	ITIES OF DAILY LIVING	F 312			
	daily living receives	nable to carry out activities of the necessary services to ion, grooming, and personal and				
	This REQUIREMEN	IT is not met as evidenced by:				
	interview for one (1) determined that faci necessary services personal hygiene fo	on, record review and staff of 15 sampled residents, it was lity staff failed to provide the to maintain good grooming and r Resident # 8 as evidenced by a soiled hand mittens. Resident				
	The findings include	:				
	Resident # 8 was of resident emitted a s had soiled hand mit	07 at approximately 7:50 AM, oserved in bed awake. The trong body odor. The resident tens on both hand and two rs of mittens at the resident 's				
	completed October most of the time and all of his/her activities	arterly Minimum Data Set (MDS) 25, 2007, he/she is bedfast d totally dependent on staff for es of daily living: ambulation, nygiene, toileting and bathing. presents with				

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

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	CORRECTION	IDENTIFICATION NUMBER:	A. BUII		IPLE CONSTRUCTION (X3) DATE SU COMPLET		
		095024	B. WIN	G	-	11/0	8/2007
	OVIDER OR SUPPLIER	SHINGTON-HADLEY SNF		44	EET ADDRESS, CITY, STATE, ZIP CODE 601 ML KING AVE SW VASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES OF BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD E REFERENCED TO THE APPROPRIATE DI	BE CROSS-	(X5) COMPLETION DATE
F 323 SS=D	bowel and bladder Diseases listed in S Mellitus, Hypertens Alzheimer's, Dem disease. A review of an Inte last entry dated Au following "Probler on nursing for all a will be well groome Provide daily care of According to the daresident was sched and Tuesdays. According to the " October and Nover a bed bath daily. The resident received and November 2007. A face-to-face inter Employee # 8 on Napproximately 7:55 the resident had a shand mittens. Addir why the resident had a shand mittens.	incontinence (Section H1). Section I included: Diabetes sion, Congestive Heart failure and entia other than Alzheimer's rdisciplinary Care Plan with the gust 3, 2007 revealed the n: Resident is totally dependent spects of care Goals: Resident d, free of odors Approaches: for resident." ally shower list revised 2007, the fulled for a shower on Mondays Resident Care Flow Record " for mber 2007, the resident received here was no evidence that the shower for October and view was conducted with ovember 8, 2007 at AM. He/she acknowledged that strong body odor, and soiled tionally He/she could not explain ad not received a shower in		312	 Resident #8's hand mittens were discon November 8, 2007. The shower sheen revised to reflect the actual shower that the care plan for resident #8 was up November 12, 2007 and resident #8 shower. The RCCs reviewed all resident show schedules and will continue to monitor compliance with shower schedule and that ADL flow sheets accurately refles bathing modality i.e. shower, bed bathing modality i.e. shower in the interest who may be diffirm maneuver. In addition, the IDT determsome residents have a history of refusioners. Social Services and resident representatives will assist the facility encouraging those residents to show Residents who are non-compliant with will be documented and care planned. Compliance monitoring outcomes refersident showers will be presented by at the QA meetings on a quarterty bathing personal hygiene of our residents. Completion 12.22.07 	chedule has wer days. dated on received a ver or for d ensure cts the h etc. aily rounds c. The fuct an in- ics, and icult to mined that ising nt family staff with er, h showers d. ated to y the RCCs sis in	

12/1/07 PRINTED: 11/19/2007 DEPARTMENT OF HEALTH AND HUMAN SERVICES **FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B WING 095024 11/08/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4601 ML KING AVE SW SPECIALTY HOSPITAL OF WASHINGTON-HADLEY SNF WASHINGTON, DC 20032 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-DATE OR LSC IDENTIFYING INFORMATION) TAG TAG REFERENCED TO THE APPROPRIATE DEFICIENCY) F 323 Continued From page 12 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 This REQUIREMENT is not met as evidenced by: was re-educated on the proper placement of detergent on November 6, 2007. The Resident Based on observations during the survey period, it verbalized understanding. was determined that the facility staff failed to maintain a hazard free environment as evidenced by an unsecured box of laundry detergent in a 2. The Charge Nurse, Housekeeping, and resident's room. The environmental tour was Maintenance conducted daily room rounds in conducted on November 6, 2007 between 10:30 AM all rooms- in order to maintain a hazard free and 11:35 AM in the presence of Employees #4, 5. environment. 6 and 7. 3. The facility staff will be in-serviced by RCCs or The findings include: Designee on the facility's practice of maintaining a hazard free environment and the A box of dish detergent was observed unsecured on need environmental room rounds. a table in a resident's room, #335. 4. Compliance monitoring outcomes related to Employee #4, 5, 6 and 7 acknowledged the above maintaining a hazard free environment will be finding at the time of the observations. presented by the Maintenance Manager at the F 371 483.35(i)(2) SANITARY CONDITIONS - FOOD F 371 QA meetings on a quarterly basis. PREP & SERVICE SS=E 5. Completion by 12-22-07 + Ongoing 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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		095024	B. WING			11/08/2007	
	ROVIDER OR SUPPLIER	ASHINGTON-HADLEY SNF		46	REET ADDRESS, CITY, STATE, ZIP CODE 1601 ML KING AVE SW WASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MU	STATEMENT OF DEFICIENCIES ST BE PRECEDED BY FULL REGULATORY DENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETION DATE
F 371	were made in the and 9 on November 11:00 AM. The findings included 1. One (1) case of (1) case of great is observed in the ward at the secondariance of the secondariance on the secondariance on the secondariance on the secondariance on the secondariance of the	with an oil leak. The observations presence of Employee #4, 5, 6, 7 er 7, 2007 between 8:45 AM and de: great shake plus nutrient and one shake supplement nutrient were alk in refrigerator with expiration er 11, 2007 in two (2) of two (2) all supplement observed. d and unlabeled zip lock bag in and a biscuit and one (1) et were observed in one (1) of two enursing units. ffaces of the compressor body the walk in refrigerator were soiled dust and debris in one (1) of one	F	371	 F 371 – 18.2 No residents were affected by this particle All other areas in the kitchen were into ensure no other expired foods are Expired foods were removed immed 08-07. The chicken and biscuit were immediately. There were no residents affected practice. All areas of the kitchen were to ensure that no foods were expired case of great shake plus nutrient a case of great shake supplement not observed in the walk in refrige expiration dates of September 11, immediately removed from the refrigerator. An audit was done immensure that no other food items were. Staff in-service was scheduled by from service manger on proper storage alabeling and dating practices, mostly the importance of rotation of food by understanding the (First In First Out Quarterly staff in-services will be confucted to educate new staff and reinforce state policy practice. Food service supervisors will monitor boxes 3 times a day and track the fireport all deficient findings to month Improvement / Performance Commitmeetings. Completion: 12-22-07 	nspected e present. diately 11- e removed ed by this ere checked ed. The (1) and one (1) utrient were erator with the 2007 was e walk in mediately to the found. food and the y stressing the Method) nducted to modard or walk in indings and the Quality	

NAME OF PROVIDER OR SUPPLIER SPECIALTY HOSPITAL OF WASHINGTON-HADLEY SNF STREET ADDRESS, CITY, STATE, ZIP CODE 4601 ML KING AVE SW WASHINGTON, DC 20032 [(X4) ID PREFIX TAG [EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 456 SS=D The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: This REQUIREMENT is not met as evidenced by: STREET ADDRESS, CITY, STATE, ZIP CODE 4601 ML KING AVE SW WASHINGTON, DC 20032 F 7871 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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
SPECIALTY HOSPITAL OF WASHINGTON-HADLEY SNF 4601 ML KING AVE SW WASHINGTON, DC 20032 CAUSTING SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMMANDER TO THE APPROPRIATE DEFICIENCY			095024	B. WING			11/08/2007	
washer observed. Employees #4, 5, 6, 7 and 9 acknowledged the above findings at the time of the observations. 483.70(c)(2) SPACE AND EQUIPMENT The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. F 456 This REQUIREMENT is not met as evidenced by: F 456 In 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. P 456 S 2 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	SPECIAL (X4) ID PREFIX	TY HOSPITAL OF WAR	STATEMENT OF DEFICIENCIES ST BE PRECEDED BY FULL REGULATORY	PREF	46 W	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD	D BE CROSS-	(X5) COMPLETION DATE
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	washer observed. Employees #4, 5, 6 above findings at the 483.70(c)(2) SPACE. The facility must melectrical, and patinoperating condition. This REQUIREME. Based on observatives determined the line were damaged survey, it was determined the line was damaged one (1) outlet insolve line was damaged one (1) outlet lacked of a cold box to opinto the outlet sock observed at 12:30. 2. The environment on November 6, 20 AM in the presence.	6, 7 and 9 acknowledged the he time of the observations. CE AND EQUIPMENT naintain all essential mechanical, ent care equipment in safe h. NT is not met as evidenced by: Itions during the dietary survey, it at electrical outlets near the tray d; and during the environmental ermined that Heating Ventilation hig (HVAC) systems were not hereidents' rooms. De: of the dietary department, one (1) Italied in the floor near the tray and not secured to the floor and ed power as evidenced by failure erate when the cord was plugged attent two (2) of three (3) outlets PM on November 6, 2007. Italitatiour on 3 West was conducted 2007 between 10:30 AM and 11:35 e of Employees #4, 5, 6 and 7.			 No resident was affected by this The exterior surfaces of the conbody and fan covers in the walk refrigerator that were soiled with accumulated dust and debris will cleaned by maintenance. No other residents were found a this practice. An audit was done immediately to ensure that no ovents were soiled. An in-service scheduled by the food service in address the cleanliness of the clean body and fan cover. Maintenance will be requested to compressor body and fan cover ensure that the practice does not compressor body and fans cover boxes 3 times a day and track than different all deficient findings Quality Improvement / Performation Committee meetings. Completion 12-22-07 + Ongoing F 371 – 4 No resident was affected by this The exterior panels, inner panel and burner surfaces of deep frywere soiled with food deposits at the context of the context o	affected by estate fans or estate has been manager to compressor to clean resmonthly to ot recur. Will monitor eres in walk in the findings to monthly ance g s practice. Is, valves wers that	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A BUILDING (X3) DATE SURVEY COMPLETED

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING		S	COMPLETED	
		095024	B. WIN	G		11/0	8/2007
NAME OF PROVIDER OR SUPPLIER SPECIALTY HOSPITAL OF WASHINGTON-HADLEY SNF			STREET ADDRESS, CITY, STATE, ZIP CODE 4601 ML KING AVE SW WASHINGTON, DC 20032				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTION S REFERENCED TO THE APPROV	SHOULD BE CROSS-	(X5) COMPLETION DATE
F 456	Continued From page 15 338. A face-to-face interview was conducted on November 6, 2007 at \$1:25 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. 483.70(h)(4) PHYSICAL ENVIRONMENT- PEST CONTROL		F 456	456	 No other resident were ideaffected by this practice. A immediately to ensure that weren't soiled with food digrease. The systemic changes pure inforcing to staff the improllowing cleaning schedul quarterly staff in-services to educate new staff and policy practice. The Food Service supervictooking equipment 3 times the findings and report all to monthly Quality Improving Performance Committee in Services Completed 12-22-07 + Or Completed 12-22-07 + Or No resident was affected The observed mechanical 	An audit was done at all deep fryers eposits and It in place will be contance of ale. In addition, will be conducted reinforce standard assor will monitor as a day and track deficient findings rement / meetings. In addition, will be conducted assor will monitor as a day and track deficient findings rement / meetings.	
33-0	The facility must ma	cility must maintain an effective pest control m so that the facility is free of pests and s.			adjacent to cooking hoods operation for repair. No other residents were a practice. An audit was do mechanical mixer to ensuleakage.	affected by this one on the other	
	This REQUIREMEN	NT is not met as evidenced by:					
	Based on observati	ons during the environmental		[

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1.	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		1	A. BUILDING				
095024		B. WING			11/08/2007		
NAME OF PROVIDER OR SUPPLIER SPECIALTY HOSPITAL OF WASHINGTON-HADLEY SNF			STREET ADDRESS, CITY, STATE, ZIP CODE 4601 ML KING AVE SW WASHINGTON, DC 20032				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS- TAG REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
F 469	69 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	 Maintenance will be requested to preventative maintenance on the needed once mixer is repaired. The Food Service supervisor will mechanical mixers and report all findings to Maintenance and Qual Improvement / Performance Commeetings on a monthly basis. Completed by 12.22.07 F 371-6 			
F 492 SS=D	compliance with all a local laws, regulation accepted profession apply to professional facility. This REQUIREMENT Based on observation interview, it was detended to ensure that one (remployees had a currecord upon hire and facility policy for significations. Residents The findings include 1. Facility staff failed Nurse Aide (CNA) his the facility.	operate and provide services in all applicable Federal, State, and ations, and codes, and with sional standards and principles that onals providing services in such a defent of the constant		492	 No residents were affected. Food was removed from the clean side of the dishwasher tray immediately. An in-service has been scheduled, which will center on proper dish washing techniques. The Food Service Supervisor will monitor the dish-washing practices. The results of the inservice will be reported to QA on a monthly basis. Completion date 12-22-07 F 456 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. 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. 		
	According to 22 DCMR 3203.2, "A list of						

PRINTED: 11/19/2007 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED AND PLAN OF CORRECTION A. BUILDING B. WING 095024 11/08/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4601 ML KING AVE SW SPECIALTY HOSPITAL OF WASHINGTON-HADLEY SNF WASHINGTON, DC 20032 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE OR LSC IDENTIFYING INFORMATION) TAG TAG F 492 Continued From page 17 F 492 Environmental rounds will include 3. employees, with the appropriate current license or housekeeping, maintenance and the department certification numbers shall be on file at the facility head or manager. and available to the Director." Results from rounds will be reported to the EOC A Certified Nurse Aide (CNA), Employee #13, was committee and to the Performance Improvement hired at the facility on April 14, 2007. During the Committee on a quarterly basis. review of certifications on November 7, 2007, it was observed that Employee #13's record lacked a Repairs to outlets to be completed by 11/30/07. 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 F 469 worked on November 4 and 6, 2007, day shift (7:00 All rooms were checked for insects. No insects 1. AM to 3:30 PM). He/she was on duty on November were observed. 7, 2007, day shift, and was relieved of his/her duties after it was revealed that a certificate was not No residents were affected by this practice in on record. Room #317, was cleaned creating a flying insects free room. Present in the employee's record was a copy of a receipt from the post office that documented that an Monitoring of the environment for flying and application for a District of Columbia CNA other insects in the facility will be conducted certification was mailed on quarterly and as needed. Our pest control March 16, 2007. There was no further information in services will continue treatment of the facility for the employee's record regarding the status of the insects and provide a staff in-service on application for certification. "Creating a Insect Free Zone." On November 7, 2007, at approximately 10:30 AM, During environmental rounds the evidence of a face-to-face interview was conducted with insects will be monitored and reported to the

up on the application.

orders for Resident #1.

Employee #2 who indicated that Employee #13 had

applied for the DC certification, but had not followed

2. The physician failed to sign and date monthly

According to 22 DCMR 3207.8, "Each physician

shall adhere to the written policies and regulations that govern the health services provided in the

Pest Management Company for immediate

Our plan to monitor performance and ensure

Committee by the housekeeping supervisor.

solutions are sustained includes: reporting

results from rounds to the EOC and Performance Improvement/Performance

elimination treatment.

Completion by 12-22-07

12/26/2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED		
	095024			_		11/0	8/2007	
NAME OF PROVIDER OR SUPPLIER SPECIALTY HOSPITAL OF WASHINGTON-HADLEY SNF				STREET ADDRESS, CITY, STATE, ZIP CODE 4601 ML KING AVE SW WASHINGTON, DC 20032				
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F 492	facility." A review of the Attending Physicin Section V (1): the following: "Do supervision of early orders and progress and progress and progress every 30 data and November 1 dated were note: A nurse practition the record for Auprogress note was 6, 2007. On November 7, face-to-face inte Employee #8 whisign and date or was reviewed or 3. The physician orders for Reside A review of Resignal A review of	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 clirical 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		492	 No resident affected by this practice November 7, 2007, Employee #13 of duty until this employee followed DC C.N.A Certification. The Human Resources Manager, Designee will verify all licensed and personnel to ensure that all care-give certifications are valid and up-to-date beginning employment. The Human Resources Manager are managers will verify all licensed and personnel to ensure that all care-give certifications are valid and up-to-date monthly basis. A current list of active licenses/certifications are valid and up-to-date monthly QA Meetings as well employee orientation. Completion by 12-22-07 	was relieved up with the DON or unlicensed wers te prior to and all hiring d unlicensed wers te on a		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		•	(X3) DATE SURVEY COMPLETED	
		095024	B. WING		· · · · · · · · · · · · · · · · · · ·	11/08/2007	
NAME OF PROVIDER OR SUPPLIER SPECIALTY HOSPITAL OF WASHINGTON-HADLEY SNF			STREET ADDRESS, CITY, STATE, ZIP CODE 4601 ML KING AVE SW WASHINGTON, DC 20032 ID PROVIDER'S PLAN OF CORRECTION				(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	CY MUST BE PRECEDED BY FULL REGULATORY			(EACH CORRECTIVE ACTION SHOULD B	COMPLETION DATE	
F 492 F 514 SS=D	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. 483.75(I)(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:			F 514 F 514 I. The care plans for resident F1 were used to and instituted on November 8, 2007. Updated care plans addresses approgoals and approaches for resident be Resident F1's Physician and family we notified. Residents identified with behavioral is reviewed in our weekly At-Risk Meeting recently instituted behavioral monitor sheet will capture the resident's behavioral monitor for compliance with schedule, hoarding and personal hyperactices. What measure will be put in place or systemic changes you will make to endeficient practice does not recur? The Charge Nurse or Designee will put daily room rounds in order to maintain sanitary environment. Results from the behavioral monitoring sheet, ADL Flow sheet and other commonitoring outcomes will be discussed QA meetings on a quarterty basis as our weekly At-Risk Meetings. 5. Completion 12.22.07		The opriate ehaviors. was issues are tings. The ring flow aviors. The th shower giene what ensure the operform in a mg flow mpliance ed at the	
	8, 2007 at 7:50 AM, Resident F1's room, spitting on the floor observed . On Nove 7:50 AM, strong urin	07 at 9:20 AM and November during the environmental tour of the resident was observed and flying insects were ember 8, 2007 at approximately ne odors were detected.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 095024			(X2) MULTIPLE A. BUILDING	E CONSTRUCTION ((X3) DATE SURVEY COMPLETED		
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F 514	November 8, 2007 He/she stated, "I He/she has had the incontinence] for your concern about this fruit and dessert at flies. Housekeepi and wash down the resident I encourachange clothes, bocare." A face-to-face interesident puts a too CNAs go into the floor. The resident He/she has unnare he/she does not work when I started woo beginning of the your cleans after the regroom smells again he/she doesn't was see trash we remove the floor. A face-to-face interesident's aforement of the put of the null acked evidence or resident's aforement of the floor. The resident was the floor of the your cleans after the regroom smells again he/she doesn't was see trash we remove the floor of the null acked evidence or resident's aforement of the floor of the floor of the null acked evidence or resident's aforement after the floor of the flo	at 10:10 AM with Employee #12. assist the resident sometimes. his problem [expectorating and rears. Even his/her family has a s. The resident likes to hold on to and that's why he/she has the fruiting assists. They mop the floor he bed. When I care for the age him/her to take a shower and but he/she yells and refuses to be erview was conducted on at a 19:55 AM with Employee #8. He/she] spits on the floor. The well on the floor and when the room they take the towel off the but is non-compliant with care, by incontinence at times and the rear it was a concern. The staff asident and within one hour the but is a concern. The staff asident and within one hour the but is a concern. The staff asident and within one hour the but is a concern. The staff asident and within one hour the but is assist him/her. When we not it." The resident is on Lasix and and us to assist him/her. When we have it." The resident and with a concern are sident for the focumentation regarding the continued behaviors. The resident's record regarding the resident's record regarding and the resident's record regarding the record was reviewed.	F 514					