STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	096030	A. BUILDING _____ B. WING _____	06/04/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIBLEY MEM HOSP RENAISSANCE	5255 LOUGHBORO ROAD NW WASHINGTON, DC 20016

(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 000	INITIAL COMMENTS A recertification survey was conducted on June 2 through 4, 2010. The following deficiencies were based on observations, record review and staff and resident interviews. The sample included 11 residents based on a census of 42 residents on the first day of survey and 1 supplemental resident.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update	F 157	F157 483.10(b)(11) Notify of Changes (Injury/Decline/Room, etc) Sibley Memorial Hospital SNF provides services that meet professional standards of quality. During the most recent survey, it was determined that the facility failed to notify the resident's family member in a timely manner when the resident's physician wrote an order for Plendil, which is non-formulary thereby asking patient to bring their own [POM]. There are no further corrections as the resident has been discharged to home. No other residents are receiving POM. Findings for Resident #8 1. There are no further corrections as this resident has been discharged to home. The medication was subsequently discontinued. Records of other residents were checked with no other orders for family notification needed. — 5/17/2010 2. Other residents with the potential to be affected will be identified upon admission, through review of the admitting physician orders, and/or as prescribed. — 7/19/2010 3. The following systemic changes will be implemented to ensure the deficient practice does not recur: — 7/19/2910 • The nurse will check the initial physician orders to verify whether there is a POM pending pharmacy verification in the record. • Staff will be re-educated regarding Hospital Policy 02-31-02 *Medications Brought Into the Hospital* to ensure that all medications received by residents are appropriately identified and handled in accordance with authorized prescriber orders, pharmacy laws, regulations & standards. • The pharmacist's role will be re-stated to identify medications brought from home by patient, to label these medications appropriately, and to enter medications into the MAR.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Robert L [illegible] — TITLE: Administrator — (X6) DATE: 7/2/10

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 157	Continued From page 1 the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and family interview for one (1) of 11sampled residents, it was determined that the facility staff failed to notify the responsible party that Plendil [anti-hypertensive medication] was not available for Resident #8. The findings include: A face-to-face interview conducted on June 4, 2010 at approximately 10:30AM with Resident #8's [responsible party] stated, " I was not notified that my[resident] was not receiving his Plendil until eight days after being admitted." According to the Physician ' s Admitting Orders dated and signed May 10, 2010, directed "Plendil 10mg [by mouth] daily for [hypertension]". According to the Medication Administration Record generated May 11, 2010 revealed, " Plendil 10mg by mouth daily for [hypertension] ... Non-formulary ...ask [patient] to bring own [POM]. A review of the clinical record for Resident #8 lacked documentation that facility staff had notified the responsible party that Plendil was not available. The electronic nurses notes dated between May 11-16, 2010 revealed no documentation informing responsible party that medication was not available and to bring patient ' s own medication	F 157	• The charge nurse/resident nurse will immediately notify the family and document the date, time, reason and response from the call into the clinical record. • Nursing staff will report to the oncoming shift the status of medications written as POM. • The nurse will notify the physician if the medication (POM) is not received for sign-off at first dosage and document in clinical record. • The DON/Quality Nurse will monitor for physician orders that request POM to ensure compliance and resolution of acquiring the medication • Nursing staff will receive further education on the importance of notification to families and documentation of those conversations into the clinical records when POMs are not available for resident. 4. The quality assurance process will be utilized to monitor and sustain compliance. The findings will be presented at the quarterly meeting of the Renaissance Quality Committee.	7/27/2010

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F 157	Continued From page 2 [POM]. The Physician ' s Order Sheets dated May 18 and May 27, 2010, directed [Discontinue Plendil - not taking not available. A face-to-face interview was conducted with Employees #12, #13, and #14 on June 4, 2010 at approximately 11:55 AM. They stated that the resident's [responsible party] was informed to bring patient ' s medicine in from home. Employee #14 stated he/she informed the [responsible party] face-to-face on May 12, 2010. The employees acknowledged that there were no electronic notes to reference the conversation. Although, staff stated through interview that the [responsible party] was notified, there was no documented evidence of conversations. Additionally, there was no untoward effect to Resident #8 related to not receiving Plendil as prescribed the physician.. The chart was reviewed on June 4, 2010.	F 157	F253 - 483.15(h)(2) Housekeeping & Maintenance Services Sibley Memorial Hospital Renaissance SNF provides housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior. During the survey, a few deficiencies were identified that have been cited in this report. The following plan of corrections addresses the few deficiencies that were identified: 1. No specific residents were identified in the survey report as being affected by the deficient practices. The following corrective actions were taken to address the survey findings: • Finding 1: Room curtains were repaired and re-hung on the day of inspection in rooms #305, #310, and #330, and the rehabilitation room. — 6/3&4/2010 • Finding 2: Torn shower curtain in room #320 is a special size and a new curtain has been ordered. — 7/14/2010 • Finding 3: Bathroom vents were cleaned in rooms #308, #316, #317, #328, and #330. — 6/3&4/2010 • Finding 4: Bed frames were dusted when noted at time of inspection in rooms #316 and #317. — 6/3&4/2010 • Finding 5: Windows sills were dusted when noted at time of inspection in rooms #310 and #328. — 6/3&4/2010 2. All rooms will be checked and cleaned and/or repaired as needed. — 7/19/2010 3. The following systemic changes have been or will be put in place to ensure the deficient practices will not recur: • Finding 1: — 6/25/2010 ° Laundry staff will be retrained to ensure that all carriers are attached to curtains when changed out in room. ° Laundry staff will conduct periodic inspections of empty rooms to determine if any carriers need replacing or reattaching. ° Laundry will transition to a universal style carrier that can be used in more types of tracking.	
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES 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 made during environmental tours of the facility on January 3 and 4, 2010, it was determined that the facility failed to provide effective maintenance services in residents rooms as evidenced by: detached privacy curtains in four (4) of 13 rooms surveyed,	F 253		

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F 253	Continued From page 3 torn shower curtain in one (1) of 12 rooms surveyed, soiled and dusty bathroom vents in five (5) of 12 resident ' s rooms, dusty bed frames in two (2) of 12 residents' rooms and dusty window sills in two (2) of 12 residents' rooms. The findings include: 1. Privacy curtains were hanging off the hooks in rooms # 305, 310, 330, and in the rehabilitation room; 2. The shower curtain was torn in room # 320; 3. Bathroom vents were soiled with accumulated dust in rooms #308, 316, 317, 328 and 330; 4. Bed frames were soiled with dust in rooms # 316 and 317; 5. Windowsills were dusty in rooms # 310 and 328. These findings were acknowledged by Employees # 4 and 9 who were present at the time of observation.	F 253	° Managers will make routine inspections during curtain changes and ensure that all privacy curtain carriers are in working order. • Finding 2: ° Environmental Services staff will be retrained to make a visual inspection of items while cleaning to ensure the shower curtains are in good repair and working order at all times. Items needing replacement or repair will be reported. ° EVS team managers will inspect curtains while making rounds. • Finding 3: ° EVS staff will be retrained to ensure that a visual inspection of bathroom vents is completed while cleaning. For items in need of cleaning, a work order will be submitted. ° EVS team managers will monitor vents when completing inspections and rounds. • Finding 4: ° Bed frames will be wiped down at time of discharge. ° EVS associates will track the length of stay of residents and coordinate with nursing assistants to dust frames at time of linen change. ° EVS management will monitor bed frames for dust when conducting inspections. • Finding 5: ° EVS associates will complete the 7 step cleaning method each day in each room to avoid overlooking dust and debris on window sills. ° EVS team managers will monitor windows sills for dust when conducting inspections.	7/19/2010 ONGOING 7/19/2010 ONGOING 6/4/2010 6/4/2010 ONGOING 7/19/2010 ONGOING
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed.	F 278	4. The quality assurance process will be utilized to monitor and sustain compliance. The findings will be presented at the quarterly meeting of the Renaissance Quality Committee. F278 - 483.20(g)-(j) Assessment Accuracy/ Coordination/Certified The Sibley Memorial Hospital SNF maintains accurate assessments of resident status for application into the MDS. The SNF was cited in the most recent survey based on the facility failing to accurately code residents for an allergy, a fall, and a surgical wound into the MDS. The following plan of correction addresses these problems.	7/27/2010

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F 278	Continued From page 4 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 record review and staff interview for three (3) for 11 sampled residents, it was determined that facility staff failed to accurately code the Minimum Data Sets (MDS) for one (1) resident with an allergy, for one (1) resident for falls and one (1) resident for a surgical wound. Residents' #2, 9 and 10. The findings include: 1. Facility staff failed to code Resident #2 for allergies on the admission MDS. A review of the History and Physical for Resident #2 signed and dated by the physician on May 19, 2010, revealed, " Allergies: Sulfa " .	F 278	Findings for Residents #2, #9, and #10: 1. Facility failed to code the MDS for resident that sustained a fall, a resident with a surgical wound, and a resident with an allergy to sulfa. There are no further corrections as these residents have been discharged to home. 2. All other residents having the potential to be affected by the same deficiencies will be identified upon admission or through incident reports. 3. The following systemic changes will be implemented to ensure the deficient practice will not recur: • The MDS coordinator and his/her designee will be notified and thoroughly review all assessments and clinical documents to ensure accurate coding of wounds, allergies, and falls on the MDS. • In-service education was given to re-educate staff on the importance of accurate assessment of the residents and clinical documentation. • The DON, Quality Nurse, and/or charge nurses will work in collaboration with MDS coordinators to ensure all occurrences are communicated to assist with accurate resident assessments. 4. The quality assurance process will be utilized to monitor and sustain compliance. The findings will be presented at the quarterly meeting of the Renaissance Quality Committee.	6/5/2010 & 6/11/2010 7/19/2010 7/19/2010 7/2/2010 7/19/2010 7/27/2010

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F 278	Continued From page 5 The Medication Reconciliation form [from transferring hospital] dated May 1, 2010 listed Sulfonamides as an allergy. A review of Medication Administration Record (MAR) dated June 2, 2010 revealed, " Allergies: no known allergies " . A review of the admission MDS completed May 18, 2010, Section I [Disease Diagnoses] " Diseases: Allergies" was not checked to indicate that Resident #2 had allergies. There was no documented evidence that facility staff coded the admission MDS for allergies. A face-to-face interview was conducted on June 4, 2010 at approximate 2:25 PM with Employee #5. He/she acknowledged that the admission MDS was not coded for allergies. The record was reviewed on June 4, 2010. 2. Facility staff failed to accurately code Resident #9's Minimum Data Set [MDS] for a fall. A review of the clinical record for Resident #9 revealed that the admission MDS with a completion date of May 27, 2010 was coded with a zero in Section J4 [accidents]. Section J4a indicates that the resident fell in past 30 days. Section J4b indicates that the resident fell in past 31-180 days. The review of J4a and J4b revealed that both sections were coded with a zero indicating that the resident had no fall. Review of documentation in the nurses' notes and the Unusual Occurrence Report dated May 19, 2010 both revealed that the resident sustained an assisted fall that was without injury on the	F 278		

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F 278	Continued From page 6 aforementioned date. A face-to-face interview was conducted with Employee #5 at approximately 10:45AM on June 4, 2010. He/she reviewed the record and acknowledged that the resident's MDS was not coded for the fall which he/she suffered on May 19, 2010. The record was reviewed on June 3, 2010. 3. Facility staff inaccurately coded Resident #10 for having a surgical wound. A review of the admissions MDS (Minimum Data Set) signed May 24, 2010 revealed that Resident #10 was coded In Section M (Skin Condition) M four (4) and five (5) as having a surgical wound and or surgical wound care In the last seven (7) days after the Assessment Reference Date (last date for observation) of May 15, 2010. A review of the History and Physical dated and signed May 11, 2010 revealed no evidence that the resident had a surgical wound in the last seven (7) days. A face-to-face interview was conducted on June 4, 2010 at approximately 10:00 AM with Employee #15 and Resident # 10. After review of the resident, he/she acknowledged that Resident #10 did not have any surgical wounds in the last seven (7) days. A face-to-face interview was conducted with Employee #5 on June 4, 2010 at approximately 10:00 AM. After review of the admissions MDS record he/she did not identify that the resident had a surgical wound in the last seven (7) days.	F 278		

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F 278	Continued From page 7 Facility staff inaccurately coded Resident #10 for having a surgical wound in the last seven (7) days. The record was reviewed on June 4, 2010.	F 278		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP 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 under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for two (2) of 11 sampled residents, it was determined that facility staff failed to develop a care plan with appropriate goals and approaches for one (1) resident for the care and use of an abductor brace and one (1) resident for the care use of a swath and sling for a Left humerus fracture. Residents' #7 and 10.	F 279	F279 - 483.20(d), 483.20(k)(1) Develop Comprehensive care Plans Comprehensive care plans are developed for all Renaissance SNF residents. During the most recent survey, two of eleven sampled residents did not have a satisfactory care plan. The following plan of correction addresses this important issue: Findings for Residents #7 and #10 1. Facility staff failed to initiate a satisfactory plan of care with objectives, goals, and approaches to address residents with bracing and support devices. Although we recognize this failure, no further corrections are needed as those specific residents have been discharged home in good health. 2. All other resident care plans will be reviewed and updated as indicated to reflect usage of bracing and support devices. 3. The following systemic changes will be implemented to prevent the same deficient practice will not recur: • Care plan was developed and implemented to identify goals, approaches, and interventions to ensure compliance with residents utilizing braces and support devices (abductor brace/ swath/sling) • The Interdisciplinary Care Team will review the care plans/problem lists at meetings to monitor compliance and update as needed. • Nursing staff will be in-serviced and instructed on the importance of care of residents utilizing brace and support devices. • The MDS Coordinator will in-service staff on how to individualize the care plans. • A Quality Assurance tool will be developed to randomly monitor ten care plans for compliance related to bracing/support devices. 4. The quality assurance process will be utilized to monitor and sustain compliance. The findings will be presented at the quarterly meeting of the Renaissance Quality Committee.	6/11/2010 & 6/18/2010 7/19/2010 6/28/2010 7/19/2010 7/19/2010 7/19/2010 7/19/2010 7/27/2010

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F 279	Continued From page 8 The findings include: 1. Facility staff failed to develop a care plan with appropriate goals and approaches for use and care of a left hip abductor brace for Resident #7. A review of the " Physician Order Sheet (POS) signed and dated on May 21, 2010 at 1600, revealed the following orders Abduction brace 0-80 degrees flexion, no active abduction. " A review of care plans that were last updated on May 21, 2010 revealed that there was no problem identified and no care plan developed with appropriate goals and approaches for the care and use of an abductor brace for left hip. A face-to-face interview was conducted with Employee #3 on June 3, 2010 at approximately 10:50 AM. After review of the care plans he/she acknowledged that the record lacked a care plan for the use and care of a left hip abductor brace for Resident #7. Facility staff failed to develop a care plan for the care and use of a left hip abductor brace for Resident #7. The record was reviewed on June 3, 2010. 2. Facility staff failed to develop a care plan for the use and care of a swath and sling for Resident #10 with a left humerus fracture. Review of the " Physician Order Sheet (POS) dated and signed May 20, 2010 0830, PT/OT (physical therapy/occupational therapy, revealed " I. NWB (non weight bearing) left upper extremity. May remove sling for active/active assisted ROM (range of motion) elbow and hand.	F 279		

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F 279	Continued From page 9 No shoulder ROM, 2. WBAT (weight bearing as tolerated) left LE (lower extremities) " A review of the care plans that were last updated on May 11, 2010 revealed that there was no problem identified and no care plan developed with appropriate goals and approaches for use and care or a swath and sling for Resident #10 with a left humerus fracture. A face-to-face interview was conducted on June 4, 2010 at approximately 11:30 AM with Employee #2. After review of the care plans he/she acknowledged that the care plans lacked evidence of goals and approaches for the use of and care of a swath and sling for Resident #10 with a left humerus fracture. Facility staff failed to develop a care plan for the use and care of a swath and sling for Resident #10 with a left humerus fracture. The record was reviewed on June 4, 2010.	F 279		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview for two (2) of 11 sampled residents, it was determined that facility staff failed to follow	F 309	<u>F309 – 483.25 Provide Care/Services for Highest Well Being</u> The Sibley Memorial Hospital SNF provides services that meet professional standards of quality. During the most recent survey, a number of problems were identified and cited in this report. The following plan of correction addresses these items: <u>Finding for Resident #2:</u> 1. Clinical documentation identifying sulfa as an allergy was placed into pharmacy notification system to print on all electronic medication administration records. This resident has been discharged to home. It has been reinforced with staff that all residents will have the specific allergy identified upon admission and information documented into the electronic MAR. Allergies of other residents on the unit are documented into the MAR. 2. Other residents having the potential to be affected by the same deficient practice will be identified upon admission through the monitoring of physician H&Ps, admission documents from previously facility, family, and/or resident reporting.	6/5/2010 7/19/2010

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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 309	Continued From page 10 the physicians order for application of embolic stockings for one (1) resident, and failed to ensure that medication was administered in accordance with physicians orders for one (1) resident, failed to enter an allergy to "Sulfa" into the electronic Medication Administration Records system for one (1) resident. Residents' #2, 7 and 8. The findings include: 1. Facility staff failed to enter Resident #2's allergy to "Sulfa" into the electronic Medication Administration Records system. A review of the History and Physical for Resident #2 signed and dated May 19, 2010, revealed, " Allergies: Sulfa " . According to the Medication Reconciliation form dated May 1, 2010 from [transferring Hospital] lists Sulfonamides as an allergy. The Physician Admitting Orders dated May 5, 2010 and signed by the physician on May 11, 2010, revealed that " Allergies " was checked, however no allergies were listed. A review of Medication Administration Record (MAR) dated June 2, 2010 revealed, " Allergies: no known allergies " . There was no documented evidence that facility staff entered the allergy to Sulfa/ Sulfonamides into the electronic medical records system to print on the MAR(s). A face-to-face interview was conducted on June 3, 2010 at 10:30 AM with Employee #11. He/she	F 309	3. The following systemic changes will be implemented to ensure the deficient practice does not recur: • The nurse will review the transferring facility MAR upon admission for allergy information and if applicable. • The Quality Nurse/DON will re-inservice staff of the importance of identifying resident allergies and documentation to decrease the incidence of an adverse drug reaction (ADR). • The nurse will review the H&P for allergies upon admission. • The Quality Nurse will check for presence of allergies of all residents admitted to the unit while performing daily chart reviews of previous day admissions. • The MDS Coordinator will educate the nursing staff of the changes to the problem list and care plan for allergy recognition. • Twenty-four hour charts will be utilized to ensure allergies are verified and documented into the pharmacy system. • The secretarial associates will check transferring facility documentation for presence of allergies and to ensure physician order sheets and label charts are documented accordingly. • The admitting nurse will ask the resident/family member status of allergies and place into computer system immediately, if applicable. 4. The quality assurance process will be utilized to monitor and sustain compliance. The findings will be presented at the quarterly meeting of the Renaissance Quality Committee. Finding for Resident #7 1. The resident was present at the time of the survey. The ted hose were placed on the resident. There are no further corrections as the resident has been discharged to home without complications. 2. Other residents having the potential to be affected by the same deficient practice will be identified upon admission and subsequent physician orders. 3. The following systemic changes will be put in place to ensure the deficient practice will not recur: • The nursing staff will review physician orders to ensure orders for ted hose are placed into	7/19/2010 7/27/2010 6/18/2010 7/19/2010 7/19/2010

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	095030	A. BUILDING _____ B. WING _____	06/04/2010

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F 309	Continued From page 11 stated, " The allergies where not documented on the MAR. Nursing did not check the allergy on the Allergy Assessment, dated May 6, 2010. That would inform pharmacy to enter the allergy into the computer system. " The record was reviewed on June 4, 2010. 2. Facility staff failed to follow physician ' s orders for the application of bilateral knee high ted stockings for Resident #7. According to the History and Physical dated May 21, 2010 identified Resident #7 with a diagnosis of "S/P L (left) hip hemiarthroplasty repair of greater troch (trochanter). A review of the Physician Order Sheet (POS) dated and signed May 25, 2010 at 1610, revealed bilateral knee high ted stockings - replace QAM (every morning) remove QHS (every day at bedtime). During an observation and interview with Resident #7 and Employee # 3. It was observed that Resident #7 did not have on his/her bilateral knee high ted stockings, and had on bilateral blue colored ankle socks. A face-to-face interview was conducted on June 3, 2010 at approximately 11:54 AM with Employee #3. After review of the physician order sheet and the observation of the resident he/she acknowledged that the bilateral knee high ted stockings should have been on. Employee #3 removed the stockings from the bedside table and place them on Resident #7. Facility staff failed to follow physician orders for the application of bilateral knee high ted stockings	F 309	the QCPR system and obtained from Med Supply. • The Quality/Charge Nurses will randomly assess placement of ted hose upon daily rounds, surgeon specific. • The nursing assistants will report to the resident nurse if the resident refuses placement of ted hose. The charge nurse will document in the clinical record and notify the attending physician. 4. The quality assurance process will be utilized to monitor and sustain compliance. The findings will be presented at the quarterly meeting of the Renaissance Quality Committee. Finding for Resident #8 1. The resident was on the unit at the time of the survey. The medication Plendil had been discontinued. There are no further corrections as the resident has been discharged to home, chart reviews were completed, and all medications were being administered per physician orders. 2. Other residents with the potential to be affected by the same deficient practice will be identified upon admission and ongoing physician orders. 3. The following systemic changes will be put in place to ensure the deficient practice will not recur: • The nurse will review physician orders and ensure they are placed in the MAR system. • Nursing staff will review orders each shift to monitor and to ensure POM physician orders have been carried out for administration to the resident. • Nurse will work in collaboration with the family, physician, and pharmacists for resolution of POM orders. • The nurse will document the status of POM and conversations into the clinical record. • The 24° chart check will be utilized to monitor physician orders have been carried out and transcribed correctly for medication administration. 4. The quality assurance process will be utilized to monitor and sustain compliance. The findings will be presented at the quarterly meeting of the Renaissance Quality Committee.	7/27/2010 5/17/2010 7/19/2010 7/19/2010 7/27/2010

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F 309	Continued From page 12 for Resident #7. The record review and observation was made on June 3, 2010. 3. Facility staff failed to administer Plendil [an antihypertensive medication] to Resident #8 in accordance with physician ' s orders. According to the history and physical examination signed and dated May 10, 2010, Resident #8 ' s diagnoses included [hypertension] and history of CVA [cerebral vascular accident]. Physician ' s orders dated May 10, 2010 directed the administration of the following [hypertension] medications: Plendil 10mg daily, Lisinopril 40mg daily, and Toprol XL 50mg daily. A review of the Medication Administration Record revealed Plendil was not administered May 11-18, 2010. A review of the " Chart Review Trend Report " for May revealed resident ' s blood pressures ranged from 112/68 to 152/73. A face-to- face interview was conducted with Employees # 12, 13, and 14 on June 4, 2010 at 11:55 AM. All acknowledged that Plendil was not administered according to physician ' s order. The clinical record was reviewed on June 4, 2010.	F 309		
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food	F 371	F371 - 483.35(i) Food Procure, Store/Prepare/Serve-Sanitary Sibley Memorial Hospital's Renaissance SNF stores, prepares, distributes, and serves food under sanitary conditions. During the survey, a few deficiencies were identified that have been cited in this report. The following plan of correction addresses the deficiencies: 1. The following plan of correction addresses the deficiencies so they will not adversely impact residents: • Finding 1: All food identified in the citation was discarded. • Finding 2: All supplements identified in the citation with expired dates were removed from the supplement shelf.	6/3/2010

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F 371	Continued From page 13 under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations that were made during tours of the dietary services on June 2 and 3, 2010, it was determined that the facility failed to prepare and serve food under sanitary conditions as evidenced by: 12 of 18 loaves and packs of bread that were stored beyond their expiration date, two (2) of two (2) cases of expired nutritional supplement, six (6) of six (6) sandwiches, a pan of mixed vegetables and a bag of pepperoni slices that were neither dated nor labeled, and 10 of 21 four-inch shotgun pans that were soiled. The findings include: 1. Seven (7) of seven (7) packs of French bread were expired as of May 30, two (2) of two (2) loaves of rye bread were expired as of May 31, two (2) of six (6) packs of Kaiser rolls were expired as of May 31 and one (1) of three (3) packs of hamburger rolls was expired as of June 1. 2. 48 of 48 eight ounce cans of Glucerna nutritional supplement (strawberry) were stored in the dry goods storage area beyond their expiration date of May 2010. 3. Six (6) of six (6) sandwich packs, a pan of mixed vegetables and a bag of pepperoni slices were stored unlabeled in the reach-in refrigerator.	F 371	• Finding 3: Unlabeled food items identified in the citation in the reach-in refrigerator were labeled and dated. • Finding 4: The interior and exterior surfaces of all four-inch shotgun pans identified in the citation were cleaned. 2. All other areas affected by the deficient practices were corrected as follows: • Finding 1: All products were inspected to ensure that food beyond its expiration date was found and discarded. • Finding 2: All supplements were inspected to ensure that products beyond expiration date were removed from the shelf. • Finding 3: All reach-in refrigerators were inspected to ensure that all food items was labeled properly and dated. • Finding 4: All pots and pans were inspected and cleaned as needed. 3. The following system measures will be put in place to ensure the deficient practices do not recur and staff trained on the following: • Finding 1: ° The storeroom clerk will be retrained to rotate and check dates daily on all bread products to ensure all items are not past expiration date. ° Management will complete rounds and check items for expired dates to ensure compliance. • Finding 2: ° The storeroom clerk will be re-trained to rotate and check for expired dates on all supplement products weekly to ensure compliance. ° Management will complete rounds and check items for expired dates to ensure compliance. • Finding 3: ° Cooks and prep personnel will be retrained on the proper way to label and date food items stored in the reach-in refrigerators. ° Management will complete daily spot checks and monthly audits to ensure compliance with label and dating of food items. • Finding 4: ° Staff will be in-serviced and trained on the proper way to wash pans.	6/4/2010 6/7/2010 6/7/2010 6/30/2010 6/30/2010

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F 371	Continued From page 14 4. 10 of 21 four-inch shotgun pans stored in the clean pans area were soiled with food residue. These observations were made in the presence of Employees # 4 and #9 who acknowledged these findings during the survey.	F 371	° Nutrition Services will complete a monthly audit on pans to ensure that the procedure is being followed. 4. The quality assurance process will be utilized to monitor and sustain compliance. The findings will be presented at the quarterly meeting of the Renaissance Quality Committee.	7/27/2010
F 386 SS=D	483.40(b) PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 11 sampled records, it was determined that the physician failed to review the total plan of care for Resident #8. The findings include: A review of physician ' s orders signed May 10, 2010 directed for the administration of Plendil 10mg [by mouth] daily for [hypertension]. According to the Physician Rounds Reports signed and dated May 13, 14, 16, 17, and 18 revealed under current medications, " Felodipine [Plendil] 10 mg tab oral daily for hypertension pending verification by pharmacy'.	F 386	F386 – 483.40(b) Physician visits – Review Care/Notes/Orders Sibley Memorial Hospital Renaissance SNF physicians provide services that meet professional standards of quality. During the most recent survey, a problem was identified that has been cited in this report. The following plan of correction addresses this problem. Findings for Resident #8 1. There are no further corrections for resident #8 as the resident has been discharged from the unit and medication has been discontinued. 2. Other residents having the potential to be affected by the same deficient practice will be identified when the prescriber orders non-formulary medications. 3. The following systemic changes will be implemented to ensure the deficient practices does not recur: • The pharmacist will notify the physician and the nursing staff whether a specific medication is non-formulary. • The physician will give an order to change the medication to one that is in the formulary or have patient own medication (POM) requested for medication administration. • The physician will review resident total plan of care to ensure the resident is receiving the medication as prescribed. • The electronic MAR will be reviewed upon every visit to ensure medication administration is being administered as written. 4. The quality assurance process will be utilized to monitor and sustain compliance. The findings will be presented at the quarterly meeting of the Renaissance Quality Committee.	5/17/2010 7/19/2010 7/19/2010 7/27/2010

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F 386	Continued From page 15 A review of the " Physician Rounds " Reports dated May 13, 14, 16, 17 and 18, 2010 lacked evidence that the physician address the pharmacy' s documentation indicating that Plendil 10 mg was pending verification by pharmacy. According to the Medication Administration Record generated May 11, 2010 revealed, " Plendil 10mg by mouth daily for [hypertension] ... Non-formulary ...ask [patient] to bring own [POM]. A Physician ' s Order Sheets dated May 18, 2010 directed, " [Discontinue Plendil 10mg). A second Physician ' s Order Sheet dated May 27, 2010 directed, " [Discontinue Plendil - not taking not available]. A face-to-face interview was conducted with Employees #2 and 17 on May 4, 2010 2009 at 11:30 AM. He/she acknowledged that the physician failed to address the pending verification of the medication by pharmacy prior to May 18, 2010 when the medication was discontinued..	F 386		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and	F 425	F425 – 483.60(a), (b) Pharmaceutical SVC – Accurate Procedures, RPH Sibley Memorial Hospital Renaissance SNF provides routine and emergency drugs, biologicals and pharmaceutical services to meet the needs of all residents. Licensed pharmacists are employed to provide consultation on all aspects of the provision of pharmacy services in the facility. During the survey, it was determined that pharmacy failed to contact the prescriber regarding the non-formulary status of Plendil for Resident #8 and failed to follow-up on a pending verification of the medication for eight days. The following plan of correction addresses the deficiencies that were identified: Finding for Resident #8: 1. The resident has been discharged. No further corrective action is applicable.	5/17/2010

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F 425	Continued From page 16 administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 11 sampled residents, it was determined that pharmacy failed to follow-up on a pending verification for Plendil for eight (8) days for Resident #8. The findings include: According to " Hospital Policy" - Procedures and Responsibilities: Non-Formulary Requests: When an order is received for a non-formulary medication, the pharmacist contacts the prescriber to inform him/her of the non-formulary status and to recommend a therapeutic alternative. " According to the Physician ' s admission orders dated and signed May 10, 2010, directed Plendil 10mg daily for hypertension. According to the Medication Administration Record generated May 11, 2010, revealed "Plendil .... (Non-formulary) ask [patient] to bring own [patient own medicine]". Pharmacy ' s medication profile dated and timed	F 425	2. Other residents having the potential to be affected by the same deficient practice will be identified by prescriber order(s) for non-formulary medications. Pharmacists will be required to document electronically resolution of non-formulary medication issues. 3. The following systemic changes will be implemented to ensure the deficient practice does not recur: • Pharmacist education on the process for handling non-formulary medication which includes contacting the prescriber and a competency assessment to validate knowledge and understanding. • Pharmacist education on the process for handling patient home medications for administration during hospitalization. • Addition of "medications pending verification" to hand-off communication between pharmacists for follow-up and resolution. • Electronic documentation of non-formulary medication status and resolution. 4. Performance will be monitored by regular review of the electronic documentation and audits as appropriate. Results will be reported at the quarterly meeting of the Renaissance Quality Committee.	7/19/2010 7/19/2010 7/27/2010

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F 425	Continued From page 17 May 10, 2010 revealed, " New order for felodipine [Plendil] (patient's own medication). " According to the Physician Rounds Report for May 11-18, 2010 revealed, current [medications] Felodipine [Plendil] POM [Patient Own Medicine] - 10mg tablet oral daily at default 1000 Pending verification by pharmacy [hypertension]. A face-to-face interview was conducted with Employee #16 on June 4, 2010 at approximately 12:00 Noon. He/she acknowledged that the pharmacist did not contact the physician. The clinical record was reviewed on June 4, 2010.	F 425		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a	F 441	<u>F441 – 483.65 Infection Control, Prevent Spread, Linens</u> Sibley Memorial Hospital Renaissance SNF provides service that meet professional standards for infection control. During the most recent survey, two problem areas were identified that have been cited in this report. The following plan of correction addresses the problem. <u>Finding 1:</u> 1. There are no further corrective actions for Resident #9 as this resident has been discharged to home. The nurse administering the medication was counseled and provided with additional training on hand hygiene and proper disposal of medications. 2. All other residents who are observed placing medication on an unclean surface or having dropped the medication on the floor will have the medication discarded and an explanation for the wastage will be provided to the resident. 3. The following systemic changes have been put in place to ensure the deficient practice does not recur: • Staff was re-educated on the importance of hand hygiene when providing medication administration. • Staff will be educated on how to explain to the resident the reason a medication has to be discarded and that they will not be charged for the wastage. • The hand hygiene infection control policy will be placed in the mail box of each staff member	6/5/2010 7/19/2010 7/2/2010 7/19/2010 7/19/2010

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F 441	Continued From page 18 communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview during the survey, it was determined that proper infection control practices were not followed during medication administration for one (1) resident and facility staff failed to control and prevent the spread of infection as evidence by two (2) of two (2) ice machines soiled with mineral deposits. Resident #9. The findings include: 1. On June 2, 2010, at approximately 9:45 AM it was observed that Resident #9 spilled his/her pills onto over-the-bed table. Employee #18 then placed a tissue on the over-the-bed table and picked the pills up with his/her bare hand and placed them on the tissue. Resident #9 took the pills from the tissue and placed them in his/her mouth. A face-to-face interview was conducted on June 2, 2010, at approximately 10:15AM with	F 441	• An in-service will be given to stress the importance of ensuring resident bedside tables are clean when utilized to assist with medication administration. • The Charge Nurse/Quality Nurse will do random observations during medication pass to monitor compliance. 4. The quality assurance process will be utilized to monitor and sustain compliance. The findings will be presented at the quarterly meeting of the Renaissance Quality Committee. Finding 2: 1. Ice machines were wiped down with a germicidal solution as part of the daily 7 Step cleaning method. Heavy hard mineral deposit build-up is to be cleaned as a project when requested. 2. Ice machines with white mineral deposits must be treated with a "de-scaler" to break down the minerals to be followed-up by a cleaning with a germicidal cleaner. 3. The following systemic changes have been put in place to ensure the deficient practice does not recur: • EVS associates will be retrained to report the condition of the machines when daily sanitizing is not adequate for project cleaning to occur. • EVS management will monitor ice machines for mineral buildup when conducting inspections. 4. The quality assurance process will be utilized to monitor and sustain compliance. The findings will be presented at the quarterly meeting of the Renaissance Quality Committee.	7/19/2010 7/27/2010 6/4/2010 7/6/2010 7/19/2010 ONGOING 7/27/2010

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F 441	Continued From page 19 Employee #2 regarding the observation as cited above by Employee #18. He/she acknowledged that Employee #18 should not have administered the pills to the resident after picking them up with his/her bare hand. 2. Facility staff failed to control and prevent the spread of infection as evidence by two (2) of two (2) ice machines soiled with mineral deposits. During the environmental tours on June 2 and 3, 2010 the ice machines on 3 north and 3 south were noted to be soiled with mineral deposits. These observations were made in the presence of Employees # 4 and #9 who acknowledged these findings during the survey.	F 441		
F 469 SS=D	483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM 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 survey period, it was determined that the facility failed to maintain an effective pest control program as evidenced by flying insect observed on two (2) of two (2) nursing units and in the main kitchen. The findings include: Flying insects were observed in the following areas:	F 469	<u>F469 – 483.70(h)(4) Maintains Effective Pest Control Program</u> Sibley Memorial Hospital Renaissance SNF maintains an effective pest control program so the facility is free of pests and rodents. During the most recent survey, flying insects were observed in Room #320, Unit 3 North, and in the kitchen resulting in a citation in the report. The following plan of correction addresses the deficiencies. 1. The Renaissance SNF has a contract for pest control and a weekly service technician responds to service issues. — 6/2/2010 2. A monitor to attract flying insects was installed in both the north and sound common areas but was removed without EVS approval. A monitor was ordered and will be reinstalled to provide additional pest control for flying insects. — 6/24/2010 & 7/15/2010 3. The following systemic changes have been put in place to ensure the deficient practice does not recur: • EVS will educate Patient Care Services staff on the purpose of the electric capture device on each unit and will instruct staff that the devices are not to be removed. — 7/19/2010 • EVS team managers will monitor rooms, units, and kitchen for flying insects when conducting inspections in the area. — ONGOING	

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	095030	A. BUILDING _____ B. WING _____	06/04/2010

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F 469	Continued From page 20 June 2, 2010 in room # 320 south. June 3, 2010 on unit 3 north. June 3 2010 in the kitchen. These observations were made in the presence of Employee # 4 who was present at the time of the observation.	F 469	• EVS team managers will monitor that the electric capture devices remain in place. 4. The quality assurance process will be utilized to monitor and sustain compliance. The findings will be presented at the quarterly meeting of the Renaissance Quality Committee.	ONGOING 7/27/2010
F 492 SS=D	483.75(b) COMPLY WITH FEDERAL/STATE/LOCAL LAWS/PROF STD 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 observations made during the lunch time meal on June 2, 2010, it was determined that the facility failed to maintain cold food temperature to less than 45 degrees Fahrenheit (F), at the point of delivery. The findings include: According to 22 DCMR 3220.2, "The temperature for cold foods shall not exceed forty-five (45 degrees) and for hot foods shall be above one hundred and forty (140 (degrees)) Fahrenheit at the point of delivery to the resident." On June 2, 2010 during the lunch time meal, the milk served on the test tray was measured at 48 degrees F.	F 492	<u>F492 – 483.75(b) Comply with Federal/State/ Local/Prof Std</u> Sibley Memorial Hospital Renaissance SNF complies 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. During the most recent survey, the holding temperature for cold foods was not maintained. The following plan of correction addresses the deficiency. 1. No specific residents were identified in the survey report as being affected by the deficient practice. 2. Dairy products will be kept in a cooler and/or iced down before tray line service to ensure proper temperatures are kept below 45 degrees. 3. The following systemic changes have been put in place to ensure the deficient practice does not recur: • Staff will measure temperatures of the holding units daily to document that temperatures are kept below 45 degrees. • Test trays will be tested weekly to ensure that test tray milk products are maintained at temperatures below 45 degrees. 4. The quality assurance process will be utilized to monitor and sustain compliance. The findings will be presented at the quarterly meeting of the Renaissance Quality Committee.	6/2/2010 7/19/2010 7/19/2010 7/27/2010

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F 492	Continued From page 21 These observations were made in the presence of Employee # 9 who acknowledged the findings.	F 492		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE 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) of 11 sampled residents, it was determined that facility staff failed to enter an allergy to "Sulfa" into the electronic Medication Administration Record (MAR) system and document complete neurological assessments at the time of a fall for Resident #2. The findings include: 1. Facility staff failed to enter Resident #2's allergy to "Sulfa" into the electronic Medication Administration Records system. A review of the History and Physical for Resident #2 signed and dated May 19, 2010, revealed, " Allergies: Sulfa " .	F 514	F514 – 483.75 (l)(1) Res Records – Complete/ Accurate/Accessible Sibley Memorial Hospital's Renaissance SNF provides services that meet professional standards of quality. During the survey, a few deficiencies were identified that have been cited in this report. The following plan of correction addresses these areas. Findings (allergies) for Resident #2 1. Clinical documentation identifying sulfa as an allergy was placed into a pharmacy notification system to print on all electronic medication administration records. This resident has been discharged to home. It has been reinforced with staff that all residents will have the specific allergy identified upon admission and information documented into the electronic MAR. Allergies of other residents on the unit are documented into the MAR. 2. Other residents having the potential to be affected by the same deficient practice will be identified upon admission through the monitoring of physician H&Ps, admission documents from previous facility, family, and/or resident reporting. 3. The following systemic changes will be implemented to ensure the deficient practice does not recur: • The nurse will review the transferring facility MAR upon admission for allergy information and if applicable. • The Quality Nurse/DON will re-inservice staff of the importance of identifying resident allergies and documentation to decrease the incidence of an adverse drug reaction (ADR). • The nurse will review the H&P for allergies upon admission. • The Quality Nurse will check for presence of allergies of all residents admitted to the unit while performing daily chart reviews of previous day admissions. • The MDS Coordinator will educate the nursing staff of the changes to the problem list and care plan for allergy recognition. • Twenty-four hour charts will be utilized to ensure allergies are verified and documented into the pharmacy system.	6/5/2010 7/19/2010 7/19/2010

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F 514	Continued From page 22 The Medication Reconciliation form dated May 1, 2010 from [transferring Hospital] listed Sulfonamides as an allergy. The Physician Admitting Orders dated May 5, 2010 and signed by the physician on May 11, 2010, revealed that " Allergies " were checked, however no allergies were listed. A review of Medication Administration Record (MAR) dated June 2, 2010 revealed, " Allergies: no known allergies " . There was no documented evidence that facility staff entered the allergy to Sulfa/ Sulfonamides into the electronic medical records system to print on the MAR(s). A face-to-face interview was conducted on June 3, 2010 at 10:30 AM with Employee #11. He/she stated, " The allergies where not documented on the MAR. Nursing did not check the allergy on the Allergy Assessment, dated May 6, 2010. That would inform pharmacy to enter the allergy into the computer system." The record was reviewed on June 4, 2010. 2. Facility staff failed to document complete neurological assessments for Resident #2 at the time of the fall on May 31, 2010. A written statement from the primary nurse dated June 1, 2010 indicated that the Resident #2 fell on May 31, 2010 at 1930 [7:30 PM]. The "[Facility] Progress Record" dated May 31, 2010 at 11:30 PM [2330] written by the physician revealed, " Surgical Critical Care- ...pt fell	F 514	• The secretarial associates will check transferring facility documentation for presence of allergies and to ensure physician order sheets and label charts are documented accordingly. • The admitting nurse will ask the resident/family member status of allergies and place into the computer system immediately, if applicable. 4. The quality assurance process will be utilized to monitor and sustain compliance. The findings will be presented at the quarterly meeting of the Renaissance Quality Committee. Findings (neurological) for Resident #2 1. There are no further corrections as Resident #2 was discharged back to home. The nurse was counseled and will be provided additional training on the importance of neurological checks on any resident sustaining a head injury. 2. Other residents having the potential to be affected by the same deficient practice will be identified at the time of the injury for immediate assessment and implementation of twenty-four hour neurological checks. 3. The following systemic changes will be implemented to ensure the deficient practice will not recur: • The Unit Educator/Quality Nurse will re-educate staff on the importance of documenting in the appropriate section to ensure a complete neurological assessment and neurological check are being documented in the clinical record. • The nurse was counseled as she did not follow protocol to ensure there was stability of the resident's neurological status. • The unit educator and Quality Nurse will develop and implement a neurological checklist and educate the nursing staff on its usage. • Education will be done to teach staff that all unusual occurrences are to be entered into QCPR and Peminic immediately, not at the end of the shift. • The Quality Nurse will re-inservice staff on the importance of documenting into the clinical record all aspects of the occurrence, resident status (including neurochecks), and family/physician notification.	7/27/2010 6/5/2010 7/19/2010 7/19/2010 6/4/2010 7/19/2010 7/19/2010 7/19/2010

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F 514	Continued From page 23 backwards while attempting to ambulate and hit [his/her] head on wall. No LOC [loss of consciousness]. Recalls events and no complaints ...Head: Abrasion times 2 occiput...A/P [assessment/plan]: s/p (Status post) fall with minor abrasion to Occiput. No need for imaging at present time. If change in ms (mental status), consider CT [scan] but doubt intracranial injury due to low impact. " A review of he nursing notes revealed that the primary nurse preformed assessments on Resident #2 at the following times: May 31, 2010 at 2000; May 31, 2010 at 2100; and May 31, 2010 at 2200. "June 1, 2010 at 0520, Fall Assessment ...yes, patient fell, patient alone at time of fall, patient found on the floor. Patient fell in hallway. Patient fell on [his/her] back and hit back of [his/her] head on the bottom of the wall on the guard rails. LOC: alert-awakens/responds appropriately; Orientation: oriented to person, place and time; Pupils: pupils equal round and reactive to light and accommodation of right (R) pupil, R greater that L (left) ...Pulse=88; BP (blood pressure) 149/78 mm/Hg; Resp (respiratory rate)=22; Fall Risk Score: 20 Risk Level ... " The nursing notes revealed that a complete neurological assessment was completed on June 1, 2010 at 0520. Although the nurse documented assessments at the aforementioned times, there was no documented evidence that neurological checks were conducted. A face-to-face interview was conducted with on June 4, 2010 with Employee #2. He/she stated, " The nurse worked a 12 hour shift. He/she	F 514	• The nursing staff will give a full, accurate status report to the oncoming shift to ensure the continuity of resident care. 4. The quality assurance process will be utilized to monitor and sustain compliance. The findings will be presented at the quarterly meeting of the Renaissance Quality Committee.	7/19/2010 7/27/2010

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F 514	Continued From page 24 documented the fall at the end of the shift. " Employee #2 acknowledged that the nurse did not document the neurological checks at the time of the fall. The record was reviewed June 4, 2010.	F 514		
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on a review of the Quality Assurance Committee Sign in sheet and staff interview, it was determined that the " designated physician "	F 520	F 520 – 483.75 (o)(1) QAA Committee – Members/ Meet Quarterly/Plans The Sibley Memorial Hospital Renaissance SNF maintains a quality assurance and assessment committee that meets quarterly to identify quality issues and develop plans along with the SNF Medical Director. During the most recent survey, a citation was given due to the Medical Director's attendance at only two of four required meetings. Findings for Medical Director 1. There are no further corrections at this time. The Medical Director was in attendance at the most recent QAA quarterly meeting. — 4/27/2010 2. To prevent future citations, the remaining QAA Meeting dates have been resubmitted to the Medical Director/Secretary. — 6/6/2010 3. The following systemic changes have been implemented to ensure the deficient practices does not recur: • The remaining meetings scheduled for calendar year 2010 (July, September, January 2011) will be attended by the Medical Director or one of his assistant directors to attend for him. — 7/19/2010 • The Medical Director and/or his assistants are to sign in immediately upon entry to the meeting for recognition of his/her presence. — 7/19/2010 • Minutes of QAA meetings will be submitted to the Medical Director if an emergency prevents his/her attendance. — 7/19/2010 • QAA meeting dates for 2011 will be submitted accordingly. — 7/19/2010 4. The quality assurance process will be utilized to monitor and sustain compliance. The findings will be presented at the quarterly meeting of the Renaissance Quality Committee. — 7/27/2010	

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F 520	Continued From page 25 failed to attend meetings of the Quality Assurance Committee at least quarterly. The findings include: The Quality Assurance Committee minutes from July 2009 through April 2010 were reviewed with Employee #2 on June 4, 2010 at approximately 11:25 AM. The meetings were held quarterly. The review revealed that the designated physician was in attendance at the meetings held October 27, 2009 and April 27, 2010. There was no evidence that the designated physician attended the Quality Assurance meetings for July 28, 2009 and January 26, 2010. A face-to-face interview was conducted on June 4, 2010 with the Employee #2 at the time of the review and he/she acknowledged that the designated physician did not attend all of the quarterly meetings.	F 520		