STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095030	A. BUILDING _____ B. WING _____	05/03/2011

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 Quality Indicator Survey was conducted on April 28 through May 3, 2011. The deficiencies are based on observation, record review and resident and staff interview for 34 sampled residents.	F 000		
F 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during	F 156	F156 – 483.10(b)(5) – (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must prominently display in the facility required information related to Medicare and Medicaid Services. During the most recent survey, a problem was cited in this report. The following plan of correction addresses it: 1. No specific residents were identified in this report as being affected by this deficient practice. The deficient practice has been corrected with contact information for Medicare and Medicaid Services placed in display case. — 04/29/2011 2. All residents who have the potential to be affected by the same deficient practice will be identified upon admission. Compliance will be maintained through direct observation by the Director of Nursing (DON) and the Administrator. — 04/29/2011 3. The following systemic changes will be put in place to ensure the deficient practice will not recur: • The DON/Administrator will monitor compliance on an ongoing basis and keep information current. • Staff will be educated on where to direct residents/families as to where Medicare and Medicaid Services information is posted. — 04/29/2011 4. The quality assurance process will be utilized to maintain and sustain compliance. The findings will be presented at the quarterly meeting of the Renaissance Quality Council. — 07/06/2011	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Deborah Elise Miller — TITLE: Administrator — (X6) DATE: 7/20/11

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 156	Continued From page 1 the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must comply with the requirements	F 156		

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F 156	Continued From page 2 specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on observation, staff and residents' interviews during an environmental tour of the facility, it was determined that facility staff failed to prominently display the required information related to Medicaid and Medicare service. The findings include: Facility staff failed to prominently display the required information related to Medicaid and	F 156		

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F 156	Continued From page 3 Medicare services: for example, how to apply for benefits. An environmental tour of the facility was conducted on May 3, 2011 at approximately 10:00 AM with Employee #2. He/she identified the facility's display board and acknowledged that the facility has only one display board for residents, family and the community. The display board was located on the wall across from the day room between the staff lounge and the director of nursing's office. It was determined that facility staff failed to display information related to Medicaid and Medicare services on the only display board in the facility. When queried about non-displayed information related to Medicaid and Medicare services, Employee #2 acknowledged that the required information was not available on the display board. Facility staff failed to prominently display the required information related to Medicaid and Medicare services.	F 156		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team that includes the attending	F 280	**F280 – 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP** Comprehensive care plans are developed for Sibley Memorial Hospital Renaissance Skilled Nursing Facility residents. During the most recent survey, one (1) of 34 sampled residents did not have a satisfactory care plan. The following plan of correction addresses this important issue: **Findings for Resident #324** 1. The resident was not affected by this deficient practice. Care Plan was adjusted and resident discharged to home. 2. Other residents having the potential to be affected by the same deficient practice will be identified upon admission by review of physician orders and care plan implementation	05/13/2011 06/16/2011

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F 280	Continued From page 4 physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 34 sampled residents the facility staff failed to update the Nutritional Status care plan for Resident # 324. The findings include: The Nutritional status care plan dated April 19, 2011 for Resident #324 included the following interventions: "serve 6 small meals daily... " A review of the tray ticket revealed that Resident # 324 receives three (3) meals per day. Physician orders for April 19, 2011 to May 3, 2011 (date record was reviewed) lacked evidence of an order for six (6) small meals per day. There was no evidence that facility staff updated the care plan interventions to reflect that Resident # 324 was to receive three (3) meals per day [as opposed to 6 meals daily].	F 280	3. The following systemic changes will be put in place to ensure the deficient practice does not recur: • The licensed staff will review all physician orders to ensure all care plans have been implemented accordingly. • The MDS Coordinators will re-educate the licensed staff on importance of implementing and revising resident care plans accordingly. • Resident charts will continue to be taken to each care plan meeting and the multidisciplinary team will review, update, and revise care plans along with physician orders. 4. The quality assurance process will be utilized to maintain and sustain compliance. The findings will be presented at the quarterly meeting of the Renaissance Quality Meeting	06/16/2011 05/4/2011 06/13/2011 05/5/2011 07/06/2011

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F 280	Continued From page 5 A face-to-face interview was conducted on May 3, 2011 at approximately 2:00 PM with Employee #7. He/she acknowledged that the care plan was not updated to reflect the number of meals the resident was to receive. The record was reviewed on May 3, 2011.	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on a medication pass observation of one(1) of 34 sampled residents it was determined that facility staff failed to follow accepted standards of clinical practice when administering medications via gastrostomy feeding tube (G-tube). Resident #300. The findings include: A medication observation was conducted on May 3, 2011 at 10:15 AM with Employee #22. He/she failed to check for placement of the feeding tube prior to administering medication via the G-tube. He/she failed to flush the tubing with at least 30 cc's of water prior to and after medication administration; failed to flush with 5 cc's of water after each medication administered, and failed to allow the medication to flow in by gravity by pushing the medication down the G-tube with a plunger for Resident #300. According to the "Lippincott Manual of Nursing Practice Seventh Edition", under "General Procedures and Treatment Modalities for Enteral	F 281	F281 – 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS Sibley Memorial Hospital's Renaissance Skilled Nursing Facility provides 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 the problem. Findings for Resident #300 1. The resident was not affected by the deficient practice. The nurse at the time was immediately stopped and 1:1 inservice by senior charge nurse on how to properly check placement, flush tubing pre and post medication and administer by gravity. Other resident on unit with G-tube was observed to be receiving the feeding and medication administration per protocol. 2. Other residents with the potential to be affected by the same deficient practice were identified and G-tube management protocols and procedures were reviewed and found to be compliant. 3. The following systemic changes will be put in place to ensure the deficient practice does not recur: • The quality nurse and the charge nurse or nurse educator will provide inservice education to nursing staff with return demonstrations. • G-tube protocol posted in nursing conference room for review. • Pocket guide for G-tube protocol given to each nursing staff highlighting method for checking placement/residuals prior to medication administration and/or tube feedings and specific H_20 flush guideline/amounts. • Nursing Educator will do pre/post test followed-up by return demonstrations of G-tube feeding/medication process. • Re-educate staff to utilize the Sibley Intranet for detailed information la, Lippincott. Resource and nursing protocol for tube-feedings.	05/3/2011 05/4/2011 06/16/2011 06/3/2011 06/16/2011 06/24&08/25/2011 06/24&06/26/2011

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F 281	Continued From page 6 Feeding: Procedure Guidelines 20-1 step number seven (7): Using a catheter tip syringe, inject 20 cc-30 cc of air while listening with a stethoscope positioned at the epigastric area (laterally). Rationale: Auscultation of a "whooshing" or bubbling sound assists in confirmation of proper tube placement.; After administering the prescribed amount of formula, (medication) flush tubing with at least 30 cc of water. Rationale: Prevents clogging of feeding tube. In the "performance phase" step two (2): fill catheter tipped syringe with formula (medication) and allow to fluid to flow in by gravity; Rationale: The rate of flow is regulated by raising or lowering the syringe." A face-to-face interview was conducted with Employees #2 and #21 on May 3, 2011 at 2:00 PM. After review of the above, both acknowledged the findings. Employee #2 initiated measures to re-educate Employee #22 regarding G-tube management. Facility staff failed to follow accepted standards of clinical practice when administering medication via a G-tube. The observation was made on May 3, 2011.	F 281	4. The quality assurance process will be utilized to maintain and sustain compliance. The findings will be presented at the quarterly meeting of the Renaissance Quality Meeting	07/06/2011
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323	F 323 - 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible and that each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review, and staff resident interview for two (2) of six (6) sampled rooms inspected for hot water temperatures within acceptable parameters, it was determined that facility staff failed to ensure hot water was not greater than 110 degrees Fahrenheit in rooms 316 and 318. The following plan of correction addresses the deficiencies:	

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F 323	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff and resident interview for two (2) of six (6) sampled rooms inspected for hot water temperatures within acceptable parameters , it was determined that facility staff failed to ensure hot water was not greater than 100 degrees Fahrenheit in rooms 316 and 318. The findings include: Facility staff failed to ensure that hot water temperatures were within acceptable parameters in residents' rooms 316 and 318. During environmental tour of the facility on May 3, 2011, Employee #24, using the facility's thermometer, assessed the hot water temperatures in residents' rooms 306, 315, 316, and 318. The hot water temperature in the room 316 at approximately 12:05 AM was 114 degrees F. at the sink and the shower. The hot water temperature in the room 318 at approximately 11:55 AM, at the sink was 114 degrees F. (Fahrenheit) and 115 degrees F. at the shower. A face-to-face interview was conducted with the resident in room 316 on May 3, 2011 at approximately 4:10 PM. He/she stated that he /she can adjust the water temperature to meet his/her need. He/she denied any concern with the	F 323	Findings for Residents in Room 316 and Room 318 1. No specific residents were identified in this report as being affected by this deficient practice. The water temperature was adjusted in the boiler room, retested in the above stated rooms, and found to be within the acceptable parameters. 2. Water temperatures were monitored in surrounding rooms and again at the source located in the boiler room and found to be within the acceptable parameters 3. Water temperatures are maintained between 95-110 degrees Fahrenheit for the entire building, thus assuring that the entire unit of patient rooms' water temperatures fall within the desired range. The following systemic changes have been put in place to ensure the deficient practice does not occur: • The boiler room is staffed 24-7. Readings are taken during each of the three shifts. Domestic hot water temperatures are being logged during each shift; specified degree ranges from 95-110 degrees are now noted on the log sheet. • Chief Engineer was instructed to perform training to his staff to follow procedure as outlined above for taking temperatures and adjusting them as needed. • When temperatures are logged by the engineer on duty and the value does not fall within the parameters, immediate action will be taken to adjust the temperature into the proper range. • Engineers will note their actions on the daily log sheet. 4. For quality assurance, the Chief Engineer's Monthly Report reviews log sheets and notes problems and actions taken. The findings will be presented at the quarterly meeting of the Renaissance Quality Committee	05/03/2011 05/3/2011 05/3/2011 ONGOING 05/3/2011 ONGOING ONGOING ONGOING 0706/2011

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F 323	Continued From page 8 hot water temperature. A face-to-face Interview was conducted with the responsible party of the resident in room 318 on May 3, 2011 at approximately 4:20 PM. He/she stated that the resident has dementia and that the resident complained that the water was too hot during shower yesterday when he/she [the responsible party] gave the resident shower. A face-to-face interview was conducted with Employee #1 on May 3, 2011 at approximately 5: 25 PM. He/she stated that when facility staff received residents' complaints that the water was too cold, facility staff increase the water temperature in an attempt to meet the resident's need. A review of the daily engineer's log revealed that the hot water temperatures at the boiler level was 126, 120, and 113 degrees on 05/03/2011 at 11PM-7AM, 7AM-3PM, 3PM-11PM respectively. Employee #1 provided the engineer's log. A follow-up face-to-face interview was conducted with Employee #25 [He/she was the employee in charge of supervising and monitoring the facility's water temperature identified and brought in to answer the surveyor's questions by Employee #1] on May 3, 2011 at approximately 6:00 PM. He/she queried regarding the monitoring of the hot water temperatures in the residents' room to ensure that it is within acceptable range. Employee #25 stated that facility staff did not attempt to check individual	F 323		

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F 323	Continued From page 9 resident's room to ensure that the hot water temperature was within acceptable parameter when the hot water temperature at the boiler level was between 113 to 126 degrees on May 5, 2011. He / she further acknowledged that the facility do not have a system in place for monitoring water temperature in residents' room. Employees #1 and #25 both acknowledged that the facility relies on the resident's reports of water temperatures and respond accordingly. A follow-up assessment of the hot water temperature was conducted in the rooms 316 and 318 on May 3, 2011 at approximately 6:28 PM and 6:40 PM. The temperature in room 316 was 110 degrees F. at the sink and 104.6 degrees F. at the shower. The temperature in room 318 at the sink was 110.4 degrees F. and 104.6 degrees F. at the shower. The hot water temperatures were obtained by Employee #26. He/she used the facility's thermometer. Facility staff failed to ensure that hot water temperature in residents' rooms are within acceptable parameters. The record was reviewed on May 3, 2011.	F 323		
F 325 SS=G	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a	F 325	**F325 – 4823.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE** Based on a resident's comprehensive assessment, the facility must ensure that resident (i) maintains acceptable parameters of nutritional status, such as body weight and protein levels unless resident's condition demonstrates this is not possible; and (ii) receives a therapeutic diet when there is a nutritional problem. Findings for Resident #189 1. There are no further corrective actions as the resident has been discharged to the home. 2. Other residents having the potential to be affected by the same deficient practice will be identified through the initial nursing admission assessment, physician orders, weights, nutrition assessments,	01/21/2011 05/4/2011

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F 325	Continued From page 10 nutritional problem. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 34 sampled residents, it was determined that facility staff failed to identify an unplanned 10lbs weight loss within 30 days (from December 8, 2010 to January 12, 2011), a decrease in albumin and total protein laboratory values (from December 29, 2010 to January 10, 2011), and nutritional supplement that was not administered in accordance with physician's orders for Resident # 169 (blanks on the medication record). The findings include: Facility staff failed to follow-up with Resident # 169 with documented unplanned weight loss of 4.73Kg/10 pounds from December 8, 2010 to January 12, 2011. A review of Resident # 169's clinical record revealed the followings: The resident was admitted to the facility on November 30, 2010 and was discharged on January 21, 2011 A physician signed "History and Physical" report dated November 30, 2010. The history and physical report indicated that the resident had an active medical problem of recurrent aspiration peg tube placement. The resident's admission	F 325	review of nursing assistant flow sheets, laboratory values for Albumin/Protein Levels. Other residents on the unit have been assessed for unplanned weight loss and reweighed, if indicated. All residents on the at risk list were reviewed and no other resident was identified as having a significant weight loss. 3. The following systemic changes will be put in place to ensure the deficient practice will not recur: • All weights will continue to be documented into the clinical record upon completion. Weight loss greater than 5 lbs will be reweighed in 48 hours. • Residents will continue to be weighed every Wednesday per current weight policy unless otherwise indicated. • The Dietician will continue to post list of residents in need of weekly weights. • The nursing staff will participate in an inservice on how to ensure accuracy of weights and to review "Monitoring Resident Weights" policy. • The Quality Nurse and her designee will continue the monitoring tool in progress to trace admitting, weekly, and reassessment weights. • The Dietician will notify the Charge Nurse of nutritional recommendations through a supplemental needs tool. • The physician will notify the family of a resident's unplanned weight loss. • Random EMAR audits will be done to monitor that nutritional supplements are given/documented. • Dietician will continue to document calorie count results in the clinical record once completed. • The nurse will identify nutritional needs as part of the admission assessment and document in the clinical record. • The physician will be notified of any resident with a significant weight loss of five (5) lbs since previous weight loss or five percent (5%) weight loss in one month. Albumin levels along with other appropriate lab values will be drawn and all lab results report to the physician. • Inservice on nutritional screening presented to staff. • Current weight policy under review for revision to improve current process.	05/4/2011 05/4/2011 05/4/2011 06/7/2011 05/4/2011 05/4/2011 06/16/2011 06/16/2011 06/16/2011 05/4/2011 05/4/2011 05/24/2011 06/16/2011

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F 325	Continued From page 11 diagnoses was S/P [Status post] Front Parietal Subdural Hematoma evacuation; C5-6 (L) facet fracture. The resident's other past medical history included positive history of Hepatitis A, S/P Appendectomy, Osteoarthritis, and Hyperlipemia. A review of the facility's Chart Review Trend Report for Resident #169 revealed the following weights: Date Weight in Kilograms (kg) Weight in Pounds (lbs.) November 30, 2010 83.36 kg 183 lbs. December 7, 2010 82.73 kg 182 lbs. December 8, 2010 82.73 kg 182 lbs. December 15, 2010 82.72 kg 182 lbs. December 22, 2010 81.09 kg 178 lbs. December 30, 2010 80.00 kg 176 lbs. January 5, 2011 79.09 kg 174 lbs. January 12, 2010 68.00 kg 172 lbs. According to the documentation of weights on the facility's Chart Review Trend Report, the resident had an unplanned 4.73Kg / 10 pound weight lost [6%: a severe weight loss] between December 8, 2010 and January 12, 2011's as follows: 0.55% from first weight to obtained on 11/30/2010 to the weight on 12/15/10. 3.83% from the first weight obtained on 11/30/2010 to the weight obtained on 12/30/10. 6.4% from the first weight obtained on 11/30/2010 to weight obtained on 01/12/2011. A review of the resident's clinical record failed to reveal any documentation that addressed the	F 325	4. The quality assurance process will be utilized to maintain and sustain compliance. The findings will be presented at the quarterly meeting of the Renaissance Quality Meeting	07/06/2011

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F 325	Continued From page 12 resident's unplanned weight loss of 10 pounds as a severe weight loss. On January 10, 2010, the Dietician's nutrition assessment reviewed the resident's weight record. He/she noted: "stable without significant changes." He/she failed to address the resident's progressive unplanned weight loss of 8 pounds when he/she noted weights for December 7, 2010 as 182 pounds and January 5, 2011 as 174 pounds. In his/her intervention, he/she noted "Continue on current diet order." The dietician's nutrition assessment of January 17, 2011 failed to identify the resident's unplanned 10 pounds weight loss as a severe weight loss. The resident's documented unplanned weight loss on January 12, 2011 was not reviewed by the dietician until January 17, 2011. The resident lost 10 pounds between December 8, 2010 and January 12, 2011: a weight loss of 6%. On January 10 and 17, 2011, the dietician's nutrition intervention noted "Continue on current diet order: Jevity 1.6 cans per day with 80ml water flush before and after each bolus, 1 scoop protein powder TID (Three times daily)... Weigh weekly...Encourage and monitor po intake. Recommend initiating 3 day calorie count to determine po intake. " The resident's clinical record lacked documented evidence that facility staff followed-up with the dietician's nutrition intervention to obtain 3-day calorie count to determine po intake. On January 20, 2011 at 1447 (4:47PM), the dietician ' s nutrition consult noted "Attempted to calculate three day calorie count results, only bolus	F 325		

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F 325	Continued From page 13	F 325		

feeding recorded. Scheduled for discharge tomorrow, Friday (1/21 per chart.

In addition the facility's weight policy a resident with a weight loss greater than 5 pounds should be re-weighed within 48 hours. The resident's clinical record lacked documented evidence that the resident was re-weighed after a documented weight loss of 4.73Kg/10 pounds between December 8, 2010 and January 12, 2011.

The dietitian's interventions after the nutrition consult/assessment of January 10, 2011 included weekly weights. There was no evidence in the resident's clinical record that the resident was weighed on January 19, 2011.

A further review of the resident's clinical record revealed the following laboratory results:

Date	Albumin	Total Protein
December 29, 2010	3.0	5
December 31, 2010	PreAlbumin	20.3
January 10, 2011	2.9	5.6

Albumin Reference Range [RG]. 3.5-5.0) GM/DL
PreAlbumin Reference Range 21.0 - 43.0 Unit mg/dL
Total Protein Reference Range 5.9 - 8.1 gm/dl

A further review of the resident's clinical record including the Medication Administration Record [MAR] revealed the followings:
A review of the resident ' s MAR lacked documented evidence that facility staff consistently administered the protein scoop BID (twice daily) as per the dietician's nutritional intervention as evidenced by facility staff 's

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F 325	Continued From page 14 initials across the entry for "1 scoop protein powder via peg tube bid " on the MAR. As evidenced by the absence of facility's staff initials against the entry for " 1 scoop protein powder via peg tube bid", a review of the resident's MAR lacked documented evidence that the " 1 scoop protein powder in 4 ounces of water BID" was administered as per the physician's order of December 30, 2010 at 1650 (4:50 PM) on the following dates: January 1, 2011 at 2000. January 6, 2011 at 2200. January 10, 2011 at 2200 Furthermore, as evidenced by the absence of facility ' s staff initials against the entry for " Jevity 1.5cal 1 can Q4hrs ... " the resident ' s MAR lacked documented evidence that the tube feeding was administered as ordered on: January 7, 2011 at " 0400 " January 9, 2011 at " 0000 and 0400 " January 10, 2011 at " 2200 " A face-to-face interview was conducted with Employee # 3 on May 3, 2011 at approximately 12:55 PM. After a review of the resident' s clinical record including the dietician ' s notes and the MAR, he/she acknowledged the aforementioned findings. The dietician's nutrition consult of January 17, 2011 stated Labs: no recent labs since 1/10/2011. The resident's clinical record lacked documented evidence that facility staff addressed the resident's progressive decrease of	F 325		

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F 325	Continued From page 15 laboratory values for albumin, pre-albumin and total protein between December 29, 2010 and January 10, 2011. A follow-up face-to-face interview was conducted with Employee #27 at approximately 10:00AM on May 3, 2011. He/she stated, "I was not aware of the resident's weight loss until January 17, 2011, and I do not have a record that a re-weigh was assessed. When I returned to follow-up with the resident, I was told he/she was discharged. A face-to-face interview was conducted with Employee #3 on May 3, 2011 at approximately 1:00 PM. When queried about the resident's weight loss of 10 pounds between December 8, 2010 and January 12, 2011, after a review of the resident's clinical record, he/she stated that the only reliable weight record for the facility is what is documented in the computer. Employee #3 stated that per the facility's policy, when a resident presented with a weight loss of 5 pounds or more within a month that the resident must be re-weighed within 48 hours. Employee further added that there's was no documented evidence that a re-weigh assessment was done after the resident presented with a weight loss of 8 pounds between December 7, 2010 and January 5, 2011 and a weight loss 10 pounds between December 8, 2010 and January 12, 2011. When queried regarding the dietician's three day calorie count intervention to determine PO intake, after a review of the resident's clinical record, Employee #3 replied, "It is not in the record. It was not done." A follow-up telephone interview was conducted on May 5, 2011 at approximately 11:00 AM, with Employees # 2 and #5. They both stated that the	F 325		

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F 325	Continued From page 16 built-in scale in the resident's bed offered an added security of obtaining an accurate and consistent weight while he/she is in bed. Both Employees #2 and #5 acknowledged that the resident's clinical record lacked a documented evidence that the resident was re-weighed when the resident presented with a weight loss of 8 pounds between December 7, 2010 and January 5, 2011 and a weight loss 10 pounds (6%) between December 8, 2010 and January 12, 2011. Employee # 5 added that the "tech/CNA" weighs the resident and a registered nurse confirms the weight for accuracy. Employee # 5 further added, both the CNA and the nurse are privileged to view the trend of the weight and should have noted the weight loss and perform a re-weigh per the facility ' s policy for a re-weigh within 48 hours for a weight loss of 5 pound or greater in a month. When queried regarding the dietician's three day calorie count intervention to determine po intake, after a review of the resident's clinical record, Employees #2 and 5 stated "It was not done." The facility staff failed to follow-up on the resident's severe unplanned weight loss. The resident's weight was not obtained after the weight obtained on January 12, 2011 that indicated a weight loss of approximately 10 pounds or 4.73Kg (6%) between December 8, 2010 and January 12, 2011. There was no documented evidence that the responsible party was informed of the resident's unplanned weight loss. The record was reviewed May 3, 2011.	F 325		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive	F 328	F328 – 483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS Sibley Memorial Hospital's Renaissance Skilled Nursing Facility provides 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 the problem.	

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F 328	Continued From page 17 proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on a medication pass observation of one(1) of 34 sampled residents it was determined that facility staff failed to follow accepted standards of clinical practice when administering medications via gastrostomy feeding tube (G-tube). Resident #300. The findings include: A medication observation was conducted on May 3, 2011 at 10:15 AM with Employee #22. He/she failed to check for placement of the feeding tube prior to administering medication via the G-tube. He/she failed to flush the tubing with at least 30 cc's of water prior to and after medication administration; failed to flush with 5 cc's of water after each medication administered, and failed to allow the medication to flow in by gravity by pushing the medication down the G-tube with a plunger for Resident #300. According to the "Lippincott Manual of Nursing Practice Seventh Edition", under "General Procedures and Treatment Modalities for Enteral	F 328	Findings for Resident #300 1. There are no further corrections needed as this resident has been discharged home. Other resident on unit with G-tube was observed to be receiving the feeding and medication administration per protocol. — 05/3/2011 2. Other residents with the potential to be affected by the same deficient practice will be identified upon initial nursing admission assessment and physicians orders. — 05/4/2011 3. The following systemic changes will be put in place to ensure the deficient practice does not recur: • The quality nurse and the charge nurse or nurse educator will provide inservice education to nursing staff with return demonstrations: — 06/16/2011 • G-tube protocol posted in nursing conference room for review — 06/3/2011 • Pocket guide for G-tube protocol given to each nursing staff highlighting method for checking placement/residuals prior to medication administration and/or tube feedings and specific H20 flush guideline/amounts. — 06/16/2011 • Nursing Educator will do pre/post test followed-up by return demonstrations of G-tube feeding/medication process. — 06/24&06/25/2011 • Re-educate staff to utilize the Sibley intranet for detailed information ie, Lippincott. Resource and nursing protocol for tube-feedings. — 06/24&06/25/2011 4. The quality assurance process will be utilized to maintain and sustain compliance. The findings will be presented at the quarterly meeting of the Renaissance Quality Meeting. — 07/06/2011	

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F 328	Continued From page 18 Feeding: Procedure Guidelines 20-1 step number seven (7): Using a catheter tip syringe, inject 20 cc-30 cc of air while listening with a stethoscope positioned at the epigastric area (laterally). Rationale: Auscultation of a "whooshing" or bubbling sound assists in confirmation of proper tube placement.; After administering the prescribed amount of formula, (medication) flush tubing with at least 30 cc of water. Rationale: Prevents clogging of feeding tube. In the "performance phase" step two (2): fill catheter tipped syringe with formula (medication) and allow to fluid to flow in by gravity; Rationale: The rate of flow is regulated by raising or lowering the syringe." A face-to-face interview was conducted with Employees #2 and #21 on May 3, 2011 at 2:00 PM. After review of the above, both acknowledged the findings. Employee #2 initiated measures to re-educate Employee #22 regarding G-tube management. Facility staff failed to follow accepted standards of clinical practice when administering medication via a G-tube. The observation was made on May 3, 2011.	F 328		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any	F 329	**F329 – 483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS** The Renaissance Skilled Nursing Facility provides 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 that problem **Findings for Resident #328** 1. The resident identified in this report was not affected by the deficient practice. There are no further corrective actions as this resident has been discharged. 2. Other residents having the potential to be affected by the same deficient practice will be identified by direct observation and review of physician orders	05/3/2011 05/4/2011

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F 329	Continued From page 19 combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observations, record review and interview for one (1) of 34 sampled residents, it was determined that facility staff failed to administer " as needed " medication consistent with the prescribed indication for use. Resident #328 The findings include: Resident #328 was admitted with a diagnosis of [status post] left hip open reduction and internal fixation [ORIF]. Physician ' s admission orders dated April 24, 2011 directed the administration of Klonopin 0.25 mg by mouth every 12 hours as needed [prn] for anxiety. A review of the electronic medication administration record [MAR] for April 2011	F 329	for residents on psychotropic medications. The indication for use of psychotropic will be clarified with the physician if necessary. Nurses were instructed during the survey to assess the records/EMARS to ensure the indications, behaviors clinical documentation are consistent. 3. The following systemic changes will be put in place to ensure the deficient practice will not recur: • The charge nurse will monitor physician orders to ensure there is a specific condition for residents on psychotropic medications. 05/4/2011 • The nursing staff on each shift will document on the clinical record the behaviors exhibited by the resident for the specific medication. 05/4/2011 • The quality nurse will continue to utilize the audit tool to monitor residents on psychotropic and for presence of behaviors in the clinical record. 05/4/2011 • The pharmacist will monitor the EMARS to ensure the medication/dosage is appropriate for resident. 05/4/2011 • The DON and pharmacist will develop policy for monitoring behaviors for residents receiving psychotropic medications. 06/11/2011 • Re-educate nursing staff that when they identify that the resident is on a psychotropic medication that they must indicate the behavior in the drop down box in the clinical record (QCPR). 06/10/2011 4. The quality assurance process will be utilized to maintain and sustain compliance. The findings will be presented at the quarterly meeting of the Renaissance Quality Meeting 07/06/2011	

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F 329	Continued From page 20 revealed licensed staff administered Klonopin 0.25 mg at 2304 [military time] on April 24th; 2132 on April 26th; 2114 on April 27th; 2214 on April 28th; 2151 on April 29th and 2108 on April 30th. A review of the nursing shift assessments associated with the administration pm Klonopin as delineated above, lacked evidence that the resident exhibited symptoms of anxiety. The documentation revealed the nurse assessed the resident with " appropriate behavior, mood/affect, speech and thought processes. Normal intellectual capacity and sleep patterns. No signs or symptoms of anxiety or depression noted. " The shift assessments were documented per shift and the clinical record lacked evidence of consistent behavioral monitoring that correlated with the " as needed " administration of the psychoactive drug Klonopin. Licensed staff failed to administer Klonopin consistent with the prescribed indication for use. The findings were acknowledged during a face-to-face interview with Employee #2 on May 3, 2011 at 9:00 AM. S/he stated that nurses document the psycho-social status of the resident in the shift assessment of the electronic record system. There was no facility policy associated with the monitoring of behaviors for residents receiving psychotropic medication. The record was reviewed May 2, 2011.	F 329	**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, deficiencies were identified that have been cited in this report. The following plan of correction addresses the deficiencies: 1. The following corrective actions were taken to address the deficient practices: • Finding 1: The shelf surface in the catering area was dusted • Finding 2: The shelf surfaces in the salad room area were cleaned of soil and stains. • Finding 3: The exterior surfaces of the sugar, flour, and rice bins were cleaned of soil and stains. • Finding 4: All food items stored in the reach-in refrigerators were labeled and dated. • Finding 5: All food items stored in the reach-in refrigerators were labeled and dated. • Finding 6: All food items stored in the reach-in refrigerators with expired use-by dates were discarded. • Finding 7: All food items stored in the reach-in refrigerators were labeled and dated. • Finding 8: The interior surfaces of all hotel pans stored on shelves were completely dry before use. 2. All other areas affected by the deficient practices were corrected as follows: • Finding 1: All shelf surfaces in the catering area will be cleaned on a continuous basis to ensure there is no dust. • Finding 2: All shelf surfaces in the salad room area will be cleaned on a continuous basis to ensure there are no soiled areas. • Finding 3: All three (3) bin surfaces will be cleaned on a continuous basis to ensure there are no soiled areas. • Finding 4: Any food items that are opened and/or do not have a date or label on the package will be labeled and dated by the person putting the food item into the cooler.	04/28/2011 05/31/2011
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must -	F 371		

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F 371	Continued From page 21 (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations that were made during a tour of the main kitchen on April 28, 2011, it was determined that the facility failed to prepare and serve food under sanitary conditions as evidenced by: two (2) of three (3) shelves were soiled, three (3) of three (3) food storage bins observed soiled; 19 of 27 hotels pans stored wet and ready for use; one (1) one (1) of package of pepperoni opened and not dated, one (1) of one (1) roast beef was observed with a use by date of 3/30/11, one (1) of one (1) pack of bologna observed open and no date, and two (2) of two (2) packages of capicola opened and not dated or labeled. The findings include: During a tour or the kitchen on April 28, 2011 - 8:30 AM to 9:45 AM the following was observed: 1. One (1) of two (2) shelves observed in the catering area was soiled with dust; 2. One (1) of one (1) shelf (top shelf) in salad room was observed soiled; 3. One (1) of one (1) flour bin, one (1) of one (1)	F 371	◦ Finding 5: Any food items that are opened and/or do not have a date or label on the package will be labeled and dated by the person putting the food item into the cooler. ◦ Finding 6: Any food items that are opened and have an expired date will be discarded immediately. ◦ Finding 7: Any food items that are opened and/or do not have a date or label on the package will be labled and dated by the person putting the food into the cooler. ◦ Finding 8: All hotel pans will be cleaned in the three (3) bay sinks and completely drie before storing. 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: – Sanitation staff will be in-serviced on proper cleaning of dusty shelves. – Shelves in the catering area will be added to the sanitation checklist and will be monitored by daily rounding – All shelves in the catering area will be put on a rotation for the special cleaning schedule to ensure shelves are clear of dust ◦ Finding 2: – Shelves in the salad room will be put on rotation for special cleaning schedule to ensure cleanliness. – Shelves in the salad room will be added to the sanitation checklist and will be monitored by daily rounding. ◦ Finding 3: – Bins will be put on rotation for special cleaning schedule to ensure exterior surfaces are cleaned. – Bins will be added to the sanitation checklist and will be monitored by daily rounding. • Finding 4: – All cooks and prep personnel will be re-trained on the proper way to label and date food items stored in the reach-in coolers. – Management will complete monthly audits and daily spot checks to ensure all personnel are following policy with label and dating food items. ◦ Finding 5: – All cooks and prep personnel will be re-trained on the proper way to label and date food items stored in the reach-in coolers. – Management will complete monthly audits and daily spot checks to ensure all personnel are following policy with label and dating food items.	05/31/2011

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	095030	A. BUILDING _____ B. WING _____	05/03/2011

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F 371	Continued From page 22 sugar bin and one (1) of one (1) rice bin located in the bake room were observed with soiled exteriors. 4. One (1) one (1) of package of pepperoni opened and not dated; 5. One (1) of one (1) roast beef was observed with a use by date of 3/30/11 6. One (1) of one (1) pack of bologna observed open and no date 7. Two (2) of two (2) packages of capicola opened and not dated or labeled 8. Seven (7) of seven (7) 1/8 hotel pans; One (1) of one (1) full hotel pan; Eight (8) of eight half hotel pans and three (3) of 11 shot gun pans were observed wet and ready for use. The observations were made in the presence of Employee # 15 who acknowledged these findings.	F 371	• Finding 6: – All cooks and prep personnel will be re-trained on the proper way to label and date food items stored in the reach-in coolers. – All cooks and prep personnel will receive ServSafe food handling training and be required to take and pass the exam. – Management will complete monthly audits and daily spot checks to ensure all personnel are following policy with label and dating food items. • Finding 7: – All cooks and prep personnel will be re-trained on the proper way to label and date food items stored in the reach-in coolers – Management will complete monthly audits and daily spot checks to ensure all personnel are following policy with label and dating food items. • Finding 8: – Staff will be re-inserviced and trained on the proper way to dry pans. – Extra drying racks will be ordered. – Nutrition Services will complete a monthly audit on our pans to ensure that proper 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.	07/06/2011
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.	F 441	**F 441 - 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS** The Renaissance Skilled Nursing Facility provides infection control measures to maintain an environment that prevents the development and transmission of disease and infection. During the most recent survey a number of problems were identified that have been cited in this report. The following plan of correction addresses them: **Findings for Residents In Room 316 and Room 318** 1. The residents/staff were not adversely affected by this deficient practice. Observations were made and other residents on the unit received Lovenox in the appropriate, safe manner. The nurse at the time was stopped and a 1:1 inservice by the senior charge nurse on how to activate, retract syringes with needles and dispose correctly. 2. Other residents with Lovenox subcutaneous injections will be identified upon admission and as ordered by the physician.	05/4/2011 05/4/2011

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F 441	Continued From page 23 (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 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 a medication pass observation of one (1) Employee, and observation and interview during the kitchen tour it was determined that facility staff failed to decrease the risk for the spread of infection by leaving a needle exposed after a Lovenox injection was administered on two (2) different occasions by one (1) Employee and failed to provide a safe, sanitary and comfortable environment as evidenced by one (1) of one (1) drain line from the ice machine in the main kitchen, catering area did not have sufficient air gap. Employee #22 The findings include:	F 441	• The charge nurse and quality nurse will utilize the electronic medication record along with direct observation/return demonstration to monitor safety, competency, and compliance. • Quality auditing tool for observance of Lovenox injections will be developed in 10 audits per month and done 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.	06/16/2011 06/16/2011 07/06/2011

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F 441	Continued From page 24 A. A medication pass observation was conducted on May 3, 2011 with Employee #22 at approximately 9:55 AM and 10:38 AM respectively. Employee #22 failed to decrease the risk for the spread of infection by not retracting the needle after a Lovenox injection was administered on two (2) different occasions. 1. At 9:55 AM Employee #22 administered a subcutaneous injection of Lovenox to the resident in room 319. After completing the injection the employee placed the syringe with the needle exposed on the over bed table, covered the resident and walked to the sharps container in the resident ' s room with the needle exposed. 2. At 10:38 AM Employee #22 administered a subcutaneous injection of Lovenox to the resident in room 316. After completing the injection the employee placed the syringe with the needle exposed on the over bed table, covered the resident and walked to the sharps container in the resident ' s room with the needle exposed. On this occasion two (2) staff members entered the room, Employee #22 did not alert either of the staff members of the exposed needle. A face-to-face interview was conducted with Employee #2 on May 3, 2011 at approximately 12:00 PM. After reviewing the above, he/she acknowledged the findings. The observation was made on May 3, 2011. B. During a tour of the kitchen on April 28, 2011	F 441	**F441 – 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS** Item B 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. During a tour of the kitchen on April 28, 2011, from 8:30 to 9:45 AM, it was determined that the facility failed to provide a safe, sanitary and comfortable environment as evidenced by one (1) of one (1) drain line from the ice machine in the main kitchen, catering area did not have sufficient air gap. The following plan of correction addresses the deficiencies: 1. No specific residents were identified in the survey report as being affected by the deficiency. 2. Work order # 25887 was submitted to install missing air gap on the ice machine and accomplished by cutting pipe 1 ¼" from the lowest point of the ice machine's drain to the flood level of the floor drain that it drains into. Upon reinspection, it was determined that the air gap was installed correctly.	5/2/2011 & 6/3/2011

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F 441	Continued From page 25 from 8:30 AM to 9:45 AM, it was determined that the facility failed to provide a safe, sanitary and comfortable environment as evidenced by one (1) of one (1) drain line from the ice machine in the main kitchen, catering area did not have sufficient air gap. The findings include: One (1) of one (1) drain line from the ice machine in the main kitchen, catering area did not have sufficient air gap. The observation was made in the presence of Employee #18 who acknowledged the finding.	F 441	3. The following systemic changes have been put in place to ensure the deficient practice does not recur: • Plumbers reviewed 2000 Edition of the "Unified Plumbing Code" Chapter 8 "Indirect Wastes" Section 801.1 Airgap or Airbreak Required which states: "All indirect waste piping shall discharge into the building drainage system through an air gap or air break as set forth in this code. Where a drainage air gap is required by this Code, the minimum vertical distance as measured from the lowest point of the indirect waste pipe of the fixture outlet to the flood level rim of the receptor shall be not less than one (1) inch (25.4 mm). All plumbing installations which require and air gap will adhere to this code requirement. • All new construction, renovations and existing drain piping will be monitored to make sure the 1" clearance is maintained. 4. The quality assurance process will be utilized to maintain and sustain compliance. The findings will be presented at the quarterly meeting of the Renaissance Quality Committee.	05/3/2011 ONGOING 05/3/2011 ONGOING 07/06/2011
F 456 SS=E	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observations and interview during a tour of the Kitchen on May 3, 2011 at 10:00 am, it was determined that the facility's dish machine failed to meet the acceptable parameters to sanitize dishes and eating utensils. The findings include: A tour of the kitchen was conducted on May 3, 2011 at 10:00 AM in the presence of Employees # 15 and #20. The dish machine failed to reach 180 degrees on May 3, 2011 at 10:00 am.	F 456	F456 – 483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. During the survey, a few deficiencies were identified that have been cited in this report. The following plan of correction addresses the deficiencies: 1. When the dish machine temperature did not meet the required temperature, it was closed down and we went to paper service for all patients. We also called both service techs, who work on the dish machine, to come in immediately to fix the machine. 2. Paper products will be used for patient services until the dish machine is at proper temperature. No patients were affected by this practice.. 3. Nutrition Services employees will be re-trained on the proper shut down procedures when the dish machine does not meet temperature. In addition, employees will be in-serviced on retaining proper temperatures at each meal as required by policy. 4. Nutrition Services will monitor the daily log sheets to ensure procedures are being followed. Also, the steam station will be purchased and installed to ensure that the steam pressure is correct in providing final rinse temperatures of 180 degrees or higher.	05/3/2011 05/3/2011 05/3/2011 06/30/2011

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F 456	Continued From page 26 During the observation period on May 3, 2011 between 10:00 AM - 11:30 AM, the final rinse cycle was observed to reach temperatures of 159, 172, 174 and 179 in four observations. According to the dishwasher temperature log, rinse cycle temperatures for May 2011 were assessed during the morning, afternoon and evening hours as follows: May 1, 2011 09:45 AM - 181°; 02:45 PM - 150°; 7:40 PM - 181° May 2, 2011 10:00 AM - 185°; 12:25 PM - 183°; 7:50 PM - 160° Employees #15 and #20 acknowledged the findings during the time of observation on May 3, 2011.	F 456	5. For quality assurance purposes, nutrition services will monitor the daily log sheets to ensure procedures are being followed. The findings will be presented at the quarterly meeting of the Renaissance Quality Committee.	07/06/2011
F 469 SS=E	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 made during the environmental tour of the facility on April 28 thru May 3, 2011, it was determined that the facility failed to maintain an effective pest control program as evidenced by flying insects seen on the nursing unit during the survey and in the pot/pan area of the kitchen.	F 469	**F 469 – 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. During the most recent survey, flying pests were observed in the kitchen's pot/pan room and the nursing stations on 3 North and 3 South. The following plan of correction addresses the deficiencies: 1. At the time of observation for each of the incidents, the service log was completed and a phone call was made to request follow-up service from the pest control contract service provider. 2. The pest control contract service provider periodically inspects the area and takes corrective action as needed on both 3 North and 3 South. The kitchen is on a scheduled maintenance service routine with follow-up for any reported pest control issues noted in the service log. 3. The following systemic changes will be made to ensure that the deficient practice does not recur:	04/28/2011 04/29/2011

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F 469	Continued From page 27 The findings include: A. On April 28, 2011 during a tour of the kitchen between 8:30 AM to 9:45 AM, flying pests were observed in the pot/ pan room. This finding was observed and acknowledged by Employee # 15 at the time of the observation. B. On May 29, 2011 at 2:45 PM flying pests were in the nursing station on 3 South. On May 2, 2011 at 10:00 AM, flying pests were observed in the nursing station on 3 North.	F 469	◦ Routine rounds will be conducted to assess any service requirements for flying insect on both 3 North and 3 South nursing stations and the kitchen. • Window screens will be checked visually to ensure there are no gaps or openings that would allow for entry • Visual inspection will be conducted to ensure compliance. ◦ Reported incidents will be addressed at the time, logged into the service log, and follow-up service requested from the pest control contract service provider. 4. The quality assurance process will be utilized to maintain and sustain compliance. The findings will be reported to the Renaissance Quality Meeting at its quarterly meetings.	05/2/2011 ONGOING 05/2/2011 ONGOING 05/2/2011 ONGOING 05/2/2011 ONGOING 07/06/2011
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, it was determined that facility staff failed to accurately transcribe the indication for use of a	F 514	F514 – 483.75(l)(1) RES RECORDS - COMPLETE/ACCURATE/ACCESSIBLE Sibley Memorial Hospital's Renaissance Skilled Nursing Facility provides services that meet professional standards of quality. During the most recent survey, a problem area was identified that has been cited in this report. The following plan of correction addresses the problem: **Findings for Resident #325** 1. Appropriate use for indication was obtained. 2. No other resident was receiving oral chemotherapeutic agents. 3. The following systemic changes will be put in place to ensure the deficient practice does not incur: ◦ Upon admission the nurse will verify that the correct medication indication is transcribed according to the physician order. ◦ The pharmacist will review all orders and seek clarification from the physician for any medication/indication combinations which do not appear to be accurate. • The twenty-four (24) hour chart check will be utilized to verify and ensure medication indications are correct.	05/2/2011 05/2/2011 05/3/2011 05/3/2011 05/2/2011

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F 514	Continued From page 28 prescribed medication. Resident #325 The findings include: Physician ' s admission orders dated April 22, 2011 directed the administration of Mercaptopurine 50 mg by mouth daily for chemotherapy for a tumor. A review of the electronic medication administration record [MAR] for the period of April 23 through May 2, 2011 revealed the order was transcribed as: Mercaptopurine 50 mg daily for ulcerative colitis. The physician ' s order was inaccurately transcribed on the MAR. The findings were reviewed and acknowledged during review of the electronic MAR with Employee #5 on May 2, 2011 at 3:00 PM.	F 514	• The charge nurse and quality nurse will do random audits of the electronic record to ensure compliance of appropriate medication indications have been transcribed per physician order. • Pharmacy and the nurses will be inserviced on the importance of ensuring medication indications are present and correct as prescribed. 4. The quality assurance process will be utilized to maintain and sustain compliance. The findings will be reported to the Renaissance Quality Meeting at its quarterly meetings.	06/16/2011 06/16/2011 07/06/2011