Health Regulation Administration

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD02-0026 | (X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING ______ | (X3) DATE SURVEY COMPLETED 06/04/2010 |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| SIBLEY MEM HOSP RENAISSANCE | 5255 LOUGHBORO ROAD NW WASHINGTON, DC 20016 |

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| L 000 | Initial Comments<br><br>The annual licensure 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. | L 000 | | |
| L 051 | 3210.4 Nursing Facilities<br><br>A charge nurse shall be responsible for the following:<br><br>(a)Making daily resident visits to assess physical and emotional status and implementing any required nursing intervention;<br><br>(b)Reviewing medication records for completeness, accuracy in the transcription of physician orders, and adherences to stop-order policies;<br><br>(c)Reviewing residents' plans of care for appropriate goals and approaches, and revising them as needed;<br><br>(d)Delegating responsibility to the nursing staff for direct resident nursing care of specific residents;<br><br>(e)Supervising and evaluating each nursing employee on the unit; and<br><br>(f)Keeping the Director of Nursing Services or his or her designee informed about the status of residents. This Statute is not met as evidenced by:<br><br>Based on record review and staff interview for four (4) of 11 sampled residents, it was determined that the charge nurse failed to enter | L 051 | L051-3210.4 Nursing Facilities<br>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.<br>Findings (allergies) for Resident #2<br>*(L051 Finding 1)*<br>1. Clinical documentation identifying sulfa as an allergy was placed into the 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.<br>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.<br>3. The following systemic changes will be implemented to ensure the deficient practice does not recur:<br>• The nurse will review the transferring facility MAR upon admission for allergy information and if applicable.<br>• 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).<br>• The nurse will review the H&P for allergies upon admission.<br>• 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. | 6/5/2010<br><br>7/19/2010<br><br>7/19/2010 |

Health Regulation Administration

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

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| L 051 | Continued From page 1<br><br>an allergy to "Sulfa" into the electronic Medication Administration Record (MAR) system and document complete neurological assessments at the time of a fall for one (1) resident; failed to develop a care plan with appropriate goals and approaches for use and care of a left hip abductor brace and failed to follow physician ' s orders for the application of bilateral knee high ted stockings for one (1) resident; failed to administer Plendil to one (1) resident in accordance with physician ' s orders; and failed to develop a care plan for the use and care of a swath and sling for one (1) resident with a left humerus fracture. Resident's #2 , #7, #8 and #10.<br><br>The findings include:<br><br>1. The charge nurse failed to enter Resident #2's allergy to "Sulfa" into the electronic Medication Administration Records system.<br><br>A review of the History and Physical for Resident #2 signed and dated May 19, 2010, revealed, " Allergies: Sulfa " .<br><br>The Medication Reconciliation form dated May 1, 2010 from [transferring Hospital] listed Sulfonamides as an allergy.<br><br>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.<br><br>A review of Medication Administration Record (MAR) dated June 2, 2010 revealed, " Allergies: no known allergies " .<br><br>There was no documented evidence that facility | L 051 | • The MDS Coordinator will educate the nursing staff of the changes to the problem list and care plan for allergy recognition.<br>• Twenty-four hour charts will be utilized to ensure allergies are verified and documented into the pharmacy system.<br>• The secretarial associates will check transferring facility documentation for presence of allergies and to ensure physician order sheets and label charts are documented accordingly.<br>• The admitting nurse will ask the resident/family member status of allergies and place into the computer system immediately, if applicable.<br>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.<br>Findings (neurological) for Resident #2<br>*(L051 Finding 2)*<br>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.<br>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.<br>3. The following systemic changes will be implemented to ensure the deficient practice will not recur:<br>• 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.<br>• The nurse was counseled as she did not follow protocol to ensure there was stability of the resident's neurological status.<br>• The unit educator and Quality Nurse will develop and implement a neurological checklist and educate the nursing staff on its usage.<br>• 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. | 7/27/2010<br><br>6/5/2010<br><br>7/19/2010<br><br>7/19/2010<br><br>6/4/2010<br><br>7/19/2010<br><br>7/19/2010 |

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| L 051 | Continued From page 2 | L 051 | • 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. | 7/19/2010 |
| | staff entered the allergy to Sulfa/ Sulfonamides into the electronic medical records system to print on the MAR(s). | | • The nursing staff will give a full, accurate status report to the oncoming shift to ensure the continuity of resident care. | 7/19/2010 |
| | 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. | | 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 |
| | 2. The charge nurse failed to document complete neurological assessments for Resident #2 at the time of the fall on May 31, 2010. | | Findings for Residents #7 and #10 *(L051 Finding 3 & 6)* 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. | 6/11/2010 & 6/18/2010 |
| | 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]. | | 2. All other resident care plans will be reviewed and updated as indicated to reflect usage of bracing and support devices. | 7/19/2010 |
| | The "[Facility] Progress Record" dated May 31, 2010 at 11:30 PM [2330] written by the physician revealed, " Surgical Critical Care- ...pt fell 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. " | | 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) | 6/28/2010 |
| | | | • The Interdisciplinary Care Team will review the care plans/problem lists at meetings to monitor compliance and update as needed. | 7/29/2010 |
| | | | • Nursing staff will be in-serviced and instructed on the importance of care of residents utilizing brace and support devices. | 7/19/2010 |
| | | | • The MDS Coordinator will in-service staff on how to individualize the care plans. | 7/19/2010 |
| | | | • A Quality Assurance tool will be developed to randomly monitor ten care plans for compliance related to bracing/support devices. | 7/19/2010 |
| | 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. | | 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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| L 051 | Continued From page 3 | L 051 | Finding for Resident #7<br>*(L051 Finding #4)* | |
| | "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 ... " | | 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. | 6/18/2010 |
| | 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. | | 2. Other residents having the potential to be affected by the same deficient practice will be identified upon admission and subsequent physician orders. | 7/19/2010 |
| | 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 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. | | 3. The following systemic changes will be put in place to ensure the deficient practice will not recur:<br>• The nursing staff will review physician orders to ensure orders for ted hose are placed into the QCPR system and obtained from Med Supply.<br>• The Quality/Charge Nurses will randomly assess placement of ted hose upon daily rounds, surgeon specific.<br>• 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. | 7/19/2010 |
| | 3. The charge nurse failed to develop a care plan with appropriate goals and approaches for use and care of a left hip abductor brace for Resident #7. | | 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 |
| | 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. " | | Finding for Resident #8<br>*(L051 Finding 5)*<br>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. | 5/17/2010 |
| | A review of care plans that were last updated on | | 2. Other residents with the potential to be affected by the same deficient practice will be identified upon admission and ongoing physician orders. | 7/19/2010 |
| | | | 3. The following systemic changes will be put in place to ensure the deficient practice will not recur:<br>• The nurse will review physician orders and ensure they are placed in the MAR system.<br>• Nursing staff will review orders each shift to monitor and to ensure POM physician orders have been carried out for administration to the resident. | 7/19/2010 |

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| L 051 | Continued From page 4<br><br>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.<br><br>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.<br><br>The charge nurse 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.<br><br>4. The charge nurse failed to follow physician ' s orders for the application of bilateral knee high ted stockings for Resident #7.<br><br>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).<br><br>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).<br><br>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.<br><br>A face-to-face interview was conducted on June 3, 2010 at approximately 11:54 AM with | L 051 | • Nurse will work in collaboration with the family, physician, and pharmacists for resolution of POM orders.<br>• The nurse will document the status of POM and conversations into the clinical record.<br>• The 24° chart check will be utilized to monitor physician orders have been carried out and transcribed correctly for medication administration.<br>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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| L 051 | Continued From page 5 | L 051 | | |

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.

The charge nurse failed to follow physician orders for the application of bilateral knee high ted stockings for Resident #7. The record review and observation was made on June 3, 2010.

5. The charge nurse failed to administer Plendil 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.

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| L 051 | Continued From page 6<br><br>6. The charge nurse failed to develop a care plan for the use and care of a swath and sling for Resident #10 with a left humerus fracture.<br><br>Review of the " Physician Order Sheet (POS) dated and signed May 20, 2010 0830, PT/OT (physical therapy/occupational therapy, revealed " l. NWB (non weight bearing) left upper extremity. May remove sling for active/active assisted ROM (range of motion) elbow and hand. No shoulder ROM, 2. WBAT (weight bearing as tolerated) left LE (lower extremities) "<br><br>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.<br><br>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.<br><br>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. | L 051 | | |
| L 052 | 3211.1 Nursing Facilities<br><br>Sufficient nursing time shall be given to each resident to ensure that the resident receives the following: | L 052 | **L052 – 3211.1 Nursing Facilities**<br>Sibley Memorial Hospital Renaissance SNF provides service that meet professional standards for infection control. 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. | |

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| L 052 | Continued From page 7 | L 052 | Finding 1: | |
| | (a)Treatment, medications, diet and nutritional supplements and fluids as prescribed, and rehabilitative nursing care as needed; | | 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. | 6/5/2010 |
| | (b)Proper care to minimize pressure ulcers and contractures and to promote the healing of ulcers: | | 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. | 7/19/2010 |
| | (c)Assistants in daily personal grooming so that the resident is comfortable, clean, and neat as evidenced by freedom from body odor, cleaned and trimmed nails, and clean, neat and well-groomed hair; | | 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. | 7/2/2010 |
| | (d) Protection from accident, injury, and infection; | | • 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. | 7/19/2010 |
| | (e)Encouragement, assistance, and training in self-care and group activities; | | • The hand hygiene infection control policy will be placed in the mail box of each staff member. | 7/19/2010 |
| | (f)Encouragement and assistance to: | | • An in-service will be given to stress the importance of ensuring resident bedside tables are clean when utilized to assist with medication administration. | 7/19/2010 |
| | (1)Get out of the bed and dress or be dressed in his or her own clothing; and shoes or slippers, which shall be clean and in good repair; | | • The Charge Nurse/Quality Nurse will do random observations during medication pass to monitor compliance. | 7/19/2010 |
| | (2)Use the dining room if he or she is able; and | | 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 |
| | (3)Participate in meaningful social and recreational activities; with eating; | | | |
| | (g)Prompt, unhurried assistance if he or she requires or request help with eating; | | | |
| | (h)Prescribed adaptive self-help devices to assist him or her in eating independently; | | | |
| | (i)Assistance, if needed, with daily hygiene, including oral acre; and | | | |
| | j)Prompt response to an activated call bell or call | | | |

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| L 052 | Continued From page 8<br>for help.<br><br>This Statute is not met as evidenced by:<br>Based on observation and staff interview for one (1) of 11 sampled residents, it was determined that sufficient nursing time was not given to each resident to ensure that proper infection control practices were followed during medication administration for Resident #9.<br><br>The findings include:<br><br>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.<br><br>A face-to-face interview was conducted on June 2, 2010, at approximately 10:15 AM with 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. | L 052 | | |
| | | | <u>L099 – 3219.1 Nursing Facilities</u><br>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.<br><u>**ITEM A**</u><br>1. The following plan of correction addresses the deficiencies so they will not adversely impact residents:<br>• <u>Finding 1:</u> All food identified in the citation was discarded.<br>• <u>Finding 2:</u> All supplements identified in the citation with expired dates were removed from the supplement shelf.<br>• <u>Finding 3</u>: Unlabeled food items identified in the citation in the reach-in refrigerator were labeled and dated.<br>• <u>Finding 4:</u> The interior and exterior surfaces of all four-inch shotgun pans identified in the citation were cleaned. | 6/3/2010 |
| | | | 2. All other areas affected by the deficient practices were corrected as follows:<br>• <u>Finding 1:</u> All products were inspected to ensure that food beyond its expiration date was found and discarded.<br>• <u>Finding 2:</u> All supplements were inspected to ensure that products beyond expiration date were removed from the shelf.<br>• <u>Finding 3</u>: All reach-in refrigerators were inspected to ensure that all food items was labeled properly and dated.<br>• <u>Finding 4:</u> All pots and pans were inspected and cleaned as needed. | 6/4/2010 |
| L 099 | 3219.1 Nursing Facilities<br><br>Food and drink shall be clean, wholesome, free from spoilage, safe for human consumption, and served in accordance with the requirements set forth in Title 23, Subtitle B, D. C. Municipal Regulations (DCMR), Chapter 24 through 40.<br>This Statute is not met as evidenced by:<br>A. 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 | L 099 | 3. The following system measures will be put in place to ensure the deficient practices do not recur and staff trained on the following:<br>• <u>Finding 1:</u><br>° 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.<br>° Management will complete rounds and check items for expired dates to ensure compliance. | 6/7/2010 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | HFD02-0026 | A. BUILDING ____ B. WING ____ | 06/04/2010 |

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| SIBLEY MEM HOSP RENAISSANCE | 5255 LOUGHBORO ROAD NW WASHINGTON, DC 20016 |

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| L 099 | Continued From page 9<br><br>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; and failed to control and prevent the spread of infection as evidence by two (2) of two (2) ice machines soiled with mineral deposits.<br><br>The findings include:<br><br>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.<br><br>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.<br><br>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.<br><br>4. 10 of 21 four-inch shotgun pans stored in the clean pans area were soiled with food residue.<br><br>5. Ice machines on 3 north and 3 south were soiled with mineral deposits.<br><br>These observations were made in the presence of Employees # 4 and #9 who acknowledged these findings during the survey. | L 099 | • Finding 2:<br>° The storeroom clerk will be re-trained to rotate and check for expired dates on all supplement products weekly to ensure compliance.<br>° Management will complete rounds and check items for expired dates to ensure compliance. | 6/7/2010 |
| | | | • Finding 3:<br>° Cooks and prep personnel will be retrained on the proper way to label and date food items stored in the reach-in refrigerators.<br>° Management will complete daily spot checks and monthly audits to ensure compliance with label and dating of food items. | 6/30/2010 |
| | | | • Finding 4:<br>° Staff will be in-serviced and trained on the proper way to wash pans.<br>° Nutrition Services will complete a monthly audit on pans to ensure that the procedure is being followed. | 6/30/2010 |
| | | | 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 |
| | | | **FINDING 5 & ITEM B**<br>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. | 6/4/2010 |
| | | | 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. | 7/6/2010 |
| | | | 3. The following systemic changes have been put in place to ensure the deficient practice does not recur:<br>• EVS associates will be retrained to report the condition of the machines when daily sanitizing is not adequate for project cleaning to occur. | 7/29/2010 |
| | | | • EVS management will monitor ice machines for mineral buildup when conducting inspections. | ONGOING |
| | | | 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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| L 099 | Continued From page 10<br><br>B. 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.<br><br>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.<br><br>These observations were made in the presence of Employees # 4 and #9 who acknowledged these findings during the survey. | L 099 | | |
| L 108 | 3220.2 Nursing Facilities<br><br>The temperature for cold foods shall not exceed forty-five degrees (45°F) Fahrenheit, and for hot foods shall be above one hundred and forty degrees (140°F) Fahrenheit at the point of delivery to the resident.<br><br>This Statute is not met as evidenced by:<br>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.<br><br>The findings include:<br><br>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."<br><br>On June 2, 2010 during the lunch time meal, the milk served on the test tray was measured at 48 degrees F. | L 108 | L108 – 3220.2 Nursing Facilities<br>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.<br>1. No specific residents were identified in the survey report as being affected by the deficient practice.<br>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.<br>3. The following systemic changes have been put in place to ensure the deficient practice does not recur:<br>• Staff will measure temperatures of the holding units daily to document that temperatures are kept below 45 degrees.<br>• Test trays will be tested weekly to ensure that test tray milk products are maintained at temperatures below 45 degrees.<br>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. | 1. 6/2/2010<br>2. 7/19/2010<br>3. 7/19/2010<br>4. 7/27/2010 |

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| L 108 | Continued From page 11<br><br>These observations were made in the presence of Employee # 9 who acknowledged the findings. | L 108 | | |
| L 410 | 3256.1 Nursing Facilities<br><br>Each facility shall provide housekeeping and maintenance services necessary to maintain the exterior and the interior of the facility in a safe, sanitary, orderly, comfortable and attractive manner.<br>This Statute is not met as evidenced by:<br>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, 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.<br><br>The findings include:<br><br>1. Privacy curtains were hanging off the hooks in rooms # 305, 310, 330, and in the rehabilitation room;<br><br>2. The shower curtain was torn in room # 320;<br><br>3. Bathroom vents were soiled with accumulated dust in rooms #308, 316, 317, 328 and 330;<br><br>4. Dusty bed frames in two (2) of 12 residents' rooms;<br><br>5. Windowsills were dusty in rooms # 310 and | L 410 | <u>L410 – 3256.1 Nursing Facilities</u><br>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:<br>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:<br>• <u>Finding 1:</u> Room curtains were repaired and re-hung on the day of inspection in rooms #305, #310, and #330, and the rehabilitation room.<br>• <u>Finding 2:</u> Torn shower curtain in room #320 is a special size and a new curtain has been ordered.<br>• <u>Finding 3:</u> Bathroom vents were cleaned in rooms #308, #316, #317, #328, and #330.<br>• <u>Finding 4:</u> Bed frames were dusted when noted at time of inspection in rooms #316 and #317.<br>• <u>Finding 5:</u> Windows sills were dusted when noted at time of inspection in rooms #310 and #328.<br>2. All rooms will be checked and cleaned and/or repaired as needed.<br>3. The following systemic changes have been or will be put in place to ensure the deficient practices will not recur:<br>• <u>Finding 1:</u><br>° Laundry staff will be retrained to ensure that all carriers are attached to curtains when changed out in room.<br>° Laundry staff will conduct periodic inspections of empty rooms to determine if any carriers need replacing or reattaching.<br>° Laundry will transition to a universal style carrier that can be used in more types of tracking.<br>° Managers will make routine inspections during curtain changes and ensure that all privacy curtain carriers are in working order.<br>• <u>Finding 2:</u><br>° 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.<br>° EVS Team managers will inspect curtains while making rounds. | 6/3&4/2010<br>7/14/2010<br>6/3&4/2010<br>6/3&4/2010<br>6/3&4/2010<br>7/19/2010<br>6/25/10<br>7/19/2010<br>ONGOING |

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| L 410 | Continued From page 12<br>328.<br><br>These findings were acknowledged by Employees # 4 and 9 who were present at the time of observation. | L 410 | • Finding 3:<br>◦ 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. | 7/19/2010 |
| | | | ◦ EVS team managers will monitor vents when completing inspections and rounds. | ONGOING |
| | | | • Finding 4:<br>◦ Bed frames will be wiped down at time of discharge. | 6/4/2010 |
| L 426 | 3257.3 Nursing Facilities<br><br>Each facility shall be constructed and maintained so that the premises are free from insects and rodents, and shall be kept clean and free from debris that might provide harborage for insects and rodents.<br>This Statute is not met as evidenced by:<br><br>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.<br><br>The findings include:<br><br>Flying insects were observed in the following areas:<br><br>June 2, 2010 in room # 320 south.<br>June 3, 2010 on unit 3 north.<br>June 3 2010 in the kitchen.<br><br>These observations were made in the presence of Employee # 4 who was present at the time of the observation. | L 426 | ◦ EVS associates will track the length of stay of residents and coordinate with nursing assistants to dust frames at time of linen change. | 6/4/2010 |
| | | | ◦ EVS management will monitor bed frames for dust when conducting inspections. | ONGOING |
| | | | • Finding 5:<br>◦ EVS associates will complete the 7 step cleaning method each day in each room to avoid overlooking dust and debris on window sills. | 7/19/2010 |
| | | | ◦ EVS team managers will monitor windows sills for dust when conducting inspections. | ONGOING |
| | | | 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 |
| | | | **L 426 – 3257.3 Nursing Facilities**<br>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.<br>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:<br>• 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 be removed. | 7/19/2010 |
| | | | • EVS team managers will monitor rooms, units, and kitchen for flying insects when conducting inspections in the area. | ONGOING |
| | | | • EVS team managers will monitor that the electric capture devices remain in place. | ONGOING |
| | | | 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 |