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	HFD02-0026	A. BUILDING _____ B. WING _____	06/11/2009

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

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L 000	Initial Comments A licensure survey was conducted on June 10 through 11, 2009. The follow deficiencies were based on observations, staff interview and record review. The sample size was 12 residents based on a census of 45 on the first day of survey. There were two (2) supplemental residents.	L 000		
L 008	3202.2 Nursing Facilities Each facility shall develop and maintain personnel policies which shall include methods used to document the presence or absence of communicable disease. This Statute is not met as evidenced by: Based on staff interview and record review it was determined that facility staff failed to ensure that one (1) of six (6) newly hired employees completed the health requirements by the 15th day of employment as per facility policy. The findings include: According to the facility's policy, "Employment and Annual Physical Examination and TST Requirements" number 03-40-14, effective March 26, 2009, page 2, " New employee physical examination shall include medical history and directed physical exam, review of immunization record or immunization history, tuberculin skin test (TST) or chest x-ray (if history or positive TST) and Hepatitis B vaccination ...New employees will be suspended from duty if health requirements are not met by the 15th day of employment." A review of Employ S1' s record revealed that the employee was hired on May 4, 2009. There was no evidence in the record that the employee had received a physical examination, reviewed his/her	L 008	**L 008 – 3202.2 Nursing Facilities** Findings for S1 1. Immediately had physical, PPD, and immunization per hospital policy (Hospital Policy #03-40-14). 2. All employees hired in the past 30-60 days were compliant as required. 3. The following systemic changes are in place to prevent reoccurrence of the deficient practice: • The employees will receive a physical upon hire. • To assure compliance, Employee Health will notify the Director of Environmental Services with a written report with health clearance status of the department employees within two weeks of orientation. 4. The quality assurance process will be utilized to monitor and sustain compliance. The findings will be presented at the quarterly Quality Assurance Committee meeting.	7/10/09 7/26/09 7/26/09 7/26/09

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L 008	Continued From page 1 immunization record or received the tuberculin skin test. The employee worked May 5, 6, 12, 14, 16, 17, 19, 28, 29, 30 and 31 on the night shift in areas were resident/patient were not present. A face-to-face interview with Employee #7 was conducted on June 11, 2009 at 1:30 PM. He/she acknowledged the above cited finding.	L 008		
L 051	3210.4 Nursing Facilities A charge nurse shall be responsible for the following: (a)Making daily resident visits to assess physical and emotional status and implementing any required nursing intervention; (b)Reviewing medication records for completeness, accuracy in the transcription of physician orders, and adherences to stop-order policies; (c)Reviewing residents' plans of care for appropriate goals and approaches, and revising them as needed; (d)Delegating responsibility to the nursing staff for direct resident nursing care of specific residents; (e)Supervising and evaluating each nursing employee on the unit; and (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: A. Based on staff interview and record review for	L 051	<u>L 051 – 3210.4 Nursing Facilities</u> Comprehensive Care Plans are developed for all SNF residents. During the survey, three of twelve sampled residents did not have a satisfactory care plan. The following plan of correction addresses this important issue: <u>Findings for residents #1,#3 and #10</u> 1. Facility staff failed to initiate a satisfactory plan of care with objectives, goals, and approaches to address the residents' nutritional needs. We recognize this failure although no further corrections are needed on these specific residents since they have all been discharged home in good health. 2. All other resident care plans were reviewed and changed as needed. 3. The following systemic changes have been or will be implemented to prevent the same deficient practice from recurring and staff was educated on the following: • The multi-disciplinary care team will review nutritional care plans at each meeting to monitor compliance and update as needed. • Weekly weights will be monitored on Wednesdays for all residents assessed to be at nutritional risk for weight loss. • The dietician will attach copy of consult to each nutritional care plan of residents deemed as moderate to high nutritional risk (Level 2). • QA tool will be implemented to randomly monitor careplans for compliance. • Dietician to notify the DON and/or Quality Nurse of all residents that exhibit weight loss.	7/10/09 7/26/09 7/26/09

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L 051	Continued From page 2 three (3) of 12 sampled residents and one (1) of two (2) supplemental residents, it was determined that facility staff failed to: follow physician's orders for monitoring pulse oxcyemetry for one (1) resident, obtain complete medication orders for two (2) residents and clarify the indication for when to administer multiple pain medications for two (2) residents. Residents #1, 7, 12, and 13. The findings include: 1. A review of the clinical record for Resident #1 revealed facility staff failed to follow physician's orders for the assessment of oxygen saturation levels. Resident #1 was admitted May 23, 2009, post operative total hip replacement. Diagnoses included status post hip fracture, dehydration, macular degeneration, mitral insufficiency and congestive heart failure. Physician's orders dated May 31, 2009 directed "P02 sat q shift (pulse oximetry saturation level every shift) if =93% no oxygen, if =92% administer 2 liters of oxygen per minute via nasal cannula." A review of the electronic documentation related to the assessment of the resident' s oxygen saturation levels revealed oxygen saturation levels were not done on the following dates during the day and evening shifts: June 3, 4, 7 and 9, 2009. On June 5, 2009, the oxygen saturation level was not obtained during the night shift. The electronic record was retrieved by Employee #2 and the findings reviewed and confirmed in the presence of this employee on June 10, 2009 at 3:30 PM. The record was reviewed June 10, 2009. 2. Facility staff failed to clarify a physician's order for Megace for Resident #7.	L 051	• Careplans will be implemented to identify goals, approaches and interventions to ensure compliance with identification of residents at risk for weight loss. • The dietician will provide in-services to staff on ongoing basis to give feed back. 4. The quality assurance process will be utilized to monitor and sustain compliance. The findings will be presented at the quarterly Quality Assurance meeting. **L 051 – 3210.4 Nursing Facilities** The Rensaissance SNF provides services that meet professional standards of quality. 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 Resident #7 1. There are no further corrective actions as resident #7 has been discharged home in good health. 2. Other residents' medication orders for Megace and eyedrops were checked to ensure orders were clear. 3. The following systemic changes have been or will be put in place to ensure the deficient practice does not recur and staff was in-serviced on the following: • The nursing staff and secretarial associates will monitor physician orders and medication administration records to ensure the medication route/strength has been identified and transcribed correctly. The five rights and indications must be present. •The 24 hour chart review of the medication administration record will be utilized to monitor orders for accuracy and completeness. • The nursing staff will receive in-service training on the importance of clarification of medication orders to prevent a delay in treatment for all residents to maintain safety. 4. The quality assurance process will be utilized to monitor and sustain compliance. The findings will be presented at the quarterly Quality Assurance meeting.	7/26/09 7/10/09 7/26/09 7/26/09 7/26/09

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L 051	Continued From page 3 A review of Resident #7's record revealed a physician's order dated May 9, 2009 that directed, " Megace 2 TSP orally daily for appetitive." The order lacked the dosage for the medication. A face-to-face interview was conducted with Employee #11 on June 11, 2009 at 10:00 AM. He/she stated, " Megace comes in one strength, 40 ml per cc. A teaspoon is 5 cc so the doctor ordered 10 cc of Megace or 400 milligrams. The order as written is not really a complete order. The number of milligrams should be there." The record was reviewed June 11, 2009. 3. Facility staff failed to clarify the indication for when to administer two (2) pain medications for Resident #12. A review of Resident #12' s record revealed orders signed by the physician on May 5, 2009 that directed, " Tylenol 650 mg every 4 hours orally for mild pain" and " Tramadol 50 mg every 4 hours orally for mild pain." There was no evidence that facility staff had clarified the indication for when to administer two (2) medications, both prescribed for mild pain. The resident was administered Tylenol 650 mg on May 7, 2009. The resident never received the Tramadol. There was no explanation in the resident's record why the nurse administered Tylenol instead of Tramadol. A face-to-face interview was conducted with Employee #1 on June 10, 2009 at 1:00 PM. He/she acknowledged the above cited findings. The record was reviewed June 10, 2009. 4. Facility staff failed to clarify the indication for	L 051	Findings for Resident #1 1. There are no further corrective actions for resident #1 who has been discharged from the facility in good health. 2. Other resident oximetry records/TARS are corrected 3. The following systemic changes have been or will be put in place to ensure that the deficient practice will not recur and staff was in-serviced on the following: • A QA tool has been developed to monitor the treatment administration record and electronic record to verify that oximetries have been carried out and signed off. • Ten charts will be reviewed randomly on a monthly basis. • The charge nurse and the Quality Nurse will review the nursing staff worksheets on an ongoing basis to monitor that oximetry orders are communicated shift-to-shift. • In-service staff on the importance of ensuring all treatments are carried out and documented. • The "alteration in respiratory status" care plan will be updated to reflect pulse oximetry as indicated. 4. The quality assurance process will be utilized to monitor and sustain compliance. The findings will be presented at the quarterly Quality Assurance meeting. Findings for Residents #12 and #13 1. There are no further corrective actions as the residents have been discharged to home in good health. 2. Other residents' physician orders and medication administration records have been reviewed and transcribed correctly. 3. The following systemic changes have been or will be put in place to ensure the deficient practices does not recur and staff was in-serviced on the following:	7/10/09 7/26/09 7/26/09 7/26/09 7/10/09 7/26/09 7/26/09

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L 051	Continued From page 4 when to administer two (2) pain medications and eye drops Resident #13. A. Review of Resident #13's record revealed a physician' s orders dated April 28, 2009 that directed, " Acetaminophen 650 mg every 4 hour orally for mild pain" and "Percocet 1 tab every 4 hours for pain." There was no evidence that facility staff had clarified with the physician the indication for when to administer two (2) medications, both prescribed for pain. The resident received Tylenol as follows: April 30 at 7:10 AM, May 2 at 2:43 PM and May 3 at 9:30 AM and 3:00 PM. The resident received Percocet as follows: April 29 at 8:35 AM and 10:30 PM, April 30 at 9:55 AM and 10:30 PM, May 2 at 8:34 AM and 10:00 PM and May 3 at 9:30 AM, 3:00 PM and 11:15 PM. There was no explanation in the record why the nurse administered the particular pain medications as identified in the above cited occasions. B. A physician's order dated April 28, 2009, directed, " Timolol 0.5% gel/solution, 1 drop q HS (at bedtime)." The order failed to identify the eye(s) for which the medication was prescribed. A face-to-face interview was conducted with Employee #5 on June 10, 2009 at 1:00 PM. He/she acknowledged the above cited findings. The record was reviewed June 10, 2009. B. Based on record review and staff interview for three (3) of 12 sampled residents, it was determined that the charge nurse failed to initiate a care plan with goals and approaches to	L 051	• The staff will monitor the medication administration record and physician orders to ensure that the strength and dosages for each pain medication is clarified for each level of pain. • A QA monitoring tool has been implemented to check compliance of physician orders. • The charge nurse will remind physicians to specify which pain medication is to be administered base on scale 1-10 (mild, moderate, severe). • Additional secretary associate and nurse education will be given on the importance of verifying that all orders are written out correctly before transcribing. • The 24 chart check will be utilized to monitor physician order clarity and to obtain order clarification if so indicated. • Ten charts will be reviewed randomly on a monthly basis. 4. The quality assurance process will be utilized to monitor and sustain compliance. The findings will be presented at the quarterly Quality Assurance meeting. • The Quality Nurse on the Renaissance Unit will sample charts on a regular basis to ensure that physician orders are clear and precise. Reports will be provided to the DON and the Medical Director. Follow up action that is necessary will be identified and reported at the Quality Assurance meeting.	7/26/09 8/31/09

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L 051	Continued From page 5 address the resident' s nutritional needs and significant weight loss. Residents #1, 3 and 10. The findings include: 1. A review of the clinical record for Resident #1 revealed that the charge nurse failed to initiate a plan of care with objectives, goals and approaches to address the resident's nutritional needs. According to the history and physical examination completed by the physician on May 23, 2009, the resident's diagnoses included: status post hip fracture with total hip replacement, dehydration, macular degeneration, mitral insufficiency and congestive heart failure. According to the dietary consultation dated May 24, 2009, the resident's admission weight of 102 pounds was below the calculated Ideal Body Weight (IBW) of approximately 125 pounds. The Dietician' s assessment dated May 28, 2009 revealed that Resident #1 sustained a significant weight loss of 7% (current weight 94 pounds) over one week. The Dietician implemented recommendations and interventions to address the resident's nutritional concerns, however; the care plan developed by the interdisciplinary team, signed on May 28, 2009, June 1 and June 8, 2009 lacked evidence of problem identification, goals and approaches to address the resident' s nutritional concerns and weight loss. The findings were reviewed and confirmed during a face-to-face interview with Employee #2 on June 10, 2009 at approximately 4:30 PM. The record was reviewed on June 10, 2009.	L 051		

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L 051	Continued From page 6 2. A review of the clinical record for Resident #3 revealed that the charge nurse failed to initiate a plan of care with objectives, goals and approaches to address the resident' s nutritional needs. According to the history and physical examination completed by the physician on May 16, 2009, the resident's diagnoses included generalized weakness, failure to thrive and status post right hip replacement. According to the dietary consultation dated May 21, 2009, Resident #3 sustained a 4.6% weight loss one week post admission. The Dietician deemed the resident as a moderate to high nutritional risk (Level 2 protocol per facility policy) and implemented recommendations and interventions to address the resident' s nutritional concerns. A review of the plan of care developed by the Interdisciplinary team lacked evidence of problem identification, goals and approaches to address the resident' s nutritional concerns and weight loss. The findings were reviewed and confirmed during a face-to-face interview with Employee #2 on June 10, 2009 at approximately 5:00 PM. The record was reviewed June 10, 2009. 3. A review of the clinical record for Resident #10 revealed that the charge nurse failed to initiate a plan of care with objectives, goals and approaches to address the resident' s nutritional needs. According to the history and physical examination completed by the physician on April 3, 2009, the resident' s diagnoses included status post hip fracture, diabetes mellitus, atrial fibrillation, hypertension, hypercholesterolemia and gout.	L 051		

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L 051	Continued From page 7 According to the clinical record, the weight history for Resident #10 was 171 pounds upon admission on April 3, 2009 and on April 20, 2009 his/her weight was assessed at 154 pounds, an approximate 17 pound weight loss. Dietician consultations performed April 4, 2009 through June 9, 2009 deemed the resident a moderate to high nutritional risk (Level 2 protocol) and implemented recommendations and interventions to address the resident' s nutritional concerns. A review of the Interdisciplinary care team (IDT) notes revealed a care plan was developed by the IDT on April 13, 2009 and subsequently reviewed on April 16, 20, 23, 27, 30; May 4, 7, 11, 14, 21, 26; June 1, 4, and 11, 2009. The plan of care lacked evidence of problem identification, goals and approaches to address the resident' s nutritional concerns and weight loss. The record was reviewed on June 11, 2009.	L 051		
L 052	3211.1 Nursing Facilities Sufficient nursing time shall be given to each resident to ensure that the resident receives the following: (a)Treatment, medications, diet and nutritional supplements and fluids as prescribed, and rehabilitative nursing care as needed; (b)Proper care to minimize pressure ulcers and contractures and to promote the healing of ulcers: (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:	L 052	<u>L 052- 3211.1 Nursing Facilities</u> Based on a resident's comprehensive assessment, the facility must ensure that a resident (i) maintains acceptable parameters of nutritional status, such as body weight and protein levels unless the residents' condition demonstrates this is not possible; and (ii) receives a therapeutic diet when there is a nutritional problem. <u>Findings for Residents #1, #3, and #10</u> 1. There are no further corrective actions as all residents have been discharged to home in good health. 2. Other residents having the potential to be affected by the same deficient practice will be identified through the initial nursing admission assessment, weights and physician orders, and review of nursing assistant flow sheets. All residents meeting the criteria for nutritional assessments will be identified upon admission and a dietary consult will be entered into the computer system to flag the dietician. Other residents on the unit identified as needing weekly weights were weighed as requested.	7/10/09 7/26/09

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L 052	Continued From page 8 (d) Protection from accident, injury, and infection; (e)Encouragement, assistance, and training in self-care and group activities; (f)Encouragement and assistance to: (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; (2)Use the dining room if he or she is able; and (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 for help. Based on record review and staff interview for three (3) of 12 sampled residents, it was determined that facility staff failed to assess residents' weights per dietician recommendations and facility policy. Residents #1, 3, 10. The findings include: Facility Policy entitled "Monitoring Resident Weights" stipulated: "Residents will be weighed on a weekly or monthly basis, dependent upon	L 052	3. The following systemic changes have been or will be put in place to ensure that the deficient practice does not recur and staff was in-serviced on the following: • The charge nurse, Quality Nurse and/or her designee will review all initial clinical documentation to ensure that the appropriate action is taken for those residents meeting criteria for nutritional assessment/screens or dietary consults. • Quality monitoring tool is in progress to track admitting, weekly and reassessment weights. • Random audits of food intake will be conducted on specific residents to confirm that there is accurate documentation of the percent of food consumed on the ADL flowsheet. • All weights will be documented into the clinical record upon completion • Dietician re-inserviced staff on weights, consults, and nutrition/reassessment, weight loss in elderly. •Copies of dietary consults will be attached to the nutritional care plan to validate completion and communicate nutritional status. •Weekly weights will be done every Wednesday to track potential weight loss/gain. •Re-weights will be done as directed by the physician or dietician for ongoing monitoring. 4. The quality assurance process will be utilized to monitor and sustain compliance. The findings will be presented at the quarterly Quality Assurance Committee meeting.	7/26/09 6/17/09 & 6/29/09 6/12/09 6/11/09 7/26/09

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L 052	Continued From page 9 their nutritional risk, as determined by the dietitian and the nutrition risk policy. Residents deemed to be at a moderate or high nutritional risk (Level 1 or 2) will be weighed weekly until nutritionally stable and then monthly thereafter ...re-weight completed for any weight change of greater than or less than five (5) pounds within 30-days. Reweighs must be completed within 48-hours on the same scale, with the same amount of clothing and at approximately the same time of day to verify the weight change. Reweighs must be documented into the medical record." 1. A review of the clinical record for Resident #1 revealed facility staff failed to monitor the resident' s weight in accordance with the dietician's recommendations and pursuant to facility policy. The effectiveness of nutritional interventions was limited due to the lack of weight assessments. Resident #1 was admitted May 23, 2009 with diagnoses that included status post hip fracture with total hip replacement, dehydration, macular degeneration, mitral insufficiency and congestive heart failure. According to the admission Minimum Data Set (MDS) assessment signed June 4, 2009, the resident's vision was severely impaired, height 65 inches, weight 102 pounds and according to Section K, Oral/Nutritional status, he/she was coded for a swallowing problem. A gastroenterology (GI) consultation was conducted May 25, 2009 to address the resident's swallowing problem. The consultant determined no evidence of dysphagia or esophageal dysfunction was identified. An initial dietary consultation was conducted May 24, 2009 that revealed the resident's admission weight was 102 pounds and Ideal Body Weight (IBW) was approximately 125 pounds. He/she was below IBW upon admission due to a history	L 052		

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L 052	Continued From page 10 of inadequate intake secondary to appetite. Megace 400 mg daily, an appetite stimulate, was ordered by the physician upon admission. The dietary plan included a regular diet, encourage the intake of ensure (dietary supplement) and ice cream and assistance with meals secondary to visual deficits. Weekly weights were requested. The subsequent dietary consultation dated May 28, 2009 revealed a current weight of 94 pounds, identified as an unintentional 7% significant weight loss. The resident's intake was variable at approximately 50% consumption and diet texture was changed to mechanical soft. Dietician follow up visits would follow the " Level 1 Nutrition Risk Protocol." The recommendations included encourage, monitor and assist with oral intake. Physician's orders dated May 28, 2009 directed a 1200 milliliter per day fluid restriction and the order was discontinued on May 29, 2009. The weight record for Resident #1 revealed weights were assessed on May 23, 2009 and May 28, 2009. The record lacked evidence of weight assessments subsequent to May 28, 2009. According to the facility policy delineated above, individuals deemed as a moderate/high nutritional risk (Level 1 or 2) must have weights assessed on a weekly basis and a re-weights within 48-hours of a 5 pound variance. The record lacked evidence of a re-weight when it was determined that the resident sustained a significant weight loss. Additionally, staff failed to follow the facility's weight monitoring policy and the dietitian's request for weekly weights. Subsequent dietary consultations revealed continued requests for weight assessments. The dietary summaries revealed the resident' s intake improved as evidenced by the intake monitoring record entitled Activities of Daily Living (ADL) Flowsheets. The flow sheets revealed the	L 052		

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L 052	Continued From page 11	L 052		

resident' s intake increased 50-75% and 50-100% respectively. The resident and the resident' s responsible party verbalized that mealtime intake and appetite had improved.
The findings were reviewed and confirmed during a face-to-face interview with Employee #2 on June 10, 2009 at approximately 4:30 PM. The record was reviewed on June 10, 2009.

2. A review of the clinical record for Resident #3 revealed facility staff failed to monitor the resident's weight in accordance with the dietician's recommendations and in accordance with facility policy.
Resident #3, an 88 year old, was admitted May 15, 2009 with diagnoses that included, generalized weakness, failure to thrive and status post right hip replacement. According to the admission MDS assessment, signed May 28, 2009, the resident's height was 69 inches and weight 174 pounds. Section G, Physical functioning, revealed the resident required extensive assistance with eating and according to Section K, Oral/Nutritional status, he/she did not have oral problems and left 25% or more of food uneaten at most meals. The resident's drug regimen on admission included Megace 400 mg daily as an appetite stimulant.
According to the dietary consultation dated May 21, 2009, Resident #3 sustained a 4.6% weight loss in one week post admission (current weight 166 pounds on May 20, 2009). The dietician determined the resident to be a Level 2 nutritional risk and interventions included homemade ensure shakes three times daily, re-weight and weekly weights.
The dietary consultation dated June 9, 2009 revealed the resident's weight was assessed on June 3, 2009 at 161 pounds, a 7.4% significant weight loss since admission. The dietician recommended a re-weight to verify the accuracy

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L 052	Continued From page 12 of the June 3, 2009 weight. Again, weekly weights were requested. A review of the resident' s weight history revealed the resident' s weight was assessed on May 15, 2009; May 20, 2009 and June 3, 2009. The record lacked evidence that facility staff performed weekly weights as per the dietician's request and in accordance with facility policy. Additionally, re-weights were not assessed within 48 hours as per policy and as per the dietician's request. The findings were reviewed and confirmed during a face-to-face interview with Employee #2 on June 10, 2009 at approximately 5:00 PM. The record was reviewed June 10, 2009. 3. A review of the clinical record for Resident #10 revealed facility staff failed to monitor the resident's weight in accordance with the dietician's recommendations and in accordance with facility policy. The effectiveness of nutritional interventions was limited due to the lack of weight assessments. Resident #10, a 91 year old, was admitted April 3, 2009 with diagnoses that included status post hip fracture, diabetes mellitus, atrial fibrillation, hypertension, hypercholesterolemia and gout. According to the initial nutritional consult dated April 4, 2009, the resident's admission weight was 173 pounds and height 70 inches. The dietician determined the resident to be a Level 2 nutritional risk. Nutritional interventions included an 1800 calorie ADA (American Diabetic Association) diet and Glucerna supplements three times daily. The physician ordered Megace 400 mg daily upon admission, as an appetite stimulant. Dietician consultations performed May 21, 2009 and June 9, 2009 revealed repeated requests for weekly weights and a determination of the Level 2 nutritional protocol.	L 052		

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L 052	Continued From page 13 The record revealed Resident #10's weights were assessed as follows: April 3, 2009, 173 pounds; April 8, 2009, 171 pounds; April 20, 2009, 154 pounds; April 22, 2009, 156 pounds; April 24, 2009, 152 pounds; May 5, 2009, 155 pounds May 8, 2009 149 pounds. There was no evidence of weights assessed subsequent to May 8, 2009. The record lacked evidence that facility staff performed weekly weights as per the dietician' s request and in accordance with facility policy. The record was reviewed June 11, 2009.	L 052		
L 099	3219.1 Nursing Facilities 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. This Statute is not met as evidenced by: Based on observations during the survey period it, was determined that dietary services were not adequate to ensure that foods were prepared and served in a safe and sanitary manner as evidenced by: improper storage of mops and brooms on floor surfaces in two (2) of two (2) areas observed, foods stored in the walk in refrigerator beyond the use by date in four (4) of seven (7) containers of stored food observed, the interior and exterior surfaces of salamander pans soiled with leftover foods and not allowed to dry in 19 of 20 pans observed, five (5) of five (5) sheet pans soiled with grease and leftover foods and stored for reuse before drying, coffee cups stained after washing in 16 of 16 coffee cups observed, and the shelf surfaces of storage racks	L 099	L **099 – 3219.1 Nursing Facilities** Sibley Memorial Hospital's Renaissance SNF stores, prepares, distributions, and serves food under sanitary conditions. During the survey, a few deficiencies were identified that have been cited in this report. The following plan of correction addresses the deficiencies: 1. The following plan of correction addresses the deficiencies so they will not adversely impact residents: Finding 1: Mops and brooms have been properly stored. Finding 2: All food identified in the citation were discarded. Finding 3: Interior and exterior surfaces of Salamander and sheet pans were cleaned. Finding 4: The interior surfaces of the plastic coffee cups were cleaned and dark stains removed. Finding 5: Shelf surfaces of storage racks were cleaned. 2. All other areas affected by the deficient practices were corrected as follows: Finding 1: All janitor closets will be inspected to ensure that mops and brooms are stored correctly.	7/10/09 7/26/09

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L 099	Continued From page 14 in the pot and pan wash area stained and soiled with debris in two (2) of three (3) shelves observed. These observations were made in the presence of the Employees #4 and 12. The findings include: 1. Mops and brooms were improperly stored on floor surfaces in the Salad Room and near the tray line in the main kitchen in two (2) of two (2) areas observed at 9:20 AM on June 10, 2009. 2. Foods were stored in the walk in refrigerator beyond the use by or preparation date such as: Beef Roast labeled 5/29/09, Deli Meat in a pan labeled 5/19/09, Banana Pudding labeled 6/7/09 and Chocolate Pudding labeled 6/7/09 in four (4) of seven (7) containers of stored foods observed at 9:30 AM and 10:30 AM on June 10, 2009. 3. The interior and exterior surfaces of 19 of 20 salamander pans and five (5) of five (5) sheet pans were observed soiled with leftover food or grease and were stored on shelves for reuse before pans were allowed to dry between 10:30 AM and 10:45 AM on June 10, 2009: 4. The interior surfaces of 16 of 16 plastic coffee cups were soiled with dark stains after washing in the dish machine at 11:00 AM on June 10, 2009. 5. The shelf surfaces of two (2) of three (3) storage racks in the pot and pan wash area were soiled with stains and other debris observed at 11:10 AM on June 10, 2009. Employees #4 and 12 acknowledged the findings at the time of the observations	L 099	Finding 2: All walk-in refrigerators will be inspected to ensure that food beyond its expiration date is found and discarded as needed. Finding 3: All pots and pans will be inspected and cleaned as needed. Finding 4: All coffee cups will be inspected and cleaned as needed. Finding 5: All shelf surfaces will be inspected and cleaned as needed. 3. The following system measures will be put in place to ensure the deficient practices do not recur and staff was trained on the following: Finding 1: • Training will be completed for all employees who use mops and brooms in the department on how to properly store the mops and brooms. • Mop and broom storage will be added to the weekly checklists and rounding to monitor compliance. Finding 2: • All production staff will be re-trained on Hazard Analysis & Critical Control Program (HACCP); Production Manager will monitor the process. • Production Manager and supervisor will complete daily rounding to make sure production staff follows procedures. Finding 3: • Nutrition services will complete a monthly audit on pans to ensure proper procedures are followed. • Staff will be in-serviced and trained on the proper way to wash/dry pans and replacement pans will be purchased. Finding 4: Retraining will be given to the dishroom staff to ensure that mugs/cups are being soaked weekly. • Supervisors and Patient Service Manager will complete sanitation audits weekly and daily rounds to ensure mugs/cups are clean. Finding 5: • Sanitation staff will be in-serviced on proper cleaning to racks. All racks in pot and pan area will be put on a special rotation for cleaning and be added to the sanitation checklist to monitor compliance. 4. The quality assurance process will be utilized to monitor and sustain compliance. The findings will be presented at the quarterly Quality Assurance meeting.	7/26/09 7/31/09 7/31/09 8/31/09 8/31/09 8/31/09 7/26/09

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L 167	Continued From page 15	L 167	**L 167 – 3227.18 Nursing Facilities** Sibley Memorial Hospital Renaissance SNF provides pharmaceutic services (including procedures that assure that accurate acquiring, receiving, dispensing, and administration of all drugs and biologicals) to meet the needs of each resident.	
L 167	3227.18 Nursing Facilities Each facility shall comply with all applicable District and federal laws,regulations, standards, administrative guidelines, and rules that regulate the procurement, handling, storage, administering, and recording of medication. This Statute is not met as evidenced by: Based on observations during the medication storage area inspection in four (4) of four (4) medication carts, it was determined that facility staff failed to date medications when opened. The findings include: A review of the two (2) medication carts was conducted on 3 South on June 11, 2009 at 10:30 AM in the presence of Employee #2. Three (3) of three (3) medications were observed undated when opened: Advair dispensed from the pharmacy on June 9, 2009 Maalox dispensed from the pharmacy on June 9, 2009 Hydrocortisone 1% cream dispensed from the pharmacy on June 9, 2009 A review of the two (2) medication carts was conducted on 3 North on June 11, 2009 at 10:45 AM in the presence of Employee #2. Three (3) of three (3) medications were observed undated when opened: Bacitracin ointment dispensed from the pharmacy on June 7, 2009 Deep Sea Nasal Spray dispensed from the pharmacy on June 7, 2009 Hydrocortisone 1% cream dispensed from the pharmacy on June 7, 2009	L 167	Findings 1. Medications cited in this report were removed. 7/10/09 2. All carts were inspected and other medications that were unlabelled and open were removed. 7/26/09 3. The following systemic changes have been or will be put in place to ensure that deficient practice will not recur and staff was in-serviced on the following: 7/26/09 • All medications that are multi-use will be dated once that bottle is opened and discarded in the time frame that it expires once opened. • The Quality Nurse or Charge Nurse will ensure medications have open dates on the labels/bottles utilizing medication cart inspection tool. • The nursing staff will be in-serviced and informed of importance of labeling/dating of medications once the original package/seal is broken. 4. The quality assurance process will be utilized to monitor and sustain compliance. The findings will be presented at the quarterly Quality Assurance Committee meeting. 7/26/09	

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L 167	Continued From page 16 Employee #2 acknowledged the findings at the time of the observations.	L 167		
L 201	3231.12 Nursing Facilities Each medical record shall include the following information: (a)The resident's name,age, sex, date of birth, race, martial status home address, telephone number, and religion; (b)Full name, addresses and telephone numbers of the personal physician, dentist and interested family member or sponsor; (c)Medicaid, Medicare and health insurance numbers; (d)Social security and other entitlement numbers; (e)Date of admission, results of pre-admission screening, admitting diagnoses, and final diagnoses; (f)Date of discharge, and condition on discharge; (g)Hospital discharge summaries or a transfer form from the attending physician; (h)Medical history, allergies, physical examination, diagnosis, prognosis and rehabilitation; (i)Vaccine history, if applicable, and other pertinent information about immune status in relation to vaccine preventable disease; (j)Current status of resident's condition;	L 201	**L 201 – 3231.12 Nursing Facilities** The Renaissance SFN maintains clinical records on each resident in accordance with accepted professional standards. During the survey, a problem area was identified that has been cited in this report. The following plan of correction addresses them. Findings for Resident #1 1. No further corrective action for this resident who has been discharged to home in good health. 2. Other residents had all mood and behavior monitoring initiated, assessed, reassessed, and documented correctly in the clinical record per policy. 3. The following systemic changes have been or will be put in place to ensure the deficient practices not recur and nursing staff education on the following: • All residents on psychoactive medications or with mood and behavior symptoms will have their behavior assessed and document on a shift-by-shift basis. • The Quality Nurse, DON, or her designee will review resident clinical record to ensure that the daily mood and behavior documentation is being completed on all residents with mood and behavior symptoms or on psychotropics on a daily basis. • In-service education was provided by the DON to the staff on the significance of addressing, monitoring, and documenting residents' mood and behavior. Education will be on-going. • The mood and behavior QA monitoring tool will be used to monitor compliance. • The nursing staff will review the MAR daily to assess for presence of psychotropics. 4. The quality assurance process will be utilized to monitor and sustain compliance. The findings will be presented at the quarterly Quality Assurance Committee meeting.	7/10/09 7/26/09 7/26/09 7/10/09 7/26/09

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L 201	Continued From page 17 (k)Physician progress notes which shall be written at the time of observation to describe significant changes in the resident's condition, when medication or treatment orders are changed or renewed or when the resident's condition remains stable to indicate a status quo condition; (l)The resident's medical experience upon discharge, which shall be summarized by the attending physician and shall include final diagnoses, course of treatment in the facility, essential information of illness, medications on discharge and location to which the resident was discharged; (m)Nurse's notes which shall be kept in accordance with the resident's medical assessment and the policies of the nursing service; (n)A record of the resident's assessment and ongoing reports of physical therapy, occupational therapy, speech therapy, podiatry, dental, therapeutic recreation, dietary, and social services; (o)The plan of care; (p)Consent forms and advance directives; and (q)A current inventory of the resident's personal clothing, belongings and valuables. This Statute is not met as evidenced by: Based on record review and staff interview for three (3) of 12 sampled residents, it was determined that facility staff failed to consistently include the following in the medical record:	L 201	Findings for Residents #1 and #10 1. No further corrective actions are needed for residents #1 and #10 as they have been discharged to home in good health. 2. Resident #5 and other residents on the unit have been assessed, measured for staging and documented appropriately in the Affinity computer system and on skin assessment sheets. 3. The following systemic changes have been or will be put in place to ensure the deficient practice will not recur and staff educated on the following: • The nursing staff received additional training on wound care policy and procedures. • The Quality Nurse or charge nurse will monitor the wound care skin assessment sheets every Wednesday to ensure would staging and other characteristics are carried out as ordered. • Direct observation will be conducted randomly to monitor compliance with wound care and documentation follow-through. • Physician orders will be monitored daily to alert staff where wound care monitoring is indicated. • Initial nursing assessments will be utilized to identify residents needing wound care to promote compliance with documentation in the clinical record and proper wound care orders. • In-service by facility wound nurse will be scheduled. 4. The quality assurance process will be utilized to monitor and sustain compliance. The findings will be presented at the quarterly Quality Assurance Committee meeting. Finding for Resident #5 1. Resident #5 remains on the unit at this time and the medication administration record and on-going pain assessment/reassessment sheet is now in compliance with documentation policy and procedures. 2. Other residents' medication administration records and on-going pain assessment/reassessment records have been reviewed and are compliant.	7/10/09 7/26/09 7/26/09 6/16/09 7/26/09 7/10/09 7/26/09

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L 201	Continued From page 18 behavior monitoring for one (1) resident receiving antipsychotic medication, administration of pain medication for one (1) resident and the status of wounds for two (2) residents. Residents #1, 5, and 10. The findings include: Facility policy entitled "Skin Protocol - Management of Residents at risk for Skin Breakdown and Presenting with Skin Breakdown" stipulated: page 5, "Specific Ulcer Interventions; Stage I, ...measure and document size, location and color ...do not use any dressings for intact skin of a stage I pressure area in order to monitor the pressure area site every shift. Stage II ...Document the pressure ulcer characteristics (size location, wound bed color, odor and appearance of the surrounding tissue) with each dressing change ...Measure weekly and document on pressure ulcer record." Facility policy entitled "Daily Behavior Symptom Checklist Guidelines" stipulated: "The Daily Behavior Symptoms Checklist is initiated when a resident exhibits behaviors(s) and symptoms identified on the Behavior/Symptom checklist or a resident is taking mood-altering medication such as anti-depressants, psychotropic medication and/or anti-psychotic medication ...documentation on form is completed every shift." 1. Facility staff failed to consistently document the status of the Resident #1's pressure sores as per facility policy, behaviors and clarify the usage of pain medication. A. According to documentation reviewed in the nurses' progress notes, redness on the left heel area was identified on May 25, 2009 and a Stage II pressure sore was identified on the back on June 2, 2009. There was no documentation after the initial	L 201	3. The following systemic changes have been or will be put in place to sure the same deficient practice will not recur and staff will be educated on the following: • Upon request for pain medication by the resident, the nurse will review the medication administration record, carry the record and assessment sheet to the Pyxis system, remove the medication, proceed to resident's room with both record and medication, check identification band, assess pain level, administer medication, and sign off on medication record and assessment sheet at the bedside. The action will be immediately documented. • A stand-up in-service was provided to review proper medication administration process. • MedPass QA by direct observation will be conducted by the DON and/or Quality Nurse. •In-service was done on assessment/ reassessment of pain medication for nursing staff. 4. The quality assurance process will be utilized to monitor and sustain compliance. The findings will be presented at the quarterly Quality Assurance Committee meeting.	7/26/09 6/16/09 6/16/09 7/26/09

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L 201	Continued From page 19 assessment of May 25, 2009 regarding the status of the heel area. A physician' s orders dated June 2, 2009 directed, "Cleanse pressure sore on back with normal saline and apply Mepilex dressing every 7 days." The June 2009 Treatment Administration Record (TAR) revealed the treatment was applied on June 2, 2009 and the subsequent treatment was scheduled on June 9, 2009. The box annotated for the next wound treatment was June 9, 2009 and was blank, indicating that the treatment was not administered. A face-to-face interview was conducted with Employee #2 on June 10, 2009 at approximately 4:30 PM. He/she stated that the resident's skin was currently intact. The site of the former pressure sore on the resident's back was observed in the presence of Employee #2 and was intact. Employee #2 acknowledged the lack of documentation related to the status of the resident's alteration in skin integrity. The record lacked documentation related to the status of the resident' s pressure sore and alteration in the skin integrity of the heel subsequent to the initial observation. The record was reviewed June 10, 2009. B. A review of the clinical record for Resident #1 revealed facility staff failed to monitor behaviors in accordance with facility policy. According to physician's orders dated May 26, 2009, the resident' s drug regimen included Remeron 7.5 mg at bedtime for depression, Risperdal 1/8 mg every 8 hours for agitation and Ativan 0.5 mg every 8 hours as needed for anxiety. The record revealed ongoing assessments by the psychiatrist and modifications in the psychotropic medication regimen. A review of the electronic documentation related	L 201		

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L 201	Continued From page 20 to behavioral monitoring lacked evidence of consistent monitoring every shift as per facility policy. The electronic data was ascertained by Employee #2 and the findings reviewed and confirmed in the presence of this employee on June 10, 2009. The record was reviewed on June 10, 2009. C. A review of the clinical record for Resident #1 revealed licensed staff failed to clarify between the usage of two (2) medications prescribed for pain. Physician' s orders signed by the physician June 1, 2009 directed, "Percocet 1 tablet orally every 4 hours as needed for mild pain" and " Tylenol 325 mg 2 tablets orally every 4 hours as needed for mild pain." The medication administration record for June 2009 revealed Percocet was administered June 2, 3, 5, 6, 7 and 8, 2009. The record lacked evidence that licensed staff clarified between the uses of the two (2) medications, both prescribed for mild pain. The record was reviewed June 10, 2009. 2. Facility staff failed to consistently document on the administration of pain medication for Resident #5. A review of Resident #5's record revealed a physician' s order dated April 29, 2009 that directed, " Tylenol 650 mg every 4 hours as needed for mild pain." The resident was medicated with Tylenol on June 1, June 2, June 3, June 4 and June 8, 2008. According to the nurses' notes for June 1, 2, 3, 4 and 8, 2008, there was no documentation related to the resident's pain. Additionally, there were no entries on the "On-Going Pain Assessment" sheet for June 1, 2, 3, 4 and 8, 2008.	L 201		

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	HFD02-0026	A. BUILDING _____ B. WING _____	06/11/2009

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L 201	Continued From page 21 A face-to-face interview was conducted with Employee #5 on June 11, 2009 at 10:30 AM. After reviewing the record, he/she acknowledged that documentation related to the resident' s pain was not in the record for the above cited dates. The record was reviewed June 11, 2009. 3. Facility staff failed to consistently document the status of Resident #10' s pressure sores as per facility policy. According to documentation reviewed in the nurses' progress notes, a Stage II lumbar pressure sore was identified on May 9, 2009. A nursing entry dated May 15, 2009 revealed the identification of a second pressure sore as follows, "Pressure ulcer site #2 @ spine." The documentation of May 15, 2009 lacked evidence of wound characteristics and/or staging. A subsequent nursing entry dated May 31, 2009 revealed pressure ulcer #1 was currently characterized as "Stage I, non-blanchable erythema of intact skin." The site was cleansed with normal saline and Mepilex dressing was applied in accordance with physician's orders. The record lacked any further documentation related to the status of Resident #10's pressure sores. The electronic documentation related to the resident' s pressure sores was obtained by Employee #2 on June 11, 2009 at approximately 3:00 PM. He/she stated that the resident' s skin was currently intact. The record was reviewed June 11, 2009.	L 201		
L 217	3234.4 Nursing Facilities The provision of space and the way in which the facility is equipped, furnished, and maintained shall provide a home- like setting for each	L 217	**L 217 – 3234.4 Nursing Facilities** Sibley Memorial Hospital Renaissance SNF operates and provides services in compliance with all applicable federal, state and local laws, regulations and codes. During the survey, several problem areas were identified that have been cited in this report.	

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L 217	Continued From page 22 resident while providing the staff a pleasant and functional working environment. This Statute is not met as evidenced by: Based on record review and staff interviews it was determined that facility staff failed to comply with state regulations as evidence by failing to report unusual incident/events occurrences to the state agency. The findings include: The unusual incident/event reports were reviewed from March through May 2009. A total of 29 reports were generated by the facility. Of the 29 incident reports reviewed, there were no reports of resident abuse or events that resulted in resident injury. A face-to-face interview with Employee #1 was conducted on June 11, 2009 at 8:30 AM. He/she acknowledged that none of the incident/event reports were sent to the state agency.	L 217	Finding #1 1. All reports from May 2009 to June 11, 2009, were sent to DOH. 2. The facility occurrence reporting system will be utilized to identify other potential residents that could be affected by the deficient practice. Other occurrence reports from 6/12/2009 to 7/26/2009 will be sent to DOH. 3. The following systemic changes are in place to ensure the deficient practice will not recur and nursing staff will be in-serviced on the following: • Immediately upon notification of an occurrence and subsequent investigation of the incident, the state agency will be notified electronically within the mandated reporting time frame of forty-eight (48) hours or eight (8) hour time frame if the incidence results in injury or harm to the resident. • The SNF will track all occurrence in the organization reporting system to ensure no occurrences have been missed and to report immediately to state. • All residents will be screened by the medical/surgical house officer or admitting physician upon each occurrence. 4. The quality assurance process will be utilized to monitor and sustain compliance. The findings will be presented at the quarterly Quality Assurance Committee meeting.	7/10/09 7/26/09 7/26/09 7/26/09
L 410	3256.1 Nursing Facilities 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. This Statute is not met as evidenced by: Based on observations during the survey period it, was determined that dietary services were not adequate to ensure that foods were prepared and served in a safe and sanitary manner as evidenced by: improper storage of mops and brooms on floor surfaces in two (2) of two (2) areas observed, foods stored in the walk in refrigerator beyond the use by date in four (4) of	L 410	**L 410 – 3256.1 Nursing Facilities** Sibley Memorial Hospital's Renaissance SNF stores, prepares, distributions, and serves food under sanitary conditions. During the survey, a few deficiencies were identified that have been cited in this report. The following plan of correction addresses the deficiencies: 1. The following plan of correction addresses the deficiencies so they will not adversely impact residents: Finding 1: Mops and brooms have been properly stored. Finding 2: All food identified in the citation were discarded. Finding 3: Interior and exterior surfaces of Salamander and sheet pans were cleaned.	7/26/09

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L 410	Continued From page 23 seven (7) containers of stored food observed, the interior and exterior surfaces of salamander pans soiled with leftover foods and stored wet and ready for reuse in 19 of 20 pans observed, five (5) of five (5) sheet pans soiled with grease and leftover foods and stored for reuse before drying, coffee cups stained after washing in 16 of 16 coffee cups observed, and the shelf surfaces of storage racks in the pot and pan wash area stained and soiled with debris in two (2) of three (3) shelves observed. These observations were made in the presence of the Employees #4 and 12. The findings include: 1. Mops and brooms were improperly stored on floor surfaces in the Salad Room and near the tray line in the main kitchen in two (2) of two (2) areas observed at 9:20 AM on June 10, 2009. 2. Foods were stored in the walk in refrigerator beyond the use by or preparation date such as: Beef Roast labeled 5/29/09, Deli Meat in a pan labeled 5/19/09, Banana Pudding labeled 6/7/09 and Chocolate Pudding labeled 6/7/09 in four (4) of seven (7) containers of stored foods observed at 9:30 AM and 10:30 AM on June 10, 2009. 3. The interior and exterior surfaces of 19 of 20 salamander pans and five (5) of five (5) sheet pans were observed soiled with leftover food or grease and were stored on shelves for reuse before pans were allowed to dry between 10:30 AM and 10:45 AM on June 10, 2009: 4. The interior surfaces of 16 of 16 plastic coffee cups were soiled with dark stains after washing in the dish machine at 11:00 AM on June 10, 2009.	L 410	Finding 4: ▫ The interior surfaces of the plastic coffee cups were cleaned and dark stains removed. ▫ Employees will soak mugs and coffee cups in a stain removal chemical once a week to ensure mugs and cups are free of soil and dark stains. Finding 5: Shelf surfaces of storage racks were cleaned. 2. All other areas affected by the deficient practices were corrected as follows: Finding 1: All janitor closets will be inspected to ensure that mops and brooms are stored correctly. Finding 2: All walk-in refrigerators will be inspected to ensure that food beyond its expiration date is found and discarded as needed. Finding 3: All pots and pans will be inspected and cleaned as needed. Finding 4: All coffee cups will be inspected and cleaned as needed. Finding 5: All shelf surfaces will be inspected and cleaned as needed. 3. The following system measures will be put in place to ensure the deficient practices do not recur and staff was trained on the following: Finding 1: • Training will be completed for all employees who use mops and brooms in the department on how to properly store the mops and brooms. • Mop and broom storage will be added to the weekly checklists and rounding to monitor compliance. Finding 2: • All production staff will be re-trained on Hazard Analysis & Critical Control Program (HACCP); Production Manager will monitor the process. • Production Manager and supervisor will complete daily rounding to make sure production staff follows procedures. Finding 3: • Nutrition services will complete a monthly audit on pans to ensure proper procedures are followed. • Staff will be in-serviced and trained on the proper way to wash/dry pans and replacement pans will be purchased.	7/26/09 7/26/09 7/31/09 7/31/09 8/31/09

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L 410	Continued From page 24 5. The shelf surfaces of two (2) of three (3) storage racks in the pot and pan wash area were soiled with stains and other debris observed at 11:10 AM on June 10, 2009. Employees #4 and 12 acknowledged the findings at the time of the observations	L 410	Finding 4: Retraining will be given to the dishroom staff to ensure that mugs/cups are being soaked weekly. • Supervisors and Patient Service Manager will complete sanitation audits weekly and daily rounds to ensure mugs/cups are clean. Finding 5: • Sanitation staff will be in-serviced on proper cleaning to racks. All racks in pot and pan area will be put on a special rotation for cleaning and be added to the sanitation checklist to monitor compliance.	8/31/09 8/31/09