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	095030	A. BUILDING _____ B. WING _____	07/09/2008

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

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F 000	INITIAL COMMENTS An annual recertification survey was conducted July 7 through 9, 2008. The following deficiencies were based on observations, record reviews and staff and resident interviews. The sample included 10 residents based on a census of 40 residents on the first day of survey, and one (1) supplemental resident.	F 000		
F 176 SS=D	483.10(n) SELF ADMINISTRATION OF DRUGS An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview for one (1) supplemental resident, it was determined that the facility staff failed to assess a Resident JH1 for self-administration of medication. The findings include: On Tuesday, July 8, 2008, at approximately 9:15 AM, during the morning medication pass, Resident JH1 was observed administering Advair MDI to himself/herself. The medication was in the possession of the Resident JH1. The medication was observed stored in a bag at the Resident's bedside. The physician's order signed and dated on July 4, 2008, ordered "Advair 250/50 mg inhaler daily 1 puff q12h [every 12 hours] COPD [Chronic Obsturctive Pulmonary Disease]" .	F 176	**483.10 (n) Self Administration of Drugs** Residents on the Renaissance Skilled Nursing Facility are provided services that meet professional standards of quality. During the most recent survey, a problem was identified that has been cited in this report. The following plan of correction addresses it: **Findings for Resident JH1** 1. On July 4, 2008 a nurse failed to obtain consent from the resident to self administer medication. On July 8, 2008, consent for self administration of medications was signed by the resident. All other residents electing to self administer medication will have consent signed upon admission. 2. Other residents having the potential to be affected by the same deficient practice will be identified upon admission, when a physician writes an order or when the resident wishes to self-administer. The policy will be followed and monitored by the interdisciplinary team and the nurse. 3. The following systemic changes will be put in place to ensure the deficient practice will not recur:	07/08/08 08/15/08 08/15/08

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: John L Slo — TITLE: President/CEO — (X6) DATE: 07/28/08

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 176	Continued From page 1 According to the facility's policy titled, "Self - Administration of Medications" stipulates, "1. The resident must formally indicate his or her decision to self-administer or not by completing the Right to Self-Administer Medication Form. 2. The resident's attending physician will write the orders for self-administration of medication. 3. The Interdisciplinary Team will determine if self-administration of medication is safe. Residents, who are considered candidates for self-administration, will be informed orally and in writing." The Residents chart was reviewed immediately after the medication pass. The record lacked evidence that documented Resident JH1 could self-administrator medication. A face-to-face interview was conducted on Tuesday, July 8, 2008, at 11:00 AM with Employee #1. He/She stated that the resident does not self-administrator medication, but will be allowed to do so in the future. The record was reviewed on July 8, 2008.	F 176	• The charge nurse and/or his/her designee will monitor all orders written for self administration • The nurse will verify that the consent has been signed • The care plan process for self administration will be implemented along with three day resident education process to ensure safety of self administration • Sample audits will be done monthly for a period of three months ensure compliance • The interdisciplinary team will review the care plans for compliance • The self administration consent form will be included in the nurses' admission packet to promote compliance of resident signature • The Director of Nursing will provide an inservice to the nursing staff on the importance of ensuring consent has been obtained for residents electing to self administer medications. 4. The quality process will be utilized to maintain and sustain compliance. The audit findings will be presented at a quarterly quality assurance meeting.	08/15/08
F 241 SS=D	483.15(a) DIGNITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, resident, family and staff interviews for two (2) of 10 sampled residents, it was determined that facility staff failed to provide complete privacy for one (1) resident during a	F 241	**F241 483.15 (a) Dignity** The Renaissance Skilled Nursing Facility provides services that meet professional standards of quality and maintains each resident's dignity. During a recent survey, some problems were identified that have been cited in this report. The following plan of correction addresses them: **Findings for resident #4**	

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F 241	Continued From page 2 wound dressing change and respond to one (1) resident's call light in a timely manner. Residents #4 and 7. The findings include: 1. Facility staff failed to provide complete privacy for Resident #4 during a wound dressing change. A wound treatment was observed on July 8, 2008 at approximately 12:25 PM for the right lower arm. During the treatment it was observed that the nurse failed to pull the privacy curtain completely around Resident #4's bed. A face-to-face interview was conducted with Employee #8 immediately after the wound treatment. He/she acknowledged that the privacy curtain was not completely pulled around the resident's bed and therefore did not provide the resident with complete privacy during the procedure. 2. Facility staff failed to respond to Resident #7's call light in a timely manner. During a face-to-face resident and family interview with the surveyor on July 9, 2008 at approximately 8:30 AM, Resident #7 and family members expressed dissatisfaction with facility's response time to the resident's call light. The resident stated, "I felt real bad to have to have a bowel movement and urinate on myself at least two (2) times. It takes over thirty minutes for them to answer the light. I know the staff do not like to have to clean up the mess, but it was not my fault. The staff delayed responding to my call	F 241	1. There are no further corrections for this resident as the resident has been discharged from the facility. The dignity of other residents is being maintained as all curtains are being drawn when care is being provided. 2. Other residents having the potential to be affected by the same deficient practice will be monitored by direct observation of staff providing care. Privacy will be maintained by drawing curtains completely around the residents. 3. The following systemic changes will be put in place to ensure the same deficient practice will not recur: • In-services will be conducted to remind staff of importance of keeping curtains completely closed when providing care. • Nursing staff will ensure that residents' curtains are completely closed during provision of care • The Director of Nursing, Charge Nurse and RN Quality Coordinator will monitor resident care on a daily basis to ensure compliance with drawing curtains around residents to maintain their privacy and dignity. Direct observation of resident care will be a part of daily rounds. • The Unit Educator will conduct several inservices on resident rights and abuse, including the topic of dignity. 4. The Quality assurance process will be utilized to maintain and sustain compliance. The audit findings will be presented at a quarterly quality assurance meeting.	08/15/08 07/14/08 07/23/08 08/15/08

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 241	Continued From page 3 light requests. I mean they took too long a time." Family members stated that the resident had to sometimes call home for help at midnight when the staff failed to respond promptly to his/her call light. "We in turn had to call to the facility from home to get staff to assist the resident under the facility's care, with his/her needs/requests." During the interview, the resident was observed out of bed in a side chair finishing his/her breakfast. The call light was observed to be out of the resident's reach. It was tied to the right side rail away from the resident. The surveyor instructed the family member to press the call light for assistance. It took approximately ten (10) minutes before Employee #5 followed by Employee #2 responded to the resident's call light. Both employees were unaware that the surveyor was in the resident's room before their entry. Employee # 2 stated, "I was just passing by and saw the light and came in to see what I can do for the resident. I answer the call light anytime I see it on. " A face to face interview was conducted with Employee #5 on July 9, 2008 at approximately 8:50 AM. He/she acknowledged that the resident's call light was not responded to in a timely manner. He/she stated, "I was with another resident."	F 241	**Findings for resident # 7** 1. This resident still resides on the Renaissance Unit. This resident's call light is answered in a timely manner. The importance of answering resident call lights in a timely manner has been discussed with the staff. 08/15/08 2. Other residents having the potential to be affected by the same deficient practice will be identified upon activation of their call light. Response time will be monitored to ensure timely response to maintain resident safety and satisfaction. CNA's will continue to make hourly rounds on their residents and continue to log data onto round sheets. 07/10/08 3. The following systemic changes will be put in place to ensure the same deficient practice will not recur: 08/15/08 • The Director of Nursing and/or his/her designee will continue to utilize the call light monitoring tool developed to monitor response time to call lights • Several inservices were presented to staff to share data regarding delayed response to call lights. Results will be shared with staff to note progress improvement. • Quality assurance monitoring will be ongoing to collect data and analyze findings to assess timely compliance. Sample audits will be done monthly for a period of three months ensure compliance.	
F 279 SS=D	483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.	F 279		

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F 279	Continued From page 4 The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for two (2) of ten (10) sampled residents, it was determined that facility staff failed to develop a care plan with goals and approaches for one (1) resident with depression and seizures; and one (1) resident for potential adverse drug interactions from the use of nine (9) or more medications and aspirin therapy. Residents #2 and 10. The findings include: 1. Facility staff failed to develop a care plan with goals and approaches for Resident #2 for (1) potential drug interactions from the use of nine (9) or more medications and (2) for potential bleeding from daily aspirin therapy.	F 279	• Education will be done on the Unit so that all nursing, secretarial associates and interdisciplinary team members will understand their role in responding to call lights • The Director of Nursing will explore the possibility of obtaining a communication device to alert individual nurses of resident need/call light activation. This will enable each nurse to be informed of resident needs immediately. • Re-education of all staff will take place on using the intercom system for enhancing more timely response to call lights • The Unit Educator will be presenting inservices to the nursing staff on customer service and will incorporate dignity of the residents and importance to responding to residents' calls for assistance. 4. Quality monitoring process will be utilized to maintain and sustain compliance. The audit findings will be presented at a quarterly quality assurance meeting. **483.20 (d), 483.20(k)(1) Comprehensive Care Plans** Comprehensive Care Plans are developed for all SNF residents. During the most recent survey, a problem area was identified and has been cited in this report. The following plan of correction addresses it. **Findings for resident #2** 1. A nurse failed to develop a care plan with the appropriate goals and approaches for a resident receiving aspirin therapy and with the potential	08/15/08 07/09/08

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F 279	Continued From page 5 The review of the clinical record for Resident #2 revealed a physician's order dated and signed on May 5, 2008 that included the following medications: Flovent Inhaler, Aspirin, Metoprolol XL, Ramipril, Prednisone, Combivent Inhaler, Sodium Chloride Nose Spray, Montelucast, Pantoprazole and Guiafenesin. A review of the care plan that was last updated on June 19, 2008 revealed there were no problems identified with appropriate goals and approaches to address (1) adverse drug interactions involving nine (9) or more medications and (2) for potential bleeding from daily aspirin therapy. On July 7, 2008 at approximately 2:25 PM a face-to-face interview was conducted with Employee #9. He/she acknowledged that the record lacked (1) a care plan for nine or more medications and (2) a care plan for aspirin therapy. He/she stated, "I don't understand. They should have been on the record. I will put them on right away." The record was reviewed on July 7, 2008. 2. Facility staff failed to develop a care plan with goals and approaches for Resident #10 with a diagnoses of Depression and Seizures. A review of the Admission Minimum Data Set [MDS] completed March 13, 2008 Section I [Disease Diagnoses] included Depression and Seizure disorder. The scheduled medication list dated March 3, 2008 revealed that Resident #10 received " ...Keppra 250 mg [for Seizures] and Zoloft 50 mg for Depression" .	F 279	interactions involving nine or more meds. A care plan was developed for both diagnoses on 07/09/08. It has been reinforced with the nursing staff the importance of implementation of care plans for residents admitted on aspirin therapy taking nine or more meds. All other residents on the Unit receiving aspirin therapy and/or receiving nine or more medications have had their clinical records reviewed and the deficient practice has not been found. 7-9-08 2. All residents having the potential to be affected by the same deficient practice will be identified upon admission to the facility through the initial nursing assessment, 24 hour chart reviews, physician orders, inter shift reporting, and/or by the Interdisciplinary Team. 3. The following systemic changes will be put in place to ensure the same deficient practice will not recur: • The MDS Coordinator/Director of Nursing will provide additional in-services to the nursing staff of the importance of completing the comprehensive care plan process in a timely manner. This will be done on an ongoing basis. • The RN Quality Coordinator and/or his/her designee will monitor physician orders including the medication kardex for the presence of anticoagulants and residents taking nine or more medications. This will be done upon admission and on an ongoing basis thereafter. • The RN Quality Coordinator will continue to utilize the quality assurance monitoring tool to track	08/15/08 08/15/08

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F 279	Continued From page 6 A review of the resident's care plans lacked evidence that facility staff developed a plan of care with goals and approaches to address the resident's diagnoses of Depression and Seizures. A face-to-face interview was conducted on July 8, 2008 at approximately 3:00 PM with Employee #2. He/She acknowledged that care plans for Depression and Seizures were not developed. The record was reviewed on July 8, 2008.	F 279	anticoagulant usage with nine or more medications, and ensure that comprehensive care plans are completed on an ongoing basis. • Thirty charts will be reviewed monthly for a period of three months to ensure compliance • The interdisciplinary team will review and revise all care plans during weekly meetings to ensure accuracy and compliance • The MDS Coordinator will add "potential for adverse drug events due to usage of nine or more drugs" to the problem list. 4. The quality process will be utilized to maintain and sustain compliance. The audit findings will be presented at a quarterly quality assurance meeting.	08/15/08 07/17/08
F 425 SS=E	483.60(a),(b) PHARMACY SERVICES The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, it was determined that the facility staff failed to remove expired medication from the facility's two (2) of	F 425	**Findings for resident #10** 1. There are no further corrections for this resident as the resident has been discharged from the Unit. Other residents' clinical records have been reviewed and there are no deficient practices noted. 2. Other residents having the potential to be affected by the same deficient practice will be identified upon admission to the Renaissance Unit through review of physician orders and inter-shift nursing reports. 3. The following systemic changes will be put in place to ensure the deficient practice will not recur: • There will be additional in-services conducted by the DON and his/her designee on the importance of ensuring the diagnosis of depression and seizures are incorporated into the	08/15/08 08/15/08

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F 425	Continued From page 7 two (2) automated medication dispensing machines. The findings include: , "Labeling and Storage of Medication" stipulates, "Each expired medication shall be rem On Wednesday, July 9, 2008 between 9:00 AM and 9:45 AM, an inspection of the facility's automated medication dispensing machines located on the 3North and 3South Nursing units were observed. Three (3) Lorazepam 2mg/ml injections were expired in the automated medication dispensing machine on 3 North and five (5) Lorazepam 2mg/ml injections were expired in the automated medication dispensing machine on 3 South. All eight (8) lorazepam injections expired on June 20, 2008. At the time of the observation Employee #4 acknowledged that the medications were expired.	F 425	• The RN Quality Coordinator will utilize the psychotropic QA monitoring tool on an ongoing basis to ensure compliance is being maintained and incorporated into the care plan. • The interdisciplinary care team will review all care plans during the weekly meetings to assist with compliance • The 24-hour chart review will be utilized to monitor orders written for the diagnosis of seizures and depression. • The inter-shift report must include identification of all residents with seizures and/or depression. • The MDS Coordinator will develop a care plan for seizure disorder. • Sample audits will be completed for a period of three months to ensure care planning compliance 4. The quality process will be utilized to maintain and sustain compliance. The audit findings will be presented at a quarterly quality assurance meeting.	08/15/08
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced bv: Based on record review and staff interview for	F 428	**483.60 (a),(b) Pharmacy Services** The Renaissance Skilled Nursing Facility (SNF) provides pharmaceutical services to meet the needs of each resident. During the survey, a number of problem areas were identified that have been cited in this report. The following plan of correction addresses them: 1. No specific residents were identified as being adversely affected related to deficient practices in the survey report. The following corrections have been put in place to address the deficient practices:	08/15/08

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F 428	Continued From page 8 one (1) of 10 sampled residents, it was determined that the monthly Drug Regimen Review was not consistently done for Resident #2. The findings include: On Wednesday, July 9, 2008, at approximately 11:30 AM, the inspector request of the facility to supply the name of the residents who were admitted 30 days or more days. Resident #2 was the only resident admitted 30 or more days. Upon reviewing Resident #2's chart, it was discovered that the pharmacy had not reviewed the chart since February 2, 2008. According to the Facility ' s policy titled, " Drug Regimen Review and Concurrent Utilization Review " stipulates, " All residents that are admitted to the skilled nursing unit in the Sibley Renaissance and remaining for 30 days or greater shall have a drug regimen review completed by a licensed pharmacist at least once per month ... " A face-to-face interview was conducted with Employees #1, 2, 3 and 9 at approximately 1:00 PM on July 9, 2008. They stated that another pharmacy delivered medications to Resident #2 and acknowledged that a pharmacy drug regimen review had not been conducted since February 2, 2008. The record was reviewed on July 9, 2008.	F 428	• The "outdated" functionality in the Automated Dispensing Machine will be turned on for Lorazepam. 2. Other residents having the potential to be affected by the same deficient practice will be identified during monthly expiration inspection. 3. The following systemic changes will be put in place to ensure the same deficient practices do not recur: • Monthly inspection to include an area for Automated Dispensing Machine review 4. The quality assurance process will be utilized to maintain and sustain compliance. The findings will be presented at quarterly quality assurance meetings. 483.60 (c) **Drug Regimen Review** The Renaissance Skilled Nursing Facility (SNF) Department of Pharmacy performs drug regimen review of each resident at least monthly by a licensed pharmacist. During the recent survey, a problem was identified that has been cited in this report. The following plan of correction addresses them: 1. A drug regimen review has been performed on Resident #2. 2. Other residents meeting the specific criteria for drug regimen review will be performed by a licensed pharmacist. 3. The following systemic changes have been put in place to ensure the deficient practice does not recur: • Review of drug regimen criteria to include patient's contracted with external pharmacy services	08/15/08 08/15/08 08/15/08 08/15/08 08/15/08 08/15/08
F 469 SS=D	483.70(h)(4) PHYSICAL ENVIRONMENT- PEST CONTROL The facility must maintain an effective pest control program so that the facility is free of pests and rodents.	F 469		

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 469	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on observations during the survey period, it was determined that facility staff failed to maintain a pest free environment as evidenced by flying insects observed throughout the facility. These observations were made in the presence of Employees #4 and 7. The findings include: On July 8, 2008, gnats were observed in the following areas: At 2:15 PM in room 306. At 2:45 PM in room 327. 3 North hallway at approximately 2:30 PM. On July 9, 2008, gants were observed in the following areas: At 8:30 AM in room 312. At 9:30 AM in room 321. Employees #4 and 7 acknowledged these findings at the time of the observations.	F 469	• The pharmacist involved has been informed of the procedures for the drug regimen review. 4. The quality assurance process will be utilized to maintain and sustain compliance. The findings will be presented at quarterly quality assurance meetings. 483.70 (h)(4) **Physician Environment-Pest Control** The Renaissance Skilled Nursing Facility (SNF) Department of Environmental Services maintains an effective pest control program. During the recent survey, a problem was identified that has been cited in this report. The following plan of correction addresses it: 1. No specific residents were identified in the survey report as being affected by deficient practices. 2. Any further sightings of gnats observed on the Renaissance Unit will be reported to Environmental Services immediately. 3. The following measures will be put in place to ensure the deficient practice will not recur: • Weekly inspections by our contracted pest company will be conducted and documented • A bi-weekly walk through with the charge nurse will be completed and findings will be documented. If necessary, the pest company will be contacted. 4. Quality monitoring process will be utilized to maintain and sustain compliance. The findings will be presented at quarterly quality assurance meetings.	08/15/08 08/04/08 08/04/08 08/04/08 08/04/08