ND PLAN OF	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING		(X3) DATE SURVEY COMPLETED	
		095021	B, WING	<u>\</u>	02/2	z/2008
		E		EET ADDRESS, CITY, STATE, ZIP CODE 330 MASSACHUSETTS AVENUE NW		
			V)	ASHINGTON, DC 20005		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES ST BE PRECEDED BY FULL REGULATORY JENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SHO REFERENCED TO THE APPROPRIA	ULD BE CROSS-	(XS) COMPLETIC DATE
F 000	INITIAL COMMEN	TS	F 000			
ţ	February 20 though following deficienci observations and in The semple include	cation survey was conducted h February 22, 2008. The es were based on record review, interviews with staff and residents. ed 10 residents based on a ents on the first day of survey.				
F 159 SS=E	FUNDS Upon written author must hold, safegua personal funds of t facility, as specified section. The facility must de funds in excess of account (or account the facility's operate interest earned on (In pooled account accounting for eacl The facility must m funds that do not e bearing account, in cash fund. The facility must es that assures a full a accounting principi funds entrusted to behalf.	ROTECTION OF RESIDENT inization of a resident, the facility and, manage, and account for the he resident deposited with the d in paragraphs (c) (3)-(8) of this eposit any resident's personal \$50 in an interest bearing ats) that is separate from any of ing accounts, and that credits all resident's funds to that account. s, there must be a separate h resident's share.) alintain a resident's personal exceed \$50 in a non-interest interest-bearing account, or petty stablish and maintain a system and complete and separate ing to generally accepted es, of each resident's personal the facility on the resident's preclude any commingling of facility funds or with the funds	F 159	 F159 The following corrective a the residents funds were interest bearing account from any of the facility's of accounts. Residents will quarterly banks statemen accumulated interest. 04/05/2008 All other resident account assure that they were plabearing account that is s of the facility's operating The Business office staff on the process of keepin accounts. The Business designee will audit monit accounts for compliancy 04/2008. The business office direct will report the results of the Quality Assurance Comm Completion Date 04/06/2008 	placed in an that is separate operating be provided with its that will show its were check to aced in interest eparate from any accounts. was reeducated g resident office Director or or the resident monthly starting its audit to the	

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 discloseble 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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DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES						OMB NO	<u>. 0938-0391</u>
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SUR COMPLET	
			A. BUI	LDING			
		095021	B. WIN	IG		02/2	2/2008
				1	REET ADDRESS, CITY, STATE, ZIP CODE 330 MASSACHUSETTS AVENUE NW VASHINGTON, DC 20005		
<u>.</u>			ID		PROVIDER'S PLAN OF CORRECT		(X5) COMPLETION
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE ACTION SHO		(EACH CORRECTIVE ACTION SHOULD E . REFERENCED TO THE APPROPRIATE DI	OULD BE CROSS- CC	
F 159	Continued From page	ge 1	F	159			
	of any person other	than another re s ident.					
	through quarterly sta	cial record must be available atements and on request to the r legal representative.					
	Medicaid benefits wi account reaches \$20 limit for one person, (B) of the Act; and th in addition to the val nonexempt resource	ify each resident that receives hen the amount in the resident's 00 less than the SSI resource specified in section 1611(a) (3) hat, if the amount in the account, ue of the resident's other es, reaches the SSI resource the resident may lose eligibility					
	This REQUIREMEN	T is not met as evidenced by:					
	financial accounts a determined that the four (4) residents' pe	v of four (4) of 21 residents' nd staff interview, it was facility staff failed to maintain ersonal funds in an interest esidents H1, H2, H3 and H4.				Ň	
	The findings include	:					
	was reviewed. Four	08 the residents' trial balance (4) residents were listed on the ith their current balance as					
	Resident/ amount on fund in resident account H1 - \$1,658.63 H2 - \$1,476.25 H3 - \$2,314.32 H4 - \$908.00						
	The "Petty Cash" ba	lance was \$500.00. The					

FORM CMS-2567(02-99) Previous Versions Obsolete

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Facility 1D: THOMASHOUSE

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PRINTED: 03/07/2008

FORM APPROVED

	S FOR MEDICARE	AND HUMAN SERVICES	pul p	80/4/08	FORM OMB NO.	03/07/2008 APPROVED 0938-0391	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	PLE CONSTRUCTION	(X3) DATE SUR COMPLETE		
		095021	B. WING		02/22	/2008	
NAME OF PR				REET ADDRESS, CITY, STATE, ZIP CODE 330 MASSACHUSETTS AVENUE NW			
SUNRISE	AT THOMAS CIRCLE	·	WASHINGTON, DC 20005				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETION DATE	
F 159	The facility lacked e were in an interest b from any of the facili On February 21, 200 face-to-face interview Employee #1. He/st office maintained ac	ge 2 sident Ledger" was \$5,926.25. vidence that the residents' funds earing account and separate ty's operating accounts. 08 at approximately 11:00 AM, a w was conducted with he indicated that the business counts for the four (4) residents; elected to manage their personal	F 159				
F 161 SS=D	SECURITY The facility must pur otherwise provide as Secretary, to assure	RANCE OF FINANCIAL chase a surety bond, or ssurance satisfactory to the the security of all personal eposited with the facility.	F 161	F 161 1. The following corrective action taken: proof of a current sure was obtained as of 04\06\20 2. All resident account balance.	ety bond 08. s were		
	Based on the review Bond" and staff inter facility failed to main	T is not met as evidenced by: of the "Patient Trust Fund view, it was determined that the tain a current surety bond to ents' funds held in trust.		 checked to assure that the s bonds full sum would cover t 3. The Business Office staff wa reeducated on the securing i funds. The Business Office L designee will monitor the exp date of the surety bond annu assure that the surety bond i 	hem. s esident Director or piration ally to		
	of March 25, 2005. annual receipt of pay the surety bond was On February 21, 200	ty bond was dated effective as There was no evidence of an yment attached to ensure that		 The Business Office Director designee will report there find the Quality Assurance comm annually starting 04/2008. Completion Date 04/06/2008 	ding the		
ORM CMS-256	Employee#1. He/sh aforementioned sure	ty bond was the only	Fa	cility ID: THOMASHOUSE	continuation shee	t Page 3 of 25	

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If continuation sheet Page 3 of 25

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

fund 1/108 3

PRINTED: 03/07/2008 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION	I) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED	
	095021	B. WING		02/22/2008	
NAME OF PROVIDER OR SUPPLIER SUNRISE AT THOMAS CIRCLE			STREET ADDRESS, CITY, STATE, ZIP COE 1330 MASSACHUSETTS AVENUE WASHINGTON, DC 20005		
PREFIX (EACH DEFICIENCY MUST BE	MENT OF DEFICIENCIES PRECEDED BY FULL REGULATORY FYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION S REFERENCED TO THE APPROF	HOULD BE CROSS- COMPLÉTIO	
SS=D The facility must provid maintenance services sanitary, orderly, and c This REQUIREMENT i Based on observations was determined that m housekeeping services ensure that the facility manner as evidenced t blinds and over-the-bee chairs. These findings acknowledged in the pu- February 20, 2008 betw The findings include: 1. Soiled window sills in observed 205, 208, 209 Soiled floors in one (1) observed and in one (1) observed between the Soiled blinds in seven to observed 203, 205, 200 Soiled over-the-bed lig rooms observed 205, 2	r the resident's funds. GEPING/MAINTENANCE le housekeeping and necessary to maintain a omfortable interior. Is not met as evidenced by: during the survey period, it aintenance and were not adequate to was maintained in a safe by: soiled window sills, floors, d lights and marred/scarred were observed and resence of Employee #1 on ween 9:35 AM and 11:30 AM. In four (4) of eight (8) rooms 9 and 216. of (1) biohazard closet) of one (1) stairwell lobby and first floors.	F 10 F 25	 53 F253 1. Soiled window sills observed 208, 209 and 216 were cles 03\22\2008. Soiled floors were biohazard closed between the lobil 03\22\2008 Soiled blinds were rooms 203, 205, and 217 as of 03 	aned as of e cleaned in the , the stainwell by and first floor. re cleaned in 208, 214, 216 202\2008. Wed light in rooms 14, 216 and 217 of 03/22/2008. dinning room ired as of ere checked for soiled light arred chairs. ere done as ntenance staff e housekeeping necessary to he interior of the orderly, manner. The maintenance or vindow sills, arred and scared pliance monthly ing will report the he Quality	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: FD2L11

Facility ID: THOMASHOUSE

If continuation sheet Page 4 of 25

		AND HUMAN SERVICES	and	J'	14/08 8	FORM): 03/07/2008 1 APPROVED): 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILC			(X3) DATE SU COMPLET	RVEY
、 、		095021	B. WING	i	· · · · · · · · · · · · · · · · · · ·	02/2	2/2008
NAME OF PF			5		ET ADDRESS, CITY, STATE, ZIP CODE		
SUNRISE	AT THOMAS CIRCLE				30 MASSACHUSETTS AVENUE NW ASHINGTON, DC 20005		1
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	¢	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHOU REFERENCED TO THE APPROPRIAT	LD BE CROSS-	(X5) COMPLETION DATE
F 279 SS=D		(1) COMPREHENSIVE CARE	F 2	79	F 279		
					 The hand mittens are the preference, not an assisting Residents' choice was add the residents care plan on 	ve device. dressed in	
	plan for each resider objectives and timeta medical, nursing, an	elop a comprehensive care nt that includes measurable ables to meet a resident's d mental and psychosocial fied in the comprehensive			 The DON and Unit manage all other residents. The re other clothes choices had noted in their care plan. 	sidents with	
	assessment. The care plan must of be furnished to attain highest practicable p psychosocial well-be and any services that under §483.25 but a resident's exercise of	describe the services that are to n or maintain the resident's			 The DON and Unit Manag the care plan on 02/28/08 and 03/13/08. Preference: noted on the C.N.A's daily sheets should information conveyed to agency staff. The unit Manager will aud for completeness. Results monthly audits will be repo Q.A.A. meetings and used determine in-services on a needed basis. 	, 03/06/08 s found were v assignment need to be it care plans of the orted @ to	•
	This REQUIREMEN	T is not met as evidenced by:			Completion Date 04/06/2008		
	interview for one (1) determined that facil	n, record review and staff of 10 sampled residents, it was ity staff failed to develop a care goals and approaches for the for Resident #4.					
	The findings include:						
	February 20, 2008 w his/her left hand. T	served at 12:20 PM on /ith a blue hand mitten on he resident was observed at y 20, 2008, and 1:00 PM on					
a.							

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If continuation sheet Page 5 of 25

CENTER	S FOR MEDICARE	& MEDICAID SERVICES	met gl.			<u>D. 0938-039</u>
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION	(X3) DATE SI COMPLE	
		095021	B. WING		02/2	22/2008
	OVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE		
SUNRISE	AT THOMAS CIRCLE			330 MASSACHUSETTS AVENUE NW VASHINGTON, DC 20005		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES F BE PRECEDED BY FULL REGULATORY INTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE	D BE CROSS-	(X5) COMPLETION DATE
F 279	- , ,	ge 5 vearing blue hand mittens on	F 279			
		e plan last reviewed and v 4, 2008 lacked approaches and		· ·		
	Employee #3, at app February 21, 2008. has neuropathy and hands warm. He/sh no care plan on the	view was conducted with proximately 12:00 PM on He/she stated that the resident wore the gloves to keep his/her he acknowledged that there was record for the hand mittens. The d on February 21, 2008.				
F 309	483.25 QUALITY O	FCARE	F 309			
SS=D	provide the necessa maintain the highest and psychosocial we	receive and the facility must any care and services to attain or t practicable physical, mental, ell-being, in accordance with the essment and plan of care.				
	This REQUIREMEN	IT is not met as evidenced by:		,		
	review for three (3) of determined that facil Tylenol as per physi physician's order for resident; and follow monitor and adminis	on, staff interview and record of 10 sampled residents, it was lity staff failed to: administer ician's orders; obtain a use of hand mittens for one (1) physician's orders for a Vigilon stration of Ativan and reschedule sident. Residents #1, 4 and 5.		 A) 1. Tylenol for resident #1: order cor 02/22/08. 2. DON, Unit Manager and MDS RN a residents charts on 02/25/08 thru 02/2 physician orders were audited. Correct made when applicable to physician or MAR's & TAR's. 3. Staff was in-serviced on 02/26/08, 0 and 03/20/08 with procedure for carry thru from origin by MD to MAR, TAR for current and the next month. 	audited all 18/08. All tions were ders, 02/27/08 ing orders	

		AND HUMAN SERVICES	mi	A 111	108 D	FORM	0: 03/07/2008 APPROVED 0: 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII			(X3) DATE SU COMPLET	RVEY
		095021	B. WIN	G		02/2	2/2008
				1:	EET ADDRESS, CITY, STATE, ZIP CODE 330 MASSACHUSETTS AVENUE NW /ASHINGTON, DC 20005		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD I REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETION DATE
F 309	according to the cur Resident #1. A physician's Interim January 29, 2008 re [change] Tylenol to by mouth] for pain. A review of the Febr dated and signed by 2008, revealed, "Tyl mg) PO [by mouth] 2 " This was the cu A review of the Febr Administration Reco 1gm BID P.O. for pa 2008 MAR, Tylenol AM and 5:00 PM fro and at 9:00 AM on F by the entry of nurse administration of the A face-to-face interv Employees # 3 and approximately 2:30 I that the January 29, Tylenol was not tran Physician's Order Fo February 20, 2008. 2. The facility staff f	d to administer Tylenol rent physician's order for n Order Form dated and signed vealed, "Order clarification: 1gm BID PO [1gram twice daily the physician on February 8, enol 325 mg tablet 2 tabs (650 2 times daily for Osteoarthritis irrent order for Tylenol. tuary 2008 Medication ord revealed,"[change] Tylenol to in". According to the February 1 gm was administered at 9:00 m February 1 through 19, 2008 ebruary 20, 2008 as evidenced es' initials indicating	F	309	 Monthly audits by RN's will be assess patterns and trends will drive both indivi unit education. Resultant findings will be reviewed at QAA meeting. The hand mittens are the residents preference, not an assistive device. Res choice was addressed in resident's care 02/25/08. DON. Unit Manager reviewed all other residents. Residents with clothes prefer had preference addressed in care plan. 	idual and e sidents e plan	
FORM CMS-256	67(02-99) Previous Versions Ol	bsolete Event ID: FD2L11		Fac		ontinuation she	et Page 7 of 25

Facility ID: THOMASHOUSE

If continuation sheet Page 7 of 25

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION	(X3) DATE SU COMPLE	
		095021	B. WING		02/2	2/2008
	OVIDER OR SUPPLIER		1	REET ADDRESS, CITY, STATE, ZIP CODE 1330 MASSACHUSETTS AVENUE NW NASHINGTON, DC 20005		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	ATEMENT OF DEFICIENCIES F BE PRECEDED BY FULL REGULATORY INTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOUL REFERENCED TO THE APPROPRIATE	D BE CROSS-	(X5) COMPLET DATE
	February 20, 2008 w his/her left hand. T at 3:00 PM on Febru February 21, 2008 w both hands. A review of the resid a physician's order of A face-to-face interv Employee #3 at app February 21, 2008. physician's order was the hand mittens. H neuropathy and he/s his/her hands were put the mittens on h warm. He/she does his/her hands any m The record was revi 3. Facility staff failed the use of a Vigilon Ativan and reschedu A. Facility staff failed the use of a Vigilon Review of the physic record revealed the September 17, 2007 9/13/07 and lacerate [hospital] and had si	beserved at 12:20 PM on with a blue hand mitten on the resident was also observed uary 20, 2008, and 1:00 PM on vearing blue hand mittens on dent's record lacked evidence of for the use of hand mittens. we was conducted with proximately 12:00 PM on He/she acknowledged that a as never obtained for the use of le/she added, "He/she has she used to complain that cold. We [the facility] decided to is/her hands to keep them a not complain of the pain in nore." ewed on February 21, 2008. d to follow physician's orders for monitor and administration of ule a brain MRI for Resident #5. d to follow physician's orders for monitor cian's notes for Resident # 5's following: 7 " Pt. [patient] fell out of bed ed [his/her] (L) ear. Went to utures placed" Pt. fell 10/6/07 around 10:15 AM,	F 309	 3. DON, Unit Manager in-serviced ca team on 02/28/08, 03/06/08 and 03/1 Preferences found noted on C.N.A da assignment sheets should information be conveyed to agency staff. 4. Unit manager will audit care plans to completeness. Results of monthly audit reported @ QAA meetings and used determine in-services on an as needed 1. Resident #5 received a safety monto 03/11/08 2. Charts and PT notes were audited to manager and PT staff. Chair and / or initiated when indicated. 3. At weekly care plan meetings, nurs and OT staff will assess all new admit residents with change in condition and weeks falls for appropriate interventio was in-serviced on 02/25/08, 03/06/00 03/13/08 on safety monitors. Residen safety monitors had device added to a sheet for dispersal of information to b staff and agency. 4. Information gathered will be analyz reported at QAA meetings. Audited in will be used to alter policy and proced indicated and generate in-services. Completion Date 04/06/08 	3/08. hily h need to for dits will be to ad basis. hitor on by the unit bed alarms hing, PT ts, d the ns. Staff 8 and ts with C.N.A flow oth facility ed and formation	

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If continuation sheet Page 8 of 25

		AND HUMAN SERVICES <u>& MEDICAID SERVICES</u>			FOR	D: 03/07/20 M APPROV <u>D. 0938-03</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILC	LTIPLE CONSTRUCTION	(X3) DATE S COMPLE	
		095021	B. WING		02/	22/2008
IAME OF PR	OVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·		STREET ADDRESS, CITY, STATE, ZIP CO 1330 MASSACHUSETTS AVENUE	DE	
SUNRISE	AT THOMAS CIRCLE			WASHINGTON, DC 20005		·
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	ATEMENT OF DEFICIENCIES F BE PRECEDED BY FULL REGULATORY INTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTION REFERENCED TO THE APPRO	SHOULD BE CROSS-	(X5) COMPLET DATE
F 309	Continued From page	ge 8	F 3	09		
		hair and bedunable to explain n the floorC/O [complaint of]				
	bed to wheelchair u was found on the flo	"attempting to transfer from nassisted when [he/she] fell or by staffhit the floor and . No loss of consciousness"				
	A review of the nurs record revealed the	es' notes for Resident # 5's following:				
	sitting on the comm	7 at 4:55 PM: "Resident was ode on the bathroom when commode to the floor"				
		7 at 10:00 AM: "Resident or in room close to bed, resident gn of distress"				
		9:45:"found resident sitting in eelchair] on the floor beside the n the bed"			-	
		3:00 PM: "Resident was oom on the floor close to the				
	was observed on the	at 14:30 (2:30 PM): "Resident e floor inroom while trying to nair. Did not complain of pain red"		· · ·		
		upational Therapy Daily s for Resident # 5's record ng:				
	October 10, 2007, "I	Resident had a fall from toilet				

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Event ID: FD2L11 Facility ID: THOMASHOUSE

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT OF DEPICIENCIES AND REAM OF CORRECTION (X1) RECORDERSUPPLIER_LIA (X2) RECORDERSUPPLIER_LI	CENTER	S FOR MEDICARE	MEDICAID SERVICES	OMB NO. 0938-0				
NMME OF PROVIDER OF SUPPLIER 02/22/2008 SURRISE AT THOMAS CIRCLE STREET ADDRESS, CITY, STATE, 2/P COOE SURRISE AT THOMAS CIRCLE STREET ADDRESS, CITY, STATE, 2/P COOE (%410 PIETX CRACH DEFICIENCES COMPLET SVENUE TWO WASHINGTON, DC 20005 F 309 Continued From page 9 yesterday per runsing report while attempting to get up from toilet. Recommend atem for toilet, bed and WC. Also pt. [patient] should not be left unaccompanied. Discussed with nursing supervisor who is in agreement. Also discussed need for tall back" F 309 F and Continued From page 9 yesterday per runsing report while attempting to get up from toilet. Recommend atem for toilet, bed and WC. Also pt. [patient] should not be left unaccompanied. Discussed with nursing supervisor who is in agreement. Also discussed need for tall back" F 309 F recaution" The review of Resident #5's physician's "Interim Order Form" revealed the following: December 21, 2007, "Vigilon monitor. Fail Precaution" F request safety checks by staff." The resident was observed in the dining room on Foron" and December 21, 2007. "Frequent safety checks by staff." The resident was no bed atarm on the resident's bed. A face-to-face interview was so conducted with Employee #3 in bed on February 22, 2008 at approximately 3:00 AM. There was no chailar or bathroon alar the oride for the Vigilon monitor was not followed up on. H				(X2) M	ULTIF	PLE CONSTRUCTION		
UNME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SUNRISE AT THOMAS CIRCLE 1330 MASSACHUSETTS AVENUE NW WASHINGTON, DC 2005 OPIO SUMMAY STATEMENT OF DEFICIENCIES (EACH OFFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTFYING INFORMATION) D F 309 Continued From page 9 yesterday per nursing report while attempting to get up from toilet. Recommend alarm for toilet, bed and WC. Also pt. [patient] should not be left unaccompanied. Discussed with nursing supervisor who is in agreement. Also discussed need for tail back" F 309 A review of Resident #5's physician's "Interim Order Form" revealed the following: December 21, 2007. "Vigilon monitor. Fail Precaution" F 309 The review of Resident #5's care plan revealed the following problem initiated April 7, 2007. "Resident is at risk for fails related to dementia, h/o [history of] CVA, anxiety, h/o back surgery, antidepressant use: "Approachemer 21, 2007." "Frequent safety checks by staff." The resident was observed in the dining room on February 21. 2008 at about 11:00 AM and 1:00 PM. There was no chair alarm on the resident's chair. The resident was observed by the surveyor and Employee #3 in bed on February 22, 2008 at approximately 7:35 AM. There was no bed alarm on the resident's bed. A face-to-face interview was conducted with Employee #3 on February 22, 2008 at approximately 8:00 AM. He' she acknowledged that the order for the Vigilon monitor was not followed up on. He/She said, "There is no bed/chair or bathroom alarm for use by the resident V& do not have a				A. BUI	LDING	3		
NME OF PROVIDER OR SUPPLIER STREET ADDRESS. CITY. STATE. JIP CODE SUNRISE AT THOMAS CIRCLE Istreet ADDRESS. CITY. STATE. JIP CODE MAID (EACH DEF CIENCY VIII) THE PRECODEND BY FULL REQULATORY OR LSC IDENTIFYING INFORMATION; PARE F 309 Continued From page 9 yesterday per nursing report while attempting to get up from toilet. Recommend alarm for toilet, bed and WC. Also pt. Lgatenti Should not be left unaccompanied. Discussed with nursing supervisor who is in agreement. Also discussed need for tall back" F 309 A review of Resident #5's physician's "Interim Order Form 'revealed the following: December 21, 2007, 'Vigilon monitor. Fail Precaution" F 309 The review of Resident #5's care plan revealed the following problem initiated April 7, 2007, 'Resident is at risk for fails related to dementia, h/o (history of) CVA, anxiety, h/o back surgery, antidepressant use: 'Approaches identified included, October 6, 2007: 'Alarm as ordered, avoid leaving alone in room'' and December 21, 2007. 'Frequent safety checks by staff.'' The resident was observed by the surveyor and Employee #3 in bed on February 22, 2008 at approximately 7:35 AM. There was no bed alarm on the resident's bed. A face-to face interview was conducted with Employee #3 in the origin room was not followed up on. He/She said, 'There is no bed/chair or bathroom alarm for use by the resident We do not have a			095021	B. WIN	IG		02/2	2/2008
Mail D. Marking TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE ENPECTEDED BY FULL REGULATORY OR LSC DENTERVING INFORMATION) D PRETX TAG PROVIDER'S FLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS- REFERENCED TO THE APPROPRIATE DEFICIENCY) Comment Comment Pattern F 309 Continued From page 9 yesterday per nursing report while attempting to get up from toilet. Recommend atarm for toilet, bed and W/C. Also pt. [patient] should not be left unaccompanied. Discussed with nursing supervisor who is in agreement. Also discussed need for tall back" F 309 A review of Resident # 5's physician's "Interim Order Form" revealed the following: December 21, 2007, "Vigilon monitor. Fail Precaution" F 309 The review of Resident #5's care plan revealed the following problem initiated April 7, 2007, "Resident is at risk for fails related to dementia, h/o [history of] CVA, anxiety, h/o back surgery, antidepressant use." Approaches identified included, October 6, 2007: "Narm as ordered, avoid leaving alone in room" and December 21, 2007: "Frequent safety checks by staff." The resident was observed in the dining room on February 21, 2008 at about 11:00 AM and 1:00 PM. There was no chair alarm on the resident's chair. The resident's bed. A face-to-face inferview was conducted with Employee #3 in bed on February 22, 2008 at approximately 7:35 AM. There was no bed alarm on the resident's bed. A face-to-face inferview was conducted with Employee #3 on February 22, 2008 at approximately 6:00 AM. The / she acknowledged that the order for the Vigilon monitor was not followed up on. He/She said, "There is no bed/chair or bathroom alarm for use by t	•				1	330 MASSACHUSETTS AVENUE NW	·	
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		Employee # 3 on Fe approximately 8:00 / the order for the Vigi on. He/She said, "Th alarm for use by the	bruary 22, 2008 at AM. He / she acknowledged that lon monitor was not followed up here is no bed/chair or bathroom resident. We do not have a					

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Event ID: FD2L11 Facility ID: THOMASHOUSE

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

CENTERS FOR MEDICARE & MEDICAID SERVICES						OMB NO	<u>. 0938-0391</u>
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI			(X3) DATE SUI COMPLET	
		095021	B. WIN	IG		02/2	2/2008
				1:	EET ADDRESS, CITY, STATE, ZIP CODE 330 MASSACHUSETTS AVENUE NW VASHINGTON, DC 20005	·	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD B REFERENCED TO THE APPROPRIATE DE	E CROSS-	(X5) COMPLETION DATE
F 309	a history of multiple wheelchair and toile B. Facility staff failed physician's order an A review of the resid revealed the followin "Reschedule MRI br please. Ativan 1mg MRI" A review of the resid following from a MR here 12/27/07 at 2:4 Scan was unsucce uncomfortable lying The resident's MAR 1mg P.O. prior (1ho per the physician's d evidenced by the lad A face-to-face interv Employee # 4 on Fe / she acknowledged the record that the re ordered and that the resident's MRI after December 27, 2007.	 b follow up on the provide Resident # 5, who had falls, with an alarm for the bed, t. d to administer Ativan as per the d reschedule a MRI. lent's Interim Order Form mg: November 7, 2007, ain with contrast - open MRI P.O. (orally) prior (1 hour) to lent's record revealed the I provider: " [Resident] was 5 PM to have MRI of the brain essful due to patient being down. " lacked evidence that Ativan ur) to MRI was administered as order on December 27, 2007 as ck of a nurse's initials. iew was conducted with bruary 22, 2008 at 9:30 AM. He that there was no evidence in esident received Ativan as facility did not reschedule the the unsuccessful attempt of 	F	309			
F 323 SS=D	483.25(h) ACCIDEN The facility must ens	TS AND SUPERVISION sure that the resident s as free of accident hazards	F	323			

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Facility ID: THOMASHOUSE

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PRINTED: 03/07/2008 FORM APPROVED OMB NO 0938-0391

	S FOR MEDICARE 8	AND HUMAN SERVICES	fun	Malalos &	FORM OMB NC	D: 03/07/2008 A APPROVED D. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		(X3) DATE SL COMPLE	
		095021	B. WING		02/2	2/2008
NAME OF PR	OVIDER OR SUPPLIER		.S	TREET ADDRESS, CITY, STATE, ZIP CODE 1330 MASSACHUSETTS AVENUE N		
SUNRISE	AT THOMAS CIRCLE			WASHINGTON, DC 20005		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION SHO REFERENCED TO THE APPROPRI	OULD BE CROSS-	(X5) COMPLETION DATE
F 323	F 323 Continued From page 11 as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.		F 32	1. Resident #5 was provided on 03/11/08 and a new low b protective borders on 03/11/0 2. Charts / PT notes au Unit Manager and PT S	ed with 08 dited by the taff. Chair and	
	Based on observation review for one (1) of determined that the adequate supervision multiple falls. Facilit safe and hazard free	T is not met as evidenced by: n, staff interview and record 10 sampled residents, it was facility staff failed to provide n for Resident #5 who had y staff also failed to maintain a e environment as evidenced by: esident areas and unsecured		 bed alarms were initiate indicated. 3. At weekly care plan r Nursing, PT and OT sta all new admits, resident in condition and the wer appropriate intervention serviced on 02/25/08, 0 03/13/08 on safety mea monitors. 4. Computations of wee will be reported at mont meetings; information w drive in-servicing when 	ed as neetings, iff will assess is with change eks falls for is. Staff was in- 3/06/08 and sures / kly findings hly QAA vill be used to	
	 Facility staff failed to provide adequate supervision for Resident # 5 who had a history of multiple falls. A review of the physicians' notes for Resident # 5's record revealed the following: 			Completion Date 04/06/08		
		, "Pt. [patient] fell out of bed d his/her (L) ear. Went to itures placed"				
	per nursing report, p between the wheelch	. fell 10/6/07 around 10:15 AM, t. was found on the floor hair and bedunable to explain the floorC/O [complained of]				
		, "attempting to transfer from assisted when he/she				

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Event ID: FD2L11 Facility ID: THOMASHOUSE

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFNITERO FOR MEDIOARE & MEDIOARD CERVICES

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<u>UENTER</u>	S FOR MEDICARE	& MEDICAID SERVICES					<u>). 0938-0391</u>
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SU COMPLE	
		095021	B. WIN	۹G		02/2	2/2008
NAME OF PR		-	•	STR	REET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
SUNRISE	AT THOMAS CIRCLE				330 MASSACHUSETTS AVENUE NW		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	ATEMENT OF DEFICIENCIES F BE PRECEDED BY FULL REGULATORY INTIFYING INFORMATION)	ID PREF TAG	XI	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE	BE CROSS-	(X5) COMPLETION DATE
F 323	Continued From pa	ge 12	F	323			
		the floor by staffhit the floor chair. No loss of consciousness					
· ·	A review of the nurs record revealed the	es' notes for Resident # 5's following:					
	by team members of the floor mat with he	7 at 1:20 AM, "Resident heard alling for help. Pt. observed on ead on W/C [wheelchair]. Skin 't. assessed and order given to					
	sitting on the comm	7 at 4:55 PM, "Resident was ode on the bathroom when ommode to the floor"					
		7 at 10:00 AM, "Resident or in room close to bed, resident gn of distress"	,				
·		9:45, "found resident sitting in eelchair] on the floor beside the n the bed"					
		3:00 PM, "Resident was om on the floor close to the					
	was observed on th	at 14:30 (2:30 PM) "Resident e floor inroom while trying to nair. Did not complain of pain red"					
		upational Therapy Daily s for Resident # 5's record ng:				·	
	October 10, 2007, "	Resident had a fall from toilet		·			
	•		·				

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Facility ID: THOMASHOUSE

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CENTERS FOR MEDICARE & MEDICARD SERVICES OB38-031 STATEMAN OF DEFICIENCES (2) MULTIPLE CONSTRUCTION IDEMINIFICATION NUMBER: (2) MULTIPLE CONSTRUCTION A. BULDING (2) MULTIPLE CONSTRUCTION A. BULDING </th <th></th> <th></th> <th>AND HUMAN SERVICES</th> <th></th> <th></th> <th></th> <th></th> <th>APPROVED</th>			AND HUMAN SERVICES					APPROVED
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A BUILDING COMPLETED NUME OF PROVIDER OR SUPPLER SUMMARY STATEMENT OF DEFICIENCIES STREET ADDRESS OTTY STATE. JP CODE SUMMARY STATEMENT OF DEFICIENCIES STREET ADDRESS ATTY STATE. JP CODE 130 MASSACHUSETTS AVENUE NW VALID THOMAS CIRCLE PROVIDER OR SUPPLER SUMMARY STATEMENT OF DEFICIENCIES PROVIDER TO AVENUE NW VALID THOMAS CIRCLE SUMMARY STATEMENT OF DEFICIENCIES PROVIDER TO AVENUE NW VASHINGTON, DC 20005 F 323 Continued From page 13 yesterday per nursing report while attempting to get up from toilet. Recommend atarm for toilet, bed and WCC. Also pt. [patient] should not be left unaccompanied. Discussed with nursing supervisor who is in agreement. Also discussed need for tall back" F 323 A physician's order dated December 21, 2007, revealed, "Monitor. Fall Precaution." F 323 The review of Resident #5's care plan revealed the following problem initiated April 7, 2007 "Resident is at risk for falls related to dementia, hvo [history of] CVA, anxiety, hvo back surgery, antidepressant use. "Approaches identified included, October 6, 2007, atarm as ordered, avoid leaving atone in room, December 21, 2007. Frequent safety checks by staft." The resident was observed in the dining during on February 21, 2008 at abporximately 7.35 Man accompanied by Employee 43, there was no back alarm on the resident's bed. A face-to-face interview was conducted with Employee 43 on February 22, 2008 at approximately 63 on ALM efshes said, "There is no bed/cha	[
MARE OF PROVIDER OR SUPPLIER 02/22/2008 SUNRISE AT THOMAS CIRCLE STREET ADDRESS, CITY, STATE, ZP. CO. MUD SUMMARY STATEMENT OF DEFICIENCIES MUD SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRACEDED BY FULL REGULTORY OR LSC IDENTFYING INFORMATION) Dr. F 323 Continued From page 13 yesterday per nursing report while attempting to get up from toilet. Recommend alarm for toilet, bed and WC. Also pl. [patient] should not be left unaccompanied. Discussed with nursing supervisor who is in agreement. Also discussed need for tail back" F 323 A physician's order dated December 21, 2007, revealed, "Monitor. Fall Precaution." F Resident #5's care plan revealed the following problem initiated April 7, 2007 "Resident is at risk for falls related to dementia, ho [history of] CVA, anxiety, hi/o back surger, antidepressant use: Approaches identified included. October 6, 2007. atarm as ordered, avoid leaving alone in noom. December 21, 2007. Frequent safety checks by staft." The resident was observed in the dining during on February 21, 2008 at about 11:00 AM and 100 PM. There was no chair alarm on the resident's wheelchair. The resident was observed in bed on February 22, 2008 at approximately 7:35 AM accompanied by Employee #3, on February 22, 2008 at approximately 6:00 AM. Heishe acknowledged that the recommendation and order for bed/chair and bathroom alarm was not implemented. He/5ke said, "There is on bed/chair or bathroom alarm for use by the resident. We do not have a record for frequent.				. ,				
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February 22, 2008.	F 323	yesterday per nursin up from toilet. Recor W/C. Also pt. [patier unaccompanied. Dis who is in agreement back" A physician's order of revealed, "Monitor The review of Reside following problem ini at risk for falls relate CVA, anxiety, h/o ba use." Approaches id 2007: alarm as orde room, December 21, by staff. " The resident was ob February 21, 2008 a There was no chair a wheelchair. The resident was ob 2008 at approximate Employee #3, there resident's bed. A face-to-face interv Employee #3 on Feb approximately 8:00 A the recommendation bathroom alarm was "There is no bed/cha the resident. We do safety checks by sta	ing report while attempting to get mmend alarm for toilet, bed and it] should not be left iccussed with nursing supervisor . Also discussed need for tall dated December 21, 2007, . Fall Precaution." ent #5's care plan revealed the itiated April 7, 2007 "Resident is d to dementia, h/o [history of] ack surgery, antidepressant entified included, October 6, red, avoid leaving alone in , 2007: Frequent safety checks served in the dining during on t about 11:00 AM and 1:00 PM. alarm on the resident's served in bed on February 22, by 7:35 AM accompanied by was no bed alarm on the iew was conducted with oruary 22, 2008 at AM. He/she acknowledged that and order for bed/chair and not implemented. He/She said, iir or bathroom alarm for use by not have a record for frequent	F	323			

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Event ID: FD2L11

Facility ID: THOMASHOUSE

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PRINTED: 03/07/2008

STATEMENT	OF DEFICIENCIES F CORRECTION	K MEDICAID SERVICES V (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	b - for stem "b" D - for stem "b" ple construction g	(X3) DATE SU COMPLE	
		095021	B. WING		02/2	2/2008
	ROVIDER OR SUPPLIER		1	REET ADDRESS, CITY, STATE, ZIP CODE 330 MASSACHUSETTS AVENUE NW VASHINGTON, DC 20005		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOULI REFERENCED TO THE APPROPRIATE	D BE CROSS-	(X5) COMPLETION DATE
F 323 F 356 SS=D	 Facility staff failed free environment; du following was observe A. Extension cords w living/activities area Dxygen tanks wei tanks observed in th The findings observe were acknowledged #1 on February 20, 2 11:30 AM. 483.30(e) NURSE S The facility must post daily basis: o Facility name. The facility must post daily basis: o Facility name. The total number at the following categori nursing staff directly per shift: Registered nurse - Licensed practive vocational nurses (area Certified nurse o Resident census. The facility must post specified above on at each shift. Data must o Clear and readable o In a prominent place residents and visitors 	to maintain a safe and hazard uring the environmental tour the yed: were observed in the general connected to lamps. re unsecured in three (3) of 17 e oxygen closet. ed during the environmental tour in the presence of Employee 2008 between 9:35 AM and TAFFING at the following information on a and the actual hours worked by ries of licensed and unlicensed responsible for resident care ses. cal nurses or licensed s defined under State law). aides. at the nurse staffing data i daily basis at the beginning of st be posted as follows: e format. ce readily accessible to s. on oral or written request, make	F 323	 providing company 02/25/08 Post pick – up by company of un set tanks, all oxygen tanks improperly set Oxygen room checks have been act Unit Manager and DON environmental In-services were done on 02/25/08 with staff. Compliance of environmental check reported at QAA meetings by the Unit for further intervention when indicated Completed on 04/06/08 	ecured cured. Ided to the il rounds. th licensed Manager Manager I. orm was n the No further ng form e nurse will be A meeting. post the neet in the	

Facility ID: THOMASHOUSE

If continuation sheet I

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

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	G	(X3) DATE SU COMPLET	
		095021	B. WING		02/2	2/2008
	ROVIDER OR SUPPLIER		1	REET ADDRESS, CITY, STATE, ZIP C 1330 MASSACHUSETTS AVENU NASHINGTON, DC 20005	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	ATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OI (EACH CORRECTIVE ACTION REFERENCED TO THE APPR	N SHOULD BE CROSS-	(X5) COMPLETION DATE
F 356	standard. The facility must ma staffing data for a m	ge 15 not to exceed the community aintain the posted daily nurse hinimum of 18 months, or as w, whichever is greater.	F 356			
		IT is not met as evidenced by:				
	determined that fact staffing information accessible to reside Observations made 2008 revealed that t	from February 20 through 22, the nurse staffing for total				
	Registered nurse, L Certified nurse aide	orked by the categories icensed practical nurse, and was not posted in a prominent sible to residents and visitors.				
F 371 SS=F	483.35(I) (2) SANIT PREP & SERVICE	ARY CONDITIONS - FOOD	F 371			
	The facility must sto serve food under sa	re, prepare, distribute, and nitary conditions.				
	This REQUIREMEN	IT is not met as evidenced by:				
	the survey period, it services were not a were prepared and manner as evidence	ons and staff interview during was determined that dietary dequate to ensure that foods served in a safe and sanitary ed by: water (condensation) illing above the automatic dish				

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Event (D: FD2L11

Facility ID: THOMASHOUSE

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

funulty/08 b
(X2) MULTIPLE CONSTRUCTION

PRINTED: 03/07/2008 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI			(X3) DATE SI COMPLE	
		095021	B. WIN	G		02/2	22/2008
	ROVIDER OR SUPPLIER	·		1330	T ADDRESS, CITY, STATE, ZIP CODE D MASSACHUSETTS AVENUE N SHINGTON, DC 20005		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION SHO REFERENCED TO THE APPROPRI	OULD BE CROSS-	(X5) COMPLETION DATE
F 371	machine area, soile ovens, deep fryer, r machine and floors refrigerators beyond burner with a non-fit thawed in standing outside the dumpst and acknowledged on February 20, 20 AM and at 12:20 Pf The findings include 1. On February 21, (condensation) was damaged ceiling ab area onto chinawar peeling paint and a damaged ceiling]. A face-to-face inter Employee #5 on Fe He/she stated, "The to fix the exhaust fa condensation build off for about a mont A face-to-face inter Employee #2 on Fe He/she stated, "We residents within the upset or diarrhea." information gathere Program revealed t gastrointestinal issu 2. Soiled interior su	Ad cooking hoods, grill surfaces, mixer stand, shelves, fruit juice ; food items stored in d expiration date and/or spoiled, unctional pilot light, chicken water and boxes stacked er. The findings were observed in the presence of Employee #5 08 between 8:20 AM and 9:30 M - 12:50 PM. e: 2008 at 12:20 PM water s observed dripping from a oove the automatic dish machine e ready for reuse. [Mold, rust, hole was observed on the view was conducted with ebruary 20, 2008 at 12:21 PM. ere have been several attempts in that is the cause of the up. It has been this way on and th." view was conducted with ebruary 21, 2008 at 11:45 AM. [the facility] have not had any last month with Gastrointestinal Additionally, a review of d for the Infection Control hat there were no incidents of les. rfaces of the cooking hoods and tchen were soiled with grease in	F	371	 automatic dis area repaired 02/21/2008. Soiled interior the cooking h filters in the m that were soil were cleaned 03/22/08. Soiled cook s ovens, stove, and grill were 03/01/2008. Soiled mixer s machine and food preparat cleaned as of Soiled floors i kitchen and th area near the refrigerator, tt and the dry g were cleaned 03/01/2008. All expired foo in the refriger discarded at t survey 02/20/ Frozen chicke being thawed compartment, water was dis 02/20/2008. 	ling above the h machine as r surfaces of oods and nain kitchen ed with grease as of urfaces on deep fryer cleaned as of stand, juice sheves in the ion area were 5 03/01/2008. in the main he hallway walk-in he service door oods pantry as of ods observed ators were the time of the /2008. en observed al sink full of ccarded on Staff was in he proper way	

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Facility ID: THOMASHOUSE

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	MENT OF HEALTH	*	AII	ww	JUDE A	PRINTED: 03/07/2008 FORM APPROVED OMB NO <u>. 093</u> 8-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SU IDENTIFICATIO	JPPLIER/CLIA	(X2) MUL A. BUILD		3) DATE SURVEY COMPLETED
		(95021	B. WING	G	02/22/2008
	OVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE 1330 MASSACHUSETTS AVENUE NW WASHINGTON, DC 20005	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFIC BE PRECEDED BY NTIFYING INFORMA	FULL REGULATORY	ID PREFIX TAG		
F 371	Continued From page cooking hoods. Soiled cooking surfation one (1) of one (1) destove, and one (1) of soiled with grease. Soiled - One (1) of of one (1) juice maching preparation area we Soiled floors were of the hallway area near service door and the 3. Expired foods were as follows: A hotel pan with plass cranberry sauce date Beef dated February rack was observed to areas. A box of lettuce date observed to be withe 5. On February 20, 2 was observed being sink full of water. 6. On February 20, 2 20 labeled boxes wit (1) bag of trash were the ground of the set	aces on two (2) eep fryer, one (f one (1) mixer st ee, and shelves re observed in the ar the walk-in re observed in the arthe walk-in re dry goods par re observed in stic covering co ed February 6, 14, 2008 and o have an odo ed January 20, ered. 2008 at 8:20 Af thawed in a co 2008 at 11:10 A h produce and o observed stor rvice area.	1) of one (1) vere observed and, one (1) of in the food viled. main kitchen and efrigerator, the nty. the refrigerators ontained 2008. stored on a meet r and brown 2008 was VI, frozen chicken ompartmental AM approximately /or food and one	F 37	 20 labeled boxes with produce and /or food ar one bag of trash observice and yor dod the service and was discarded at the tir the survey 02/20/2008. 2. All other areas in the kitchen were checked for soiled surfaces, expiring food items, food thawing technique and trash removal for compliance other issues were found. 03/01/20 3. The dinning service staff was in serviced on keeping Food and driclean, wholesome, free from spoil safe for human consumption, and served in accordance with the requirements as of 03/31/2008. T Director of Dinning services or designee will audit for soiled surface xpired food items, food thawing techniques and trash removal for compliance monthly as of 04/2000 4. The Director of Dinning Services of designee will report the findings of these audits to the Quality Assura Committee monthly X 3, April, Ma and June 2008. Completion Date 04/06/2008 	ved rea me of ed ed les . No D08. nk lage, he aces, B. or f
F 386 SS=D	483.40(b) PHYSICIA	N VISITS	. •	F 38		
FORM CMS-256	7(02-99) Previous Versions Ot	osolete	Event ID: FD2L11		Facility ID: THOMASHOUSE If continu	ation sheet Page 18 of 25

ATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) ML A. BUIL			(X3) DATE SU COMPLET	
		095021	B. WINC	§		02/2	2/2008
	(EACH DEFICIENCY MUST	TEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFI) TAG	(EACH CORRE	TTS AVENUE NW	CROSS-	(X5) COMPLETION DATE
	program of care, incl treatments, at each v of this section; write, at each visit; and sig exception of influenz polysaccharide vacc administered per phy after an assessment This REQUIREMEN Based on staff interv (1) of 10 sampled re- the physician failed t Resident # 5. The findings include: A review of the resid following: October 3, out of the facility con A review of the resid following: November brain with contrast - 0 P.O. [by mouth] prior A review of the physi the following: Novem MRI pending"	review the resident's total luding medications and visit required by paragraph (c) sign, and date progress notes n and date all orders with the a and pneumococcal ines, which may be visician-approved facility policy for contraindications. T is not met as evidenced by: iews and record review for one sidents, it was determined that o follow up on a MRI for ent's record revealed the 2007, "MRI brain" from an sultant. im Order Form" revealed the 7, 2007, "Reschedule MRI open MRI please. Ativan 1mg 1 hour to MRI" cian's progress notes revealed ber 19, 2007, "hemiparesis - cian's progress notes revealed ber 19, 2007, "hemi paresis -	F 3	 Reside 03/17/ All cha Manag 02/25/(not foll admini DON, I spoke proced carried docum will ma docum not abl informa week v plan m Informa reporte Audited 	rts audited by the DON, ler and MDS RN week o 08 thru 02/28/08 for cons owed thru and medicatio stered. No further finding Unit Manager and MDS to physician with regards ure to assure consults a 1 thru and appropriately ented on 02/22/08. Physic letter of the Unit Secret e to procure requested ation. Consults for previous vill be reviewed at weekl eetings for compliance. ation will be analyzed an ed at monthly QAA meeting onlicy and procedure as ed.	Unit f sults pns not gs. RN s to sician n etary is pus y care	

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Facility ID: THOMASHOUSE

If continuation sheet Page 19 of 25

DEPARTMENT OF HEALTH AND HUMAN SERVICES

		AND HUMAN SERVICES & MEDICAID SERVICES					MAPPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL			(X3) DATE SU COMPLE	JRVEY
		095021	B. WIN	IG		02/2	2/2008
NAME OF PR	OVIDER OR SUPPLIER	· · · ·		STRE	EET ADDRESS, CITY, STATE, ZIP CODE		
SUNRISE	AT THOMAS CIRCLE				330 MASSACHUSETTS AVENUE NW ASHINGTON, DC 20005		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE I	BE CROSS-	(X5) COMPLETION DATE
F 386 F 425 SS=D	"hemiparesis - MR Employee #4 reques provider of the MRI "December 27, 20 the brainScan wa being uncomfortable The physician last a on December 21, 20 January 18, Februar evidence of follow u A face-to-face interv Employee #3 on Fel approximately 8:00 the physician failed brain MRI for Reside on February 22, 200 483.60(a), (b) PHAF	I pending" sted a fax report from the that revealed the following; 07 at 2:45 PM to have MRI of s unsuccessful due to patient lying down." ddressed the MRI as pending 07. His/her progress notes of y 5, and 6, 2008 lacked p. iew was conducted with oruary 22, 2008 at AM. He/she acknowledged that to follow up on his/her order for ent #5. The record was reviewed 8.		425	F425 483.60 Pharmacy Services 1. All expired narcotics were	removed f	
	under an agreement part. The facility ma to administer drugs under the general su A facility must provid (including procedure acquiring, receiving, of all drugs and biolo each resident. The facility must em licensed pharmacist	described in §483.75(h) of this y permit unlicensed personnel f State law permits, but only upervision of a licensed nurse. In pharmaceutical services that assure the accurate dispensing, and administering ogicals) to meet the needs of ploy or obtain the services of a who provides consultation on ovision of pharmacy services in			 from the Emergency Box on 2. The Medication carts and Medication Room was asses expired narcotics on 02/21/0 were no new findings. 3. Narcotics will no longer be in the emergency box. Emer narcotics will now be mainta double locked drawer in the medication cart. Sign-out shi shift to shift counting have be implemented. 4. Consultant Pharmacist will compliance on the monthly in report. Reports will be review monthly Q.A.A. meetings to of further interventions/ change and procedures. 	the ssed for 8. There e provided gency ined in a eet and een I monitor spection red at the determine	

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Event ID: FD2L11

Facility ID: THOMASHOUSE

If continuation sheet Page 20 of 25

PRINTED: 03/07/2008

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING		(X3) DATE SU COMPLET	
		095021	B. WING		02/2	2/2008
		·	1:	EET ADDRESS, CITY, STATE, ZIP CODE 330 MASSACHUSETTS AVENUE N VASHINGTON, DC 20005		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	ATEMENT OF DEFICIENCIES I BE PRECEDED BY FULL REGULATORY INTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION SH REFERENCED TO THE APPROPR	IOULD BE CROSS-	(X5) COMPLET DATE
F 425	Continued From page	ge 20	F 425	· · ·		
		IT is not met as evidenced by:		•		
	review, it was detern monitor and/or remo emergency box, list box on the outside of	ons, staff interview and record mined that facility staff failed to ove expired narcotics from the the contents in the emergency of the box and ensure that ds for controlled medications				· ·
:	The findings include	:				
		d to monitor and/or remove om the emergency box.				
	Medication Storage medication storage, are routinely monito	: (i) entitled, "Controlled ' stipulates "Controlled records and expiration dates red by the consultant nedication storage inspection."				
		PM, during the inspection of the Narcotic Box revealed the				
	Percocet 5/325mg 7 Percocet 5/325mg 7 Oxymoron ER 10 m 10/31/2007	tablets Expired 12/31/2007				
		d to list the contents in the the outside of the box.				

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	OF DEFICIENCIES CORRECTION	X MEDICAID SERVICES	(X2) MULTIPLE A. BUILDING		(X3) DATE SU COMPLE	
		095021	B. WING		02/2	22/2008
			133	ET ADDRESS, CITY, STATE, ZIP CODE 80 MASSACHUSETTS AVENUE NV ASHINGTON, DC 20005	v	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION SHO REFERENCED TO THE APPROPRI,	OULD BE CROSS-	(X5) COMPLETIC DATE
F 425	The facility's policy # "Emergency Pharma Emergency Pharma Emergency boxes, I' list of contents with e outside of the box.". On Wednesday, Fet approximately 2:00 f facility's Emergency listing of the content box. 3. Facility staff failed records for controller Facility's policy IID3: Medication Storage medication accounta accessible. " A. On Wednesday, approximately 2:00 f facility 's medication Narcotic Box located Station. The box wa opened, three (3) co injection was observ substance record for Lorazepam which we received from the ph Controlled Drug Aud incomplete. B. On February 20, PM during the inspec	 # IIC:4(d) 2 entitled, acy Services, Interim Drug and V Interim Box " stipulates " A expiration dates is posted on the Druary 20, 2008, at PM, during the inspection of the Narcotic box there was no s located on the outside of the I to ensure that accountability d medications were accessible. (f) entitled, "Controlled "stipulates "Current controlled ability records are readily February 20, 2008, at PM, during the inspection of the n storage areas, the Emergency d on the second floor Nursing is observed locked. When intainers of Lorazepam 2mg/ml ed, however, no controlled m was found for the build denote the amount narmacy. Additionally, the it form was observed to be 2008, at approximately 1:00 ction of the emergency narcotic tablets of Oxycodone/APAP 	F 425	 All vials of improperly statilabeled Lorazepam were from the narcotic emerg. The medication cart, me emergency box and interassessed for improperly or labeled medications. I findings. Schedule II biological as will be dispensed by facilindividual residents; not emergency or interim bo emergency box, interim arriving at the facility wit contents attached will not by the facility staff and m pharmacy. Staff was in-s02/25/08 regarding polic procedure emergency in proper labeling of all vial Consultant Pharmacist a emergency and interim the medication room, and m on 03/28/08. There were Pharmacist will monitor and interim box, medicat monthly. Data gathered analyzed with report at C which will be used to effe policy and / or procedure indicated. 	e removed ency box. dication room, rim box stored and / No further described ility to carried in tw. The box(es) hout a list of ot be accepted eturned to the serviced on by and terim box and s. audited box, edication cart e no findings. emergency tion cart will be 2AA meeting, ect changes in	

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DEPARTMENT OF HEALTH	AND HUMAN SERV	ICES
CENTERS FOR MEDICARE &	& MEDICAID SERVI	ICES

PRINTED: 03/07/2008
FORM APPROVED
OMB NO 0938-0391

<u>ENTER</u>	<u>KS FUR MEDICARE A</u>	<u> MEDICAID SERVICES</u>					<u>. 0938-0391</u>
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
095021		B. WING			02/22/2008		
NAME OF PROVIDER OR SUPPLIER					ET ADDRESS, CITY, STATE, ZIP CODE		
SUNRISE	AT THOMAS CIRCLE				30 MASSACHUSETTS AVENUE NW ASHINGTON, DC 20005		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE	BE CROSS-	. (X5) COMPLETION DATE
F 425	Continued From page	je 22	F	425			
	record #338908 doc received at the facili tablets were signed resident. At the time	The controlled substance umented that 10 tablets were ty on July 3, 2007. Six (6) out by the nurse as given to the of the inspection, one (1) blister package. Three (3) unted for.				· ·	
	20, 2008 at approxir #2. He/she acknow	iew was conducted on February nately 1:00 PM with Employee ledged that the Oxycodone e missing, and was unable to					
F 431	483.60(b), (d), (e) P	HARMACY SERVICES	F	431			
SS=D	The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.						
· · ·	labeled in accordance professional principl	Is used in the facility must be ce with currently accepted es, and include the appropriate onary instructions, and the n applicable.					
	facility must store all compartments under	State and Federal laws, the drugs and biologicals in locked r proper temperature controls, orized personnel to have					
		vide separately locked, compartments for storage of					

Event ID: FD2L11

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Facility ID: THOMASHOUSE

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		AND HUMAN SERVICES	mind	4/4/08 25	FORM): 03/07/2008 A APPROVED): 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		095021	B. WING	·	02/2	2/2008
	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1330 MASSACHUSETTS AVENUE NW WASHINGTON, DC 20005		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOUL REFERENCED TO THE APPROPRIATE	D BE CROSS-	(X5) COMPLETION DATE
F 431	Comprehensive Dru Act of 1976 and othe except when the fac drug distribution sys stored is minimal and detected. This REQUIREMEN Based on observation determined that faci- Lorazepam accordin specifications. These findings inclu According to Drug F Lorazepam storage, refrigerated, protect discolored Maybe up to 60 days." On February 20, 200 during the inspection revealed the followin undated Lorazepam The vials of Lorazep refrigerated or have when stored at room In a face-to-face inter February 20, 2008 a Employee #2. He/s listed above were not	ed in Schedule II of the ig Abuse Prevention and Control er drugs subject to abuse, illity uses single unit package items in which the quantity d a missing dose can be readily IT is not met as evidenced by: on and staff interview, it was lity staff failed to properly store ing to the manufacturer's de: acts and Comparison 2007 for "Intact vial should be ed from light; do not use a stored at room temperature for 08, at approximately 1:00 PM, n of the narcotic emergency box ng: Three (3) unopened and 2mg/ml vials were observed. bam should have been an expiration date on the vial n temperature. erview was conducted on it approximately 1:00 PM with he acknowledged that the vials of dated and/or initialed at the	F 4	 All expired narcotics were r from the Emergency box or The Medication carts and th Medication room was asses expired narcotics on 02/21/ were no new findings. Narcotics will no longer be the emergency box. Emerg narcotics will now be maint double locked drawer in the medication cart. Sign – out shift to shift counting have I implemented. Staff inservic 02/25/08 re. policy and proi emergency, interim box and labeling of all vials. Consultant Pharmacist aud emergency and interim box room and med. cart 03/28/0 Completion Date 04/06/08 	n 02/21/08. ne ssed for 08. There provided in ency ained in a sheet and been ed on been ed on been d proper dited , med.	
F 492	time of the observat 483.75(b) ADMINIS		F 49	92	,	

Event ID: FD2L11 Facility ID: THOMASHOUSE

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

(X1) PROVIDER/SUPPLIER/CLIA

IDENTIFICATION NUMBER:

095021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER

OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED A. BUILDING B. WING

02/22/2008

STREET ADDRESS, CITY, STATE, ZIP CODE

SUNRISE AT THOMAS CIRCLE			1330 MASSACHUSETTS AVENUE NW WASHINGTON, DC 20005			
(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) PLETION DATE		
F 49 SS=		F 492	 There were no residents found to have been affected by this deficient practice. The facility has contract with a registered dietitian who is licensed in the District of Columbia as of 02/22/2008. This RD will sign off on menus. 03/01/2008. 			
	 Based on observations, review of employee licenses, and staff interviews, it was determined that the facility failed to have a license on file for a dietitian. The findings include: According to Tile 22 DCMR 3202.4, "Each employee or person hired under contract who requires licensure, registration or certification in order to provide resident care shall be licensed, registered or certified under the laws and regulations of the District." A review of a spreadsheet dated January 16, 2007 used to prepare resident meals and the menus dated August 10, 2007 that are posted for residents to review, revealed a signature of a RD [registered dietitian]. The facility lacked evidence that the dietitian was licensed in the District of Columbia. A face-to-face interview was conducted with Employee #2 on February 21, 2008 at 3:45 PM. He/she acknowledged that the facility did not have a license on file for the dietitian. 		 The Director of Dinning services or designee will audit for compliance monthly as of 04/2008. The Director of Dinning Services or designee will report the findings of these audits to the Quality Assurance Committee monthly X 3, April, May and June 2008. Completion Date 04/06/2008 			

FORM CMS-2567(02-99) Previous Versions Obsolete

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Facility ID: THOMASHOUSE

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If continuation sheet Page 25 of 25

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