STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095021	A. BUILDING _____ B. WING _____	02/22/2008

NAME OF PROVIDER OR SUPPLIER	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) COMPLETION DATE
F 000	INITIAL COMMENTS An annual recertification survey was conducted February 20 though February 22, 2008. The following deficiencies were based on record review, observations and interviews with staff and residents. The sample included 10 residents based on a census of 21 residents on the first day of survey.	F 000		
F 159 SS=E	483.10(c) (2)-(5) PROTECTION OF RESIDENT FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c) (3)-(8) of this section. The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund. The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. The system must preclude any commingling of resident funds with facility funds or with the funds	F 159	**F159** 1. The following corrective action was taken: the residents funds were placed in an interest bearing account that is separate from any of the facility's operating accounts. Residents will be provided with quarterly banks statements that will show accumulated interest. 04/05/2008 2. All other resident accounts were check to assure that they were placed in interest bearing account that is separate from any of the facility's operating accounts. 3. The Business office staff was reeducated on the process of keeping resident accounts. The Business office Director or designee will audit monitor the resident accounts for compliancy monthly starting 04/2008. 4. The business office director or designee will report the results of this audit to the Quality Assurance Committee quarterly. **Completion Date 04/06/2008**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Administrator 3/26/08

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 159	Continued From page 1 of any person other than another resident. The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative. The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a) (3) (B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. This REQUIREMENT is not met as evidenced by: Based on the review of four (4) of 21 residents' financial accounts and staff interview, it was determined that the facility staff failed to maintain four (4) residents' personal funds in an interest bearing account. Residents H1, H2, H3 and H4. The findings include: On February 21, 2008 the residents' trial balance was reviewed. Four (4) residents were listed on the "Resident Ledger" with their current balance as follows: 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" balance was $500.00. The	F 159		

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F 159	Continued From page 2 balance per the "Resident Ledger" was $5,926.25. The facility lacked evidence that the residents' funds were in an interest bearing account and separate from any of the facility's operating accounts. On February 21, 2008 at approximately 11:00 AM, a face-to-face interview was conducted with Employee #1. He/she indicated that the business office maintained accounts for the four (4) residents; the other residents elected to manage their personal funds.	F 159		
F 161 SS=D	483.10(c) (7) ASSURANCE OF FINANCIAL SECURITY The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility. This REQUIREMENT is not met as evidenced by: Based on the review of the "Patient Trust Fund Bond" and staff interview, it was determined that the facility failed to maintain a current surety bond to safeguard the residents' funds held in trust. The findings include: A review of the surety bond was dated effective as of March 25, 2005. There was no evidence of an annual receipt of payment attached to ensure that the surety bond was current. On February 21, 2008 at approximately 11:00 AM a face-to-face interview was conducted with Employee#1. He/she indicated that the aforementioned surety bond was the only	F 161	**F 161** 1. The following corrective actions were taken: proof of a current surety bond was obtained as of 04\06\2008. 2. All resident account balances were checked to assure that the surety bonds full sum would cover them. 3. The Business Office staff was reeducated on the securing resident funds. The Business Office Director or designee will monitor the expiration date of the surety bond annually to assure that the surety bond is current. 4. The Business Office Director or designee will report there finding the the Quality Assurance committee annually starting 04/2008. **Completion Date 04/06/2008**	

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F 161	Continued From page 3 agreement available for the resident's funds.	F 161		
F 253 SS=D	483.15(h) (2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations during the survey period, it was determined that maintenance and housekeeping services were not adequate to ensure that the facility was maintained in a safe manner as evidenced by: soiled window sills, floors, blinds and over-the-bed lights and marred/scarred chairs. These findings were observed and acknowledged in the presence of Employee #1 on February 20, 2008 between 9:35 AM and 11:30 AM. The findings include: 1. Soiled window sills in four (4) of eight (8) rooms observed 205, 208, 209 and 216. Soiled floors in one (1) of (1) biohazard closet observed and in one (1) of one (1) stairwell observed between the lobby and first floors. Soiled blinds in seven (7) of eight (8) rooms observed 203, 205, 208, 209, 214, 216 and 217. Soiled over-the-bed lights in six (6) of eight (8) rooms observed 205, 208, 209, 211, 214 and 216. 2. Marred/scarred dining room chairs in 17 of 17 chairs observed.	F 253	**F253** 1. Soiled window sills observed in rooms 205, 208, 209 and 216 were cleaned as of 03\22\2008. • Soiled floors were cleaned in the biohazard closet, the stairwell between the lobby and first floor. 03\22\2008 • Soiled blinds were cleaned in rooms 203, 205, 208, 214, 216 and 217 as of 03\22\2008. • Soiled over the bed light in rooms 205, 208, 209, 214, 216 and 217 were cleaned as of 03/22/2008. • Marred/scarred dinning room chairs were repaired as of 04\06\2008. 2. All other resident rooms were checked for soiled floors, soiled blinds, soiled light fixtures and marred and scarred chairs. 03/01/2008. Corrections were done as needed. 03/01/2008 3. All housekeeping and maintenance staff were reeducated on provide housekeeping and maintenance services necessary to maintain the exterior and the interior of the facility in a safe, sanitary, orderly, comfortable and attractive manner. The Director of Housekeeping/ maintenance or designee will audit soiled window sills , floors, blinds, lights and marred and scared dining room chairs for compliance monthly as of 04/2008. 4. The Director of Housekeeping /Maintenance 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**	

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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. 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 observation, record review and staff interview for one (1) of 10 sampled residents, it was determined that facility staff failed to develop a care plan with appropriate goals and approaches for the use of hand mittens for Resident #4. The findings include: Resident # 4 was observed at 12:20 PM on February 20, 2008 with a blue hand mitten on his/her left hand. The resident was observed at 3:00 PM on February 20, 2008, and 1:00 PM on	F 279	F 279 1. The hand mittens are the residents' preference, not an assistive device. Residents' choice was addressed in the residents care plan on 02/22/2008. 2. The DON and Unit manager reviewed all other residents. The residents with other clothes choices had preference noted in their care plan. 3. The DON and Unit Manager In service the care plan on 02/28/08, 03/06/08 and 03/13/08. Preferences found were noted on the C.N.A's daily assignment sheets should information need to be conveyed to agency staff. 4. The unit Manager will audit care plans for completeness. Results of the monthly audits will be reported @ Q.A.A. meetings and used to determine in-services on an as needed basis. **Completion Date 04/06/2008**	

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F 279	Continued From page 5 February 21, 2008 wearing blue hand mittens on both hands. A review of the record revealed that the interdisciplinary care plan last reviewed and updated on January 4, 2008 lacked approaches and goals for the hand mittens. A face-to-face interview was conducted with Employee #3, at approximately 12:00 PM on February 21, 2008. He/she stated that the resident has neuropathy and wore the gloves to keep his/her hands warm. He/she acknowledged that there was no care plan on the record for the hand mittens. The record was reviewed on February 21, 2008.	F 279		
F 309 SS=D	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review for three (3) of 10 sampled residents, it was determined that facility staff failed to: administer Tylenol as per physician's orders; obtain a physician's order for use of hand mittens for one (1) resident; and follow physician's orders for a Vigilon monitor and administration of Ativan and reschedule a MRI for one (1) resident. Residents #1, 4 and 5.	F 309	A) 1. Tylenol for resident #1: order corrected on 02/22/08. 2. DON, Unit Manager and MDS RN audited all residents charts on 02/25/08 thru 02/28/08. All physician orders were audited. Corrections were made when applicable to physician orders, MAR's & TAR's. 3. Staff was in-serviced on 02/26/08, 02/27/08 and 03/20/08 with procedure for carrying orders thru from origin by MD to MAR, TAR for both current and the next month.	

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F 309	Continued From page 6 The findings include: 1. Facility staff failed to administer Tylenol according to the current physician's order for Resident #1. A physician's Interim Order Form dated and signed January 29, 2008 revealed, "Order clarification: [change] Tylenol to 1gm BID PO [1gram twice daily by mouth] for pain. A review of the February 2008 Physician's Orders dated and signed by the physician on February 8, 2008, revealed, "Tylenol 325 mg tablet 2 tabs (650 mg) PO [by mouth] 2 times daily for Osteoarthritis ..." This was the current order for Tylenol. A review of the February 2008 Medication Administration Record revealed,"[change] Tylenol to 1gm BID P.O. for pain". According to the February 2008 MAR, Tylenol 1 gm was administered at 9:00 AM and 5:00 PM from February 1 through 19, 2008 and at 9:00 AM on February 20, 2008 as evidenced by the entry of nurses' initials indicating administration of the Tylenol. A face-to-face interview was conducted with Employees # 3 and 5 on February 21, 2008 at approximately 2:30 PM. They both acknowledged that the January 29, 2008 Physician's Order for Tylenol was not transcribed to the February 2008 Physician's Order Form. The record was reviewed February 20, 2008. 2. The facility staff failed to obtain a physician's order for the use of hand mittens for Resident # 4.	F 309	4. Monthly audits by RN's will be assessed; patterns and trends will drive both individual and unit education. Resultant findings will be reviewed at QAA meeting. 1. The hand mittens are the residents preference, not an assistive device. Residents choice was addressed in resident's care plan 02/25/08. 2. DON. Unit Manager reviewed all other residents. Residents with clothes preferences had preference addressed in care plan.	

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F 309	Continued From page 7 Resident # 4 was observed at 12:20 PM on February 20, 2008 with a blue hand mitten on his/her left hand. The resident was also observed at 3:00 PM on February 20, 2008, and 1:00 PM on February 21, 2008 wearing blue hand mittens on both hands. A review of the resident's record lacked evidence of a physician's order for the use of hand mittens. A face-to-face interview was conducted with Employee #3 at approximately 12:00 PM on February 21, 2008. He/she acknowledged that a physician's order was never obtained for the use of the hand mittens. He/she added, "He/she has neuropathy and he/she used to complain that his/her hands were cold. We [the facility] decided to put the mittens on his/her hands to keep them warm. He/she does not complain of the pain in his/her hands any more." The record was reviewed on February 21, 2008. 3. Facility staff failed to follow physician's orders for the use of a Vigilon monitor and administration of Ativan and reschedule a brain MRI for Resident #5. A. Facility staff failed to follow physician's orders for the use of a Vigilon monitor Review of the physician's notes for Resident # 5's record revealed the following: September 17, 2007 " Pt. [patient] fell out of bed 9/13/07 and lacerated [his/her] (L) ear. Went to [hospital] and had sutures placed ..." October 9, 2007 "Pt. fell 10/6/07 around 10:15 AM, per nursing report, pt. was found on the floor	F 309	3. DON, Unit Manager in-serviced care plan team on 02/28/08, 03/06/08 and 03/13/08. Preferences found noted on C.N.A daily assignment sheets should information need to be conveyed to agency staff. 4. Unit manager will audit care plans for completeness. Results of monthly audits will be reported @ QAA meetings and used to determine in-services on an as needed basis. 1. Resident #5 received a safety monitor on 03/11/08 2.Charts and PT notes were audited by the unit manager and PT staff. Chair and / or bed alarms initiated when indicated. 3. At weekly care plan meetings, nursing, PT and OT staff will assess all new admits, residents with change in condition and the weeks falls for appropriate interventions. Staff was in-serviced on 02/25/08, 03/06/08 and 03/13/08 on safety monitors. Residents with safety monitors had device added to C.N.A flow sheet for dispersal of information to both facility staff and agency. 4. Information gathered will be analyzed and reported at QAA meetings. Audited information will be used to alter policy and procedure as indicated and generate in-services. **Completion Date 04/06/08**	

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F 309	Continued From page 8 between the wheelchair and bed ...unable to explain why ...was sitting on the floor...C/O [complaint of] low back pain ..." December 21, 2007 " ...attempting to transfer from bed to wheelchair unassisted when [he/she] fell ... was found on the floor by staff ...hit the floor and head on wheelchair. No loss of consciousness ..." A review of the nurses' notes for Resident # 5's record revealed the following: September 15, 2007 at 4:55 PM: "Resident was sitting on the commode on the bathroom when [he/she] fell off the commode to the floor ..." September 26, 2007 at 10:00 AM: "Resident observed on the floor in room close to bed, resident observed with no sign of distress ..." October 6, 2007 at 9:45:"...found resident sitting in front of the W/C [wheelchair] on the floor beside the bed ...I tried to get in the bed ..." October 9, 2007 at 3:00 PM: "Resident was observed in ...bathroom on the floor close to the commode..." December 21, 2007 at 14:30 (2:30 PM): "Resident was observed on the floor in ...room while trying to move from bed to chair. Did not complain of pain and no injury observed ..." A review of the Occupational Therapy Daily Documentation notes for Resident # 5's record revealed the following: October 10, 2007, "Resident had a fall from toilet	F 309		

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F 309	Continued From page 9 yesterday per nursing report while attempting to get up from toilet. Recommend alarm 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..." A review of Resident # 5's physician's "Interim Order Form" revealed the following: December 21, 2007, "Vigilon monitor. Fall Precaution" 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, 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 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. We do not have a record for frequent safety checks by staff."	F 309		

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F 309	Continued From page 10 Facility staff failed to follow up on the recommendation to provide Resident # 5, who had a history of multiple falls, with an alarm for the bed, wheelchair and toilet. B. Facility staff failed to administer Ativan as per the physician's order and reschedule a MRI. A review of the resident's Interim Order Form revealed the following: November 7, 2007, "Reschedule MRI brain with contrast - open MRI please. Ativan 1mg P.O. (orally) prior (1 hour) to MRI ..." A review of the resident's record revealed the following from a MRI provider: "... [Resident] was here 12/27/07 at 2:45 PM to have MRI of the brain ...Scan was unsuccessful due to patient being uncomfortable lying down. " The resident's MAR lacked evidence that Ativan 1mg P.O. prior (1hour) to MRI was administered as per the physician's order on December 27, 2007 as evidenced by the lack of a nurse's initials. A face-to-face interview was conducted with Employee # 4 on February 22, 2008 at 9:30 AM. He / she acknowledged that there was no evidence in the record that the resident received Ativan as ordered and that the facility did not reschedule the resident's MRI after the unsuccessful attempt of December 27, 2007. The record was reviewed on February 22, 2008.	F 309		
F 323 SS=D	483.25(h) ACCIDENTS AND SUPERVISION The facility must ensure that the resident environment remains as free of accident hazards	F 323		

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F 323	Continued From page 11 as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review for one (1) of 10 sampled residents, it was determined that the facility staff failed to provide adequate supervision for Resident #5 who had multiple falls. Facility staff also failed to maintain a safe and hazard free environment as evidenced by: extension cords in resident areas and unsecured oxygen tanks. The findings include: 1. 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: September 17, 2007, "Pt. [patient] fell out of bed 9/13/07 and lacerated his/her (L) ear. Went to [hospital] and had sutures placed ..." October 9, 2007, "Pt. fell 10/6/07 around 10:15 AM, per nursing report, pt. was found on the floor between the wheelchair and bed ...unable to explain why...was sitting on the floor...C/O [complained of] low back pain..." December 21, 2007, "...attempting to transfer from bed to wheelchair unassisted when he/she	F 323	1. Resident #5 was provided a bed alarm on 03/11/08 and a new low bed with protective borders on 03/11/08. 2. Charts / PT notes audited by the Unit Manager and PT Staff. Chair and bed alarms were initiated as indicated. 3. At weekly care plan meetings, Nursing, PT and OT staff will assess all new admits, residents with change in condition and the weeks falls for appropriate interventions. Staff was in-serviced on 02/25/08, 03/06/08 and 03/13/08 on safety measures / monitors. 4. Computations of weekly findings will be reported at monthly QAA meetings; information will be used to drive in-servicing when indicated. **Completion Date 04/06/08**	

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	095021	A. BUILDING _____ B. WING _____	02/22/2008

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F 323	Continued From page 12 fell... was found on the floor by staff ...hit the floor and head on wheelchair. No loss of consciousness ..." A review of the nurses' notes for Resident # 5's record revealed the following: September 15, 2007 at 1:20 AM, "Resident heard by team members calling for help. Pt. observed on the floor mat with head on W/C [wheelchair]. Skin tear to the (L) ear. Pt. assessed and order given to transfer pt. to ER." September 15, 2007 at 4:55 PM, "Resident was sitting on the commode on the bathroom when he/she fell off the commode to the floor..." September 26, 2007 at 10:00 AM, "Resident observed on the floor in room close to bed, resident observed with no sign of distress..." October 6, 2007 at 9:45, "...found resident sitting in front of the W/C [wheelchair] on the floor beside the bed...'I tried to get in the bed..." October 9, 2007 at 3:00 PM, "Resident was observed in...bathroom on the floor close to the commode." December 21, 2007 at 14:30 (2:30 PM) "Resident was observed on the floor in...room while trying to move from bed to chair. Did not complain of pain and no injury observed..." A review of the Occupational Therapy Daily Documentation notes for Resident # 5's record revealed the following: October 10, 2007, "Resident had a fall from toilet	F 323		

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F 323	Continued From page 13 yesterday per nursing report while attempting to get up from toilet. Recommend alarm 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..." A physician's order dated December 21, 2007, revealed, "...Monitor. Fall Precaution." 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, 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, December 21, 2007: Frequent safety checks by staff. " The resident was observed in the dining during on February 21, 2008 at about 11:00 AM and 1:00 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, 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 recommendation and order for bed/chair and bathroom alarm was not implemented. He/She said, "There is no bed/chair or bathroom alarm for use by the resident. We do not have a record for frequent safety checks by staff: The record was reviewed on February 22, 2008.	F 323		

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F 323	Continued From page 14 2. Facility staff failed to maintain a safe and hazard free environment; during the environmental tour the following was observed: A. Extension cords were observed in the general living/activities area connected to lamps. B. Oxygen tanks were unsecured in three (3) of 17 tanks observed in the oxygen closet. The findings observed during the environmental tour were acknowledged in the presence of Employee #1 on February 20, 2008 between 9:35 AM and 11:30 AM.	F 323	1. All non- secured oxygen tanks returned to providing company 02/25/08 2. Post pick – up by company of un secured tanks, all oxygen tanks improperly secured. 3. Oxygen room checks have been added to the Unit Manager and DON environmental rounds. In-services were done on 02/25/08 with licensed staff. 4. Compliance of environmental check list will be reported at QAA meetings by the Unit Manager for further intervention when indicated. **Completed on 04/06/08**	
F 356 SS=D	483.30(e) NURSE STAFFING The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public	F 356	1. The daily nursing staffing form was moved to the front window in the nursing station. 2. Nursing station evaluated. No further infraction noted. 3. Placement of Nursing staffing form checked daily by the charge nurse each shift. 4. Compliance or lack there of will be reported in the monthly QAA meeting. Any staff member failing to post the nurse staffing information sheet in the proper location will be disciplined according to facility policy. **Completion Date 04/06/08**	

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F 356	Continued From page 15 for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation during the survey, it was determined that facility staff failed to post nurse staffing information in a prominent place readily accessible to residents and visitors. Observations made from February 20 through 22, 2008 revealed that the nurse staffing for total number of hours worked by the categories Registered nurse, Licensed practical nurse, and Certified nurse aide was not posted in a prominent place readily accessible to residents and visitors.	F 356		
F 371 SS=F	483.35(I) (2) SANITARY CONDITIONS - FOOD PREP & SERVICE The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview during the survey period, it was determined that dietary services were not adequate to ensure that foods were prepared and served in a safe and sanitary manner as evidenced by: water (condensation) dripping from the ceiling above the automatic dish	F 371		

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F 371	Continued From page 16 machine area, soiled cooking hoods, grill surfaces, ovens, deep fryer, mixer stand, shelves, fruit juice machine and floors; food items stored in refrigerators beyond expiration date and/or spoiled, burner with a non-functional pilot light, chicken thawed in standing water and boxes stacked outside the dumpster. The findings were observed and acknowledged in the presence of Employee #5 on February 20, 2008 between 8:20 AM and 9:30 AM and at 12:20 PM - 12:50 PM. The findings include: 1. On February 21, 2008 at 12:20 PM water (condensation) was observed dripping from a damaged ceiling above the automatic dish machine area onto chinaware ready for reuse. [Mold, rust, peeling paint and a hole was observed on the damaged ceiling]. A face-to-face interview was conducted with Employee #5 on February 20, 2008 at 12:21 PM. He/she stated, "There have been several attempts to fix the exhaust fan that is the cause of the condensation build up. It has been this way on and off for about a month." A face-to-face interview was conducted with Employee #2 on February 21, 2008 at 11:45 AM. He/she stated, "We [the facility] have not had any residents within the last month with Gastrointestinal upset or diarrhea." Additionally, a review of information gathered for the Infection Control Program revealed that there were no incidents of gastrointestinal issues. 2. Soiled interior surfaces of the cooking hoods and filters in the main kitchen were soiled with grease in two (2) of two (2) observations of	F 371	1. The following findings have been corrected: • Damaged ceiling above the automatic dish machine area repaired as 02/21/2008. • Soiled interior surfaces of the cooking hoods and filters in the main kitchen that were soiled with grease were cleaned as of 03/22/08. • Soiled cook surfaces on ovens, stove, deep fryer and grill were cleaned as of 03/01/2008. • Soiled mixer stand, juice machine and sheves in the food preparation area were cleaned as of 03/01/2008. • Soiled floors in the main kitchen and the hallway area near the walk-in refrigerator, the service door and the dry goods pantry were cleaned as of 03/01/2008. • All expired foods observed in the refrigerators were discarded at the time of the survey 02/20/2008. • Frozen chicken observed being thawed in a compartmental sink full of water was discarded on 02/20/2008. Staff was in serviced on the proper way to thaw foods as of 3/2008.	

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F 371	Continued From page 17 cooking hoods. Soiled cooking surfaces on two (2) of two (2) ovens, one (1) of one (1) deep fryer, one (1) of one (1) stove, and one (1) of one (1) grill were observed soiled with grease. Soiled - One (1) of one (1) mixer stand, one (1) of one (1) juice machine, and shelves in the food preparation area were observed soiled. Soiled floors were observed in the main kitchen and the hallway area near the walk-in refrigerator, the service door and the dry goods panty. 3. Expired foods were observed in the refrigerators as follows: A hotel pan with plastic covering contained cranberry sauce dated February 6, 2008. Beef dated February 14, 2008 and stored on a meet rack was observed to have an odor and brown areas. A box of lettuce dated January 20, 2008 was observed to be withered. 5. On February 20, 2008 at 8:20 AM, frozen chicken was observed being thawed in a compartmental sink full of water. 6. On February 20, 2008 at 11:10 AM approximately 20 labeled boxes with produce and/or food and one (1) bag of trash were observed stored outside on the ground of the service area.	F 371	• 20 labeled boxes with produce and /or food and one bag of trash observed stored outside on the ground of the service area was discarded at the time of the survey 02/20/2008. 2. All other areas in the kitchen were checked for soiled surfaces, expired food items, food thawing techniques and trash removal for compliance. No other issues were found. 03/01/2008. 3. The dinning service staff was in serviced on keeping Food and drink clean, wholesome, free from spoilage, safe for human consumption, and served in accordance with the requirements as of 03/31/2008. The Director of Dinning services or designee will audit for soiled surfaces, expired food items, food thawing techniques and trash removal for compliance monthly as of 04/2008. 4. 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**	
F 386 SS=D	483.40(b) PHYSICIAN VISITS	F 386		

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F 386	Continued From page 18 The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review for one (1) of 10 sampled residents, it was determined that the physician failed to follow up on a MRI for Resident # 5. The findings include: A review of the resident's record revealed the following: October 3, 2007, "MRI brain ..." from an out of the facility consultant. A review of the "Interim Order Form" revealed the following: November 7, 2007, "Reschedule MRI brain with contrast - open MRI please. Ativan 1mg P.O. [by mouth] prior 1 hour to MRI ..." A review of the physician's progress notes revealed the following: November 26, 2007, "...hemiparesis - MRI pending..." A review of the physician's progress notes revealed the following: December 19, 2007, "...hemi paresis - MRI pending..." A review of the physician's progress notes revealed the following: December 21, 2007 -	F 386	1. Resident #5 MRI was completed on 03/17/08. 2. All charts audited by the DON, Unit Manager and MDS RN week of 02/25/08 thru 02/28/08 for consults not followed thru and medications not administered. No further findings. 3. DON, Unit Manager and MDS RN spoke to physician with regards to procedure to assure consults are carried thru and appropriately documented on 02/22/08. Physician will make call requesting written documentation if the Unit Secretary is not able to procure requested information. Consults for previous week will be reviewed at weekly care plan meetings for compliance. 4. Information will be analyzed and reported at monthly QAA meeting. Audited information will be used to alter policy and procedure as indicated. **Completion Date on 04/06/08**	

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F 386	Continued From page 19 "...hemiparesis - MRI pending..." Employee #4 requested a fax report from the provider of the MRI that revealed the following; "...December 27, 2007 at 2:45 PM to have MRI of the brain ...Scan was unsuccessful due to patient being uncomfortable lying down." The physician last addressed the MRI as pending on December 21, 2007. His/her progress notes of January 18, February 5, and 6, 2008 lacked evidence of follow up. A face-to-face interview was conducted with Employee #3 on February 22, 2008 at approximately 8:00 AM. He/she acknowledged that the physician failed to follow up on his/her order for brain MRI for Resident #5. The record was reviewed on February 22, 2008.			
F 425 SS=D	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.	F 425	**F425** 483.60 Pharmacy Services 1. All expired narcotics were removed f from the Emergency Box on 02/21/08. 2. The Medication carts and the Medication Room was assessed for expired narcotics on 02/21/08. There were no new findings. 3. Narcotics will no longer be provided in the emergency box. Emergency narcotics will now be maintained in a double locked drawer in the medication cart. Sign-out sheet and shift to shift counting have been implemented. 4. Consultant Pharmacist will monitor compliance on the monthly inspection report. Reports will be reviewed at the monthly Q.A.A. meetings to determine further interventions/ change in policy and procedures.	

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F 425	Continued From page 20 This REQUIREMENT is not met as evidenced by: Based on observations, staff interview and record review, it was determined that facility staff failed to monitor and/or remove expired narcotics from the emergency box, list the contents in the emergency box on the outside of the box and ensure that accountability records for controlled medications were accessible. The findings include: 1. Facility staff failed to monitor and/or remove expired narcotics from the emergency box. Facility's policy IID3: (i) entitled, "Controlled Medication Storage" stipulates "Controlled medication storage, records and expiration dates are routinely monitored by the consultant pharmacist during medication storage inspection." On Wednesday, February 20, 2008, at approximately 2:00 PM, during the inspection of the facility's Emergency Narcotic Box revealed the following expired medications: Percocet 5/325mg 17 tablets Expired 11/30/2007 Percocet 5/325mg 7 tablets Expired 12/31/2007 Oxymoron ER 10 mg 9 tablets Expired 10/31/2007 2. Facility staff failed to list the contents in the Emergency box on the outside of the box.	F 425		

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F 425	Continued From page 21 The facility's policy # IIC:4(d) 2 entitled, "Emergency Pharmacy Services, Interim Drug and Emergency boxes, IV Interim Box " stipulates " A list of contents with expiration dates is posted on the outside of the box.". On Wednesday, February 20, 2008, at approximately 2:00 PM, during the inspection of the facility's Emergency Narcotic box there was no listing of the contents located on the outside of the box. 3. Facility staff failed to ensure that accountability records for controlled medications were accessible. Facility's policy IID3: (f) entitled, "Controlled Medication Storage "stipulates "Current controlled medication accountability records are readily accessible. " A. On Wednesday, February 20, 2008, at approximately 2:00 PM, during the inspection of the facility ' s medication storage areas, the Emergency Narcotic Box located on the second floor Nursing Station. The box was observed locked. When opened, three (3) containers of Lorazepam 2mg/ml injection was observed, however, no controlled substance record form was found for the Lorazepam which would denote the amount received from the pharmacy. Additionally, the Controlled Drug Audit form was observed to be incomplete. B. On February 20, 2008, at approximately 1:00 PM during the inspection of the emergency narcotic box, three (3) of ten tablets of Oxycodone/APAP 5/325mg tablets were unable	F 425	1. All vials of improperly stored and / or labeled Lorazepam were removed from the narcotic emergency box. 2. The medication cart, medication room, emergency box and interim box assessed for improperly stored and / or labeled medications. No further findings. 3. Schedule II biological as described will be dispensed by facility to individual residents; not carried in emergency or interim box. The emergency box, interim box(es) arriving at the facility without a list of contents attached will not be accepted by the facility staff and returned to the pharmacy. Staff was in-serviced on 02/25/08 regarding policy and procedure emergency interim box and proper labeling of all vials. 4. Consultant Pharmacist audited emergency and interim box, medication room, and medication cart on 03/28/08. There were no findings. Pharmacist will monitor emergency and interim box, medication cart monthly. Data gathered will be analyzed with report at QAA meeting, which will be used to effect changes in policy and / or procedures when indicated. **Completion Date 04/06/08**	

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F 425	Continued From page 22 to be accounted for. The controlled substance record #338908 documented that 10 tablets were received at the facility on July 3, 2007. Six (6) tablets were signed out by the nurse as given to the resident. At the time of the inspection, one (1) tablet was left in the blister package. Three (3) tablets were unaccounted for. A face-to-face interview was conducted on February 20, 2008 at approximately 1:00 PM with Employee #2. He/she acknowledged that the Oxycodone three (3) tablets were missing, and was unable to account for them.	F 425		
F 431 SS=D	483.60(b), (d), (e) PHARMACY SERVICES 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. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of	F 431		

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SUNRISE AT THOMAS CIRCLE	1330 MASSACHUSETTS AVENUE NW WASHINGTON, DC 20005

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F 431	Continued From page 23 controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined that facility staff failed to properly store Lorazepam according to the manufacturer's specifications. These findings include: According to Drug Facts and Comparison 2007 for Lorazepam storage, "Intact vial should be refrigerated, protected from light; do not use discolored ... Maybe stored at room temperature for up to 60 days." On February 20, 2008, at approximately 1:00 PM, during the inspection of the narcotic emergency box revealed the following: Three (3) unopened and undated Lorazepam 2mg/ml vials were observed. The vials of Lorazepam should have been refrigerated or have an expiration date on the vial when stored at room temperature. In a face-to-face interview was conducted on February 20, 2008 at approximately 1:00 PM with Employee #2. He/she acknowledged that the vials listed above were not dated and/or initialed at the time of the observations.	F 431	1. All expired narcotics were removed from the Emergency box on 02/21/08. 2. The Medication carts and the Medication room was assessed for expired narcotics on 02/21/08. There were no new findings. 3. Narcotics will no longer be provided in the emergency box. Emergency narcotics will now be maintained in a double locked drawer in the medication cart. Sign – out sheet and shift to shift counting have been implemented. Staff inserviced on 02/25/08 re. policy and procedure emergency, interim box and proper labeling of all vials. 4. Consultant Pharmacist audited emergency and interim box, med. room and med. cart 03/28/08. **Completion Date 04/06/08**	
F 492	483.75(b) ADMINISTRATION	F 492		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095021	A. BUILDING _____ B. WING _____	02/22/2008

NAME OF PROVIDER OR SUPPLIER	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) COMPLETION DATE
F 492 SS=D	Continued From page 24 The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. This REQUIREMENT is not met as evidenced by: 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.	F 492	1. There were no residents found to have been affected by this deficient practice. 2. 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. 3. The Director of Dinning services or designee will audit for compliance monthly as of 04/2008. 4. 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	