| NUME OF PROVIDER OR SUPPLIER Ups0/4 STREET ADDRESS, CITY, STATE, 2P CODE CARROLL MANOR NURSING & REHAB STREET ADDRESS, CITY, STATE, 2P CODE TAS STREET ADDRESS, CITY, STATE, 2P CODE (M_1D) PREET SUMMARY STATEMENT OF DEFICIENCES (EACH DERICENCY MUST BE PRECEDED BY PULL TAS D PREVIDENT PROVIDER'S PLAN OF CORRECTION (EACH DERICENCY MUST BE PRECEDED BY PULL TAS D PREVIDENT COMMETTION (EACH DERICENCY MUST BE PRECEDED BY PULL TAS D PREVIDENT COMMETTION (EACH DERICENCY MUST BE PRECEDED BY PULL TAS NEFRENCED TO THE APPROPRIATE DEFICIENCY (EACH DERICENCY MUST BE PRECEDED BY PULL TAS D PREVIDENT COMMETTION (EACH DERICENCY MUST BE PRECEDED BY PULL TAS NEFRENCED TO THE APPROPRIATE DEFICIENCY (EACH DERICENCY DESTANDARD K 000 NTER NEFRENCED TO THE APPROPRIATE DEFICIENCY (EACH DERICENCY DESTANDARD DISTATION) K 007 STREET ADDRESS, CITY, STATE, 2P CODE COMMETTION (EACH DERICENCED TO THE APPROPRIATE DEFICIENCY (EACH DERICENCY DESTANDARD DISTATION) K 000 NEFRENCED TO THE APPROPRIATE DEFICIENCY (EACH DERICENCY DESTANDARD DISTATION) NEFRENCED TO THE APPROPRIATE DEFICIENCY (EACH DERICENCY DESTANDARD DISTATION PREVIATED DESTANDARD (EACH DERICENCE DESTANDARD DISTATION PREVE AREAD DESTANDARD K 017 STREET ADDRESS (COT INSTATE, PERVENTION DESTANDARD N ADDRET ADDRESS (COT INSTATE, PERVENTION DESTANDARD N ADDRET ADDRESS (COT INSTATE, PERVENTION DESTATED DESTANDARD (EACH DERICENCE DESTANDARD (EACH | | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | A. BUIL | | (X3) DATE SL COMPLE | |
|--|---------|---|--|---------|--|--|-----------------|
| CARROLL MANOR NURSING & REHAB 756 BUCHANAN ST. NE MARKINGTON, DC 20017 TAG PREFIX EACH DERICHCRY MUST BE PRECEDED BY ULL (EACH CORRECTIVE ACTION SHOULD BE CROSS (EACH DERICHCRY MUST BE PRECEDED BY ULL TAG D K 000 INITIAL COMMENTS PREFIX The annual Life Safety Code inspection was conducted on October 20, 2006. The following deficiencies were based on observations made during the inspection. K 000 K 017 NFPA 101 LIFE SAFETY CODE STANDARD K 017 SS=E Corridors are separated from use areas by walls constructed with at least b hour fire resistance rating. In spinklered buildings, partitions are only required to resist the passage of amioke. In non- spinklered buildings, valls properly extend above the ocelling. (Cordor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and cerical stations, walls specified in the Code. Gift shops may be separated from condros by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3. G.2.1, 19.3.6.5 This STANDARD is not met as evidenced by: Based on observations during the Life Safety Code inspection, it was determined that penetrations were observed in wall surfaces above ceiling life. These findings were observed in the presence of the Maintenance Director. The findings include: Penetrations were observed in wall surfaces | | • | 095034 | B. WING | | 10/20 |)/2006 |
| Preferix TAG EACH CORRECTWE ACTION SHOULD BE CROSS. REFERENCED TO THE APPROPRIATE DEFICIENCY Comments Date K 000 INITIAL COMMENTS The annual Life Safety Code inspection was conducted on October 20, 2006. The following deficiencies were based on observations made during the inspection. K 000 K 017 NFPA 101 LIFE SAFETY CODE STANDARD K 017 SS=E Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, mails properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, walls open to the corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, walls separated from curder cata in conditions specified in the Code. Gift shops may be separated from cordifors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3. 6.2.1, 19.3.6.5 NEVENUE A prevenuative maintenance program will be implemented to surveys will be reported to the facility's Safety Code inspection, it was determined that penetrations were present in the wall surfaces above ceiling tiles. These findings were observed in the presence of the Maintenance Director. The findings include: Penetrations were observed in wall surfaces The | | | & REHAB | | 725 BUCHANAN ST., NE | Ξ | |
| The annual Life Safety Code inspection was conducted on October 20, 2006. The following deficiencies were based on observations made during the inspection. K 017 SS=E Corridors are separated from use areas by walls constructed with at least 4 hour fire resistance rating. In sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically percentions, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5 This STANDARD is not met as evidenced by: Based on observations during the Life Safety Code inspection, it was determined that penetrations were present in the wall surfaces above ceiling tiles. These findings were observed in the presence of the Maintenance Director. The findings include: Penetrations were observed in wall surfaces. | PREFIX | (EACH DEFICIENCY | MUST BE PRECEEDED BY FULL | PREFI | X (EACH CORRECTIVE ACTION SHOU | JLD BE CROSS- | COMPLETION |
| Conducted on October 20, 2006. The following deficiencies were based on observations made during the inspection. K 017 SS=E Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non- sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3. 6.2.1, 19.3.6.5 This STANDARD is not met as evidenced by: Based on observations during the Life Safety Code inspection, it was determined that penetrations were present in the wall surfaces above ceiling lies. These findings were observed in the presence of the Maintenance Director. The findings include: Penetrations were observed in wall surfaces. BO/2/OPTY DIRECTORS OR PROVIDER ERPRESENTATIVES SIGNATURE | K 000 | INITIAL COMMEN | TS | КO | 000 | | |
| K 017 SS=E NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non- sprinklered buildings, walls properly extend above the celling. (Corridor walls may terminate at the underside of cellings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3. 6.2.1, 19.3.6.5 K 017 Standard Standard This STANDARD is not met as evidenced by: Based on observations during the Life Safety Code inspection, it was determined that penetrations were present in the wall surfaces above celling lifes. These findings were cobserved in the presence of the Maintenance Director. The findings include: Penetrations were observed in wall surfaces This STANDARD is not met as evidenced by: Based on observations during the Life Safety Code inspection, it was determined that penetrations were observed in wall surfaces The findings were cobserved in wall surfaces ROPATORY DIRECTORS OR PROVORY PROPER DIRECTORS OR PROVORY THE Corridor and the second complexite a | | conducted on Octo deficiencies were b | ber 20, 2006. The following based on observations made | | V | Codo | |
| Corridors are separated from use areas by walls constructed with at least ¼ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5 This STANDARD is not met as evidenced by: Based on observations during the Life Safety Code inspection, it was determined that penetrations were poserved in the wall surfaces above ceiling tiles. These findings were observed in the presence of the Maintenance Director. The findings include: Penetrations were observed in wall surfaces. | | NFPA 101 LIFE SA | AFETY CODE STANDARD | ĸc | | Code | |
| the gift shop is fully sprinklered.) 19.3.6.1, 19.3. 6.2.1, 19.3.6.5 This STANDARD is not met as evidenced by: Based on observations during the Life Safety Code inspection, it was determined that penetrations were present in the wall surfaces above ceiling tiles. These findings were observed in the presence of the Maintenance Director. The findings include: Penetrations were observed in wall surfaces | | constructed with at rating. In sprinkler required to resist th sprinklered building the ceiling. (Corrid underside of ceiling by Code. Charting areas, dining room open to the corrido specified in the Co | least ½ hour fire resistance ed buildings, partitions are only ne passage of smoke. In non- gs, walls properly extend above for walls may terminate at the gs where specifically permitted and clerical stations, waiting s, and activity spaces may be or under certain conditions de. Gift shops may be | | have been sealed. 2. The facility will conduct facility inspection to insure have been treated by 11/30 3. A preventative maintena will be implemented to sur monthly to identify any ne penetration. 4. Findings of the surveys to | another that all area /06. nce program vey one unit w areas of will be | |
| Based on observations during the Life Safety Code inspection, it was determined that penetrations were present in the wall surfaces above ceiling tiles. These findings were observed in the presence of the Maintenance Director. The findings include: Penetrations were observed in wall surfaces BORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | | | / sprinklered.) 19.3.6.1, 19.3. | | Committee. | | |
| Based on observations during the Life Safety Code inspection, it was determined that penetrations were present in the wall surfaces above ceiling tiles. These findings were observed in the presence of the Maintenance Director. The findings include: Penetrations were observed in wall surfaces BORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | | | | | | |) . . |
| Penetrations were observed in wall surfaces BORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE // | | Based on observat Code inspection, it penetrations were above ceiling tiles. | tions during the Life Safety was determined that present in the wall surfaces These findings were observed | · . | | | |
| BORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | | The findings incluc | le: | | | | |
| | | Penetrations were | observed in wall surfaces | | | | |
| | BORATOR | Y DIRECTOR'S OR PROVI | DER/SUPPLIER REPRESENTATIVE'S SIG | | Ling adm | i Van | |

PRINTED: 10/27/2006

| DEPARTMENT OF HEALTH CENTERS FOR MEDICAR | | | | | FORM | 10/27/2006 APPROVED 0938-0391 |
|---|--|--------------------|-----|--|------------------------|-------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) M A. BUII | | LE CONSTRUCTION 01 - MAIN BUILDING 01 | (X3) DATE SL COMPLE | IRVEY |
| | 095034 | B. WIN | IG | | 10/20 |)/2006 |
| NAME OF PROVIDER OR SUPPLIER | & REHAB | | 72 | ET ADDRESS, CITY, STATE, ZIP CODE 5 BUCHANAN ST., NE ASHINGTON, DC 20017 | | |
| PREFIX (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE D | BE CROSS- | (X5) COMPLETION DATE |
| K 017 Continued From p | age 1 | ĸ | 017 | | | |
| around electrical w following areas: | vires, cables and pipes, in the | | | | | |
| in wall surfaces ov | to 4 inch opening was observed er stairwell door # 3 in one (1) tions at 10:41 AM on October | | | | | |
| the laundry storag | observed in wall surfaces over e room and the laundry two (2) of five (5) observations ctober 20, 2006. | | | | | |
| observed around t the wall surfaces r | to 6 inch penetration was he heat and cooling pipes in hear the conference center in bservations at approximately 12 r 20, 2006. | | | | | |
| group of telecomn through the floor in | ening was observed around a nunications wires that passed n one (1) of five (5) 5 PM on October 20, 2006. | | | | | |
| | | | | | | |
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| | | H AND HUMAN SERVICES | | | FORM | 10/27/2006 APPROVED 0938-0391 |
|--------------------------|---|--|------------------------|---|--|-------------------------------------|
| | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A. BUILDI | IPLE CONSTRUCTION NG 01 - MAIN BUILDING 01 | (X3) DATE SU COMPLE | |
| | | 095034 | B. WING | <u> </u> | 10/20 | 0/2006 |
| NAME OF P | ROVIDER OR SUPPLIER | ······································ | | REET ADDRESS, CITY, STATE, ZIP CODE | | |
| CARROL | L MANOR NURSING | & REHAB | - | 725 BUCHANAN ST., NE WASHINGTON, DC 20017 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHOU REFERENCED TO THE APPROPRIAT | LD BE CROSS- | (X5) COMPLETION DATE |
| K 018 SS=E | | AFETY CODE STANDARD | K 018 | 3 | | |
| | required enclosure hazardous areas a those constructed wood, or capable of minutes. Doors in required to resist t no impediment to are provided with the door closed. I are permitted. | orridor openings in other than es of vertical openings, exits, or are substantial doors, such as of 1 ³ / ₄ inch solid-bonded core of resisting fire for at least 20 sprinklered buildings are only he passage of smoke. There is the closing of the doors. Doors a means suitable for keeping Dutch doors meeting 19.3.6.3.6 9.3.6.3 prohibited by CMS regulations acilities. | | | | |
| | | | | | | |
| | Based on observa Code inspection, i and single swingir latch. These findi presence of the M The findings inclu Third Floor the pa to close and latch observation at 11: The storage room | is not met as evidenced by: tions during the Life Safety t was determined that double ng doors failed to close and ngs were observed in the laintenance Director. de: ntry room entrance door failed in one (1) of one (1) 47 AM on October 20, 2006. and personal laundry room se and latch in two (2) of two (2) | | Ko18 NFPA 101 Life Safe Standard The identified doors w repaired by 11/30/06 t proper closure. All fire doors will again inspected by 11/30/06 Semi-annually all fire be tested and the supe perform random tests Findings will be repor Safety Committee and department director for on a monthly basis. | ill be to insure n be doors will rvisor will weekly. ted to the the | 11/30/0 |

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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| | | <u>A MEDICAID SERVICES</u> | | | | | 0938-0391 |
|--------------------------|---|---|------------------------------|-------|---|--|----------------------------|
| | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 095034 | (X2) MI A. BUII B. WIN | .DING | CONSTRUCTION 01 - MAIN BUILDING 01 | (X3) DATE SL COMPLE | TED |
| | | 095034 | | | | 10/20 | <u>)/2006</u> |
| | Rovider or Supplier | & REHAB | | 725 B | ADDRESS, CITY, STATE, ZIP CODE UCHANAN ST., NE HINGTON, DC 20017 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | x (| PROVIDER'S PLAN OF CORREC EACH CORRECTIVE ACTION SHOULD EFERENCED TO THE APPROPRIATE | BE CROSS- | (X5) COMPLETION DATE |
| K 018 | observations at 12 | age 3 :25 AM on October 20, 2006. antry door failed to close and | K |)18 | | | |
| | latch in one (1) of PM on October 20 Fifth Floor the pan failed to close and | five (5) observations at 12:30 | | | · · · | 1 | |
| K 130 SS=D | OTHER LSC DEF This STANDARD Based on observa | ICIENCY NOT ON 2786 is not met as evidenced by: tions during the survey period, that the fire gate was damaged n stairwell walls. | K | 1. | 130 NFPA 101 Miscellaneo The hinge in the stairwe between the first and gro floor will be replaced by 11/30/06 All other fire gates will be inspected to insure that in good working order a repaired as needed by 11 The supervisor will performently checks of all gad termine functional ad | ll ound they are nd /30/06. orm tes to | 11/30/06 |
| | wall on the stairwe and first floor stair | aged and separated from the ell fire gate between the ground wells in one (1) of 15 1:40 AM on October 20, 2006. | | 4 | | d to the ne | |

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

Event ID: Y4EQ21 Facility ID: CARROLLMAN

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| | OF DEFICIENCIES | E & MEDICAID SERVICES | | | OMB NO. (X3) DATE SU | |
|---------|--|---|---------------|--|-------------------------|-------------------------|
| | F CORRECTION | IDENTIFICATION NUMBER: | A BUILDIN | | COMPLE | |
| | | 095021 | B. WING | | 03/0 | 1/2006 |
| | ROVIDER OR SUPPLIER | | 1 | REET ADDRESS, CITY, STATE, ZIP CODE 1330 MASSACHUSETTS AVENUE NW WASHINGTON, DC 20005 | | |
| (X4) ID | SI IMMARY ST | | <u>ID</u> | PROVIDER'S PLAN OF CORF | | 0(5) |
| PREFIX | (EACH DEFICIENCY | MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACTION SHOL REFERENCED TO THE APPROPRIAT | ILD BE CROSS- | (X5) COMPLET DATE |
| F 000 | | ts | F 000 | F 000 | · · · · · · | |
| F 272 | February 28 throug following deficienci observations, staff The sample include | interviews and record review. ed 10 residents based on a e first day of survey. | F 272 | Responses to the cited deficiencies do not constitu an admission or agreement by the Community of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with federal and/or state law. | t | |
| SS=D | a comprehensive, a | onduct initially and periodically accurate, standardized sment of each resident's | | | | |
| | specified by the Sta include at least the Identification and do Customary routine; Cognitive patterns; Communication; | sident's needs, using the RAI ate. The assessment must | | | · · · | / |
| | Continence; | eing; and structural problems; and health conditions; | | | | |
| | Special treatments a Discharge potential; Documentation of s | | | | | • . |

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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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 095021 03/01/2006 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1330 MASSACHUSETTS AVENUE NW** THOMAS HOUSE WASHINGTON, DC 20005 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION (X4) ID ID (EACH CORRECTIVE ACTION SHOULD BE CROSS-(EACH DEFICIENCY MUST BE PRECEEDED BY FULL PRÉFIX PREFIX DATE **REGULATORY OR LSC IDENTIFYING INFORMATION)** REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG TAG F 272 F 272 **Continued From page 1** F 272 regarding the additional assessment performed With respect to how corrective through the resident assessment protocols; and Documentation of participation in assessment. action was accomplished; the 3/31/06 MDS has been retrieved, printed and placed in the resident This REQUIREMENT is not met as evidenced medical record. 3/31/06 by: Based on observation, record review and staff 2. With respect to identifying interview for one (1) of 10 sampled residents, it other residents having the was determined that facility staff failed to potential to be affected; complete an admission Minimum Data Set (MDS). Resident #7. the MDS Coordinator will audit current MDSs (since The findings include: 2/11/06) to determine that 4/7/06 they have been A review of resident #7's record revealed that he completed within 14 days /she was admitted to the facility on January 30. of admission. 2006. There was no evidence that a 4/7/06 comprehensive admission MDS assessment was completed. With respect to measures 3. According to the MDS manual page 2-3. " put in place or systemic Admission Assessment must be completed by changes made to prevent the 14th day of the resident's stay. The this practice; the DON will admission assessment is a comprehensive assessment for a new resident that must be perform random audits of 4/13/06 completed within 14 calendar days of admission MDSs for timely to the facility. " completion. 4/13/06 A face-to-face interview was conducted on March 1, 2006 at 9:00 AM with the MDS coordinator. 4. With respect to how the The surveyor requested the MDS from the MDS coordinator." He/she stated, community plans to 4/13/06 "the computers were down and the MDS could monitor performance; the not be printed." DON will monitor the audits and report to the A comprehensive MDS was not completed within QA Committee. 14 days upon admission to the facility. The 4/13/06

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

Facility ID: THOMASHOU:

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PRINTED: 03/15/2006

| | | AND HUMAN SERVICES | | | | FORM | 03/15/2006 APPROVED 0938-0391 |
|--------------------------|--|--|-------------------|-----------|---|------------------------|-------------------------------------|
| STATEMEN | T OF DEFICIENCIES DF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | IULTIF | PLE CONSTRUCTION | (X3) DATE SU COMPLE | |
| | 095021 | | | | · | 03/0 | 1/2006 |
| | PROVIDER OR SUPPLIER | | | 13 | EET ADDRESS, CITY, STATE, ZIP CODE 30 MASSACHUSETTS AVENUE NW ASHINGTON, DC 20005 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | IX | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE | BE CROSS- | (X5) COMPLETION DATE |
| F 272 | | ge 2 d on March 1, 2006. | F | 272 | | | |
| F 278 SS=E | 483.20(g) - (j) RES | DENT ASSESSMENT | F | 278 | F 278 | | |
| | resident's status. A registered nurse each assessment w participation of hea | th professionals. must sign and certify that the | | | With respect to how correctinaction was accomplished; an RAC-C (Resident Assessme Coordinator- Credentialed) heen hired and is now responsible for the MDSs. Sis currently working under supervised practice of the D | n ent nas She | |
| | Each individual who assessment must si that portion of the a | o completes a portion of the gn and certify the accuracy of ssessment. | | | for 90 days (per the Registe Nursing Regulations Sectior 5411.9) 2/11/06 | | 2/11/06 |
| | willfully and knowing false statement in a subject to a civil mo \$1,000 for each ass who willfully and kno individual to certify statement in a resid | d Medicaid, an individual who gly certifies a material and resident assessment is ney penalty of not more than essment; or an individual owingly causes another a material and false ent assessment is subject to y of not more than \$5,000 for | | | | | |
| | Clinical disagreeme material and false st | nt does not constitute a atement. | | | | | |
| | by: Based on observatio record review for fou | T is not met as evidenced n, staff interviews and ir (4) of 10 sampled ermined that facility staff | | | | | |
| | 7(02-99) Previous Versions (| Dbsolete Event ID: G5ML11 | Fac | ility ID: | THOMASHOU: if con | tinuation sheet | Page 3 of 25 |

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

| PRINTED: 03/15/2006 |
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| FORM APPROVED |
| OMB NO 0028 0201 |

| UENTE | RS FUR MEDICARE | <u>E & MEDICAID SERVICES</u> | | | | | 0938-039 |
|--------------------------|---|--|--------------------|-------------------------|---|------------------------|---------------------------|
| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | l` ' | IULTIPLE LDING | | (X3) DATE SU COMPLE | |
| | | 095021 | B. WING | | | 03/04 | /2006 |
| NAME OF P | VAME OF PROVIDER OR SUPPLIER | | | STREET | ADDRESS, CITY, STATE, ZIP CODE | | |
| THOMAS | S HOUSE | | | | MASSACHUSETTS AVENUE NW HINGTON, DC 20005 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRE EACH CORRECTIVE ACTION SHOUL REFERENCED TO THE APPROPRIATE | D BE CROSS- | (X5) COMPLETIO DATE |
| | | <u>_</u> | | | | | · |
| F 278 | Continued From pa | ige 3 | F 2 | 278 | Resident #1: The next | · | |
| | | code the Minimum Data Set (| | | MDS and future MDSs | | |
| | | by: two (2) residents coded | | | will be coded properly for | or | |
| | | e and output without clinical | | | intake and output. | | |
| | | tion I not inclusive of all | | | Resident # 3: as of | | |
| | | r one (1) resident; and the RN) signed that the MDS was | | | 2/11/06, the MDSs will I | <u>ле</u> | |
| | | her disciplines entering | | | coded property for intak | | |
| | | (1) resident. Residents #1, 3, | | | and output. | C I | |
| | 5 and 8. | | | | • | | |
| | | | | | Resident # 5: as of | | |
| | The findings include | e: | | | 2/11/06 the MDS and | | |
| | | | | | future MDSs will include | | |
| | | ed Resident #1 as being | | | all diagnoses appropria | e | |
| | record support. | and output without clinical | | | to that review period. | | |
| | record support. | | | | Resident # 8: The next | | |
| | A review of Resider | nt #1's record revealed that a | | | MDS and future MDSs | | |
| | | d January 6, 2006 and a | | | will be reviewed and | | |
| L | | ADS dated October 9, 2005 | | | signed by the RN after a | all | |
| | | on P "Special Treatments and | | | other disciplines have | | |
| | | onitoring intake and output (P | | | completed their section: | S. ` | |
| | , | evidence in the record that a a nursing intervention was | | | 4/13/06 | | 4/13/06 |
| | initiated to monitor i | | | | | | |
| | A food to food inter | iou with the unit menager | | • | | · · · | |
| | | view with the unit manager ebruary 28, 2006 at 2:30 PM. | | | | | |
| | | ed that the resident was not | | | 2. With respect to identify | ing | |
| | | and output for the above | | | other residents having | the | |
| | | cord was reviewed February | | | potential to be affected | | |
| | 28, 2006. | | | | the MDS Coordinator v | vill | |
| | | d Decident #2 on bains | | | review MDSs to | | |
| | | ed Resident #3 as being | | | determine that they are | e | |
| | monitored for intake and output without clinical record support. | | | coded properly for inta | ke | | |
| | roovid ouppoit. | | | | and output, that they h | ave | |
| | A review of Resider | t #3's record revealed that an | | | all diagnoses and othe | r | |
| 1 | | | | | un elagricere el a | | |

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

Facility ID: THOMASHOU

If continuation sheet Page 4 of 25

| STATEMEN | <u>RS FOR MEDICARE</u> FOF DEFICIENCIES OF CORRECTION | & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) M A. BU | | PLE CONSTRUCTION | (X3) DATE S COMPL | |
|--------------------------|---|---|-------------------|-----|--|---|---|
| | | 095021 | B. Wi | NG_ | | 03/ | 01/2006 |
| NAME OF P | ROVIDER OR SUPPLIER | | - I | 1: | EET ADDRESS, CITY, STATE, ZIP C 330 MASSACHUSETTS AVENUE | ODE | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAC | ix | VASHINGTON, DC 20005 PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION S REFERENCED TO THE APPROP | HOULD BE CROSS- | (X5) COMPLETION DATE |
| F 278 | Procedures" for mo d). There was no e that a physician's or was initiated to mor A face-to-face inter- was conducted on F He/she acknowledg monitored for intake cited date. The rec 28, 2006. 3. Facility staff faile diagnoses on the ar A review of Resider annual MDS was cc 2005. Section I, "D include pancreatic in Gastroesophageal F A physician's order i and subsequently re since that date direct units) by mouth befor for pancreatic insuff physician's order inin renewed every 30 to directed, " Prevacio one tab by mouth ever | "Special Treatments and nitoring intake and output (P1 vidence in the clinical record rder or a nursing intervention nitor intake and output. view with the unit manager February 28, 2006 at 2:30 PM. ed that the resident was not e and output for the above ord was reviewed February d to include all active nnual MDS for Resident #5. ht #5's record revealed that an empleted on November 2, isease Diagnoses" did not | F | 278 | them prior to the review and signa 4/13/06 3. With respect to m put in place or sy changes made to this practice; the perform random MDSs for proper diagnoses and signatures. 4/13/06 and ongo 4. With respect to h community plans monitor perform a DON will monitor audits and report QA Committee. 4/13/06 and ongo | ature. neasures stemic prevent DON will audits of coding, ping ow the to unce; the the to the | 4/13/06 4/13/06 and ongoin 4/13/06 and ongoin |
| | unit manager on Fe He/she acknowledge not coded on the res | bruary 28, 2006 at 2:30 PM. ed that the diagnoses were sident's annual MDS. The 1 February 28, 2006. | | | | | |

Event ID: G5ML11

Facility ID: THOMASHOU:

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| | DEPARTMENT OF HEALTH | H AND HUMAN SERVICES | |
|---|---------------------------|-----------------------------|------------------|
| • | CENTERS FOR MEDICARE | E & MEDICAID SERVICES | |
| | STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CO |

| PRINTED: | 03/15/2006 |
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| FORM / | APPROVED |
| OMB NO. | 0938-0391 |

| _ | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTI A. BUILDIN | PLE CONSTRUCTION | (X3) DATE SU COMPLE | |
|--------------------------|--|--|--------------------------|---|---|----------------------------|
| | | 095021 | B. WING | | 03/0 | 1/2006 |
| | PROVIDER OR SUPPLIER | · · · | 1: | EET ADDRESS, CITY, STATE, ZIP C 330 MASSACHUSETTS AVENUE (ASHINGTON, DC 20005 | XODE | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION S REFERENCED TO THE APPROF | HOULD BE CROSS- | (X5) COMPLETION DATE |
| F 278 | 4. The RN failed to had entered informa prior to signing und 8. A review of Resider admission MDS sig the assessment (Se 2006. In Section A who completed a po assessment or track therapist, dietician, signatures were dat activity therapist's s January 4, 2006. According to the dir Manual ", page 212 Coordinator must no completion of the as assessors have finis | ensure that other disciplines ation on the admission MDS er Section AA9 for Resident # Int #8's record revealed an ned by the RN coordinating ection R2b) dated January 2, A9, "Signatures of persons ortion of the accompanying king form" the physical and social worker's ed January 3, 2006, and the ignature was completed ections in the "MDS 2.0 2, "The RN Assessment | F 278 | | | |
| SS=D | CARE PLANS A facility must use the to develop, review a comprehensive plan The facility must develop plan for each reside objectives and timet medical, nursing, an needs that are identi- assessment. | (1) COMPREHENSIVE the results of the assessment and revise the resident's of care. velop a comprehensive care nt that includes measurable ables to meet a resident's d mental and psychosocial ified in the comprehensive | F 279 | F 279 1. With respect to H action was acco resident # 6, the updated to inclu- usage. 3/2/06 | mplished; for care plan was de antithrombotic | 3/2/06 |

ility ID: TH If continuation sheet Page 6 of 25

| | | HAND HUMAN SERVICES | | <u> </u> | FORM | 03/15/200 APPROVEI 0938-039 |
|------------------------------|-----------------------|--|-------------------------|---|------------------------|-----------------------------------|
| STATEMEN | FOF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A. BUILDIN | IPLE CONSTRUCTION | (X3) DATE SI COMPLE | |
| | | 095021 | B. WING | | 03/0 | 1/2006 |
| NAME OF PROVIDER OR SUPPLIER | | | | REET ADDRESS, CITY, STATE, ZIP CODI 1330 MASSACHUSETTS AVENUE NW | | |
| | | | 1 | WASHINGTON, DC 20005 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION SHOU REFERENCED TO THE APPROPRIAT | ILD BE CROSS- | (X5) Completion Date |
| F 279 | Continued From pa | ge 6 | F 279 | | | |
| | are to be furnished | to attain or maintain the | | 2. With respect to identif | - | |
| | resident's highest p | racticable physical, mental, | | other residents having | | |
| | | ell-being as required under § | | potential to be affected | | |
| | · · | rvices that would otherwise be | | the records of residen | | 3/7/06 |
| | | 3.25 but are not provided due | | receiving antithrombo | | |
| | | ercise of rights under §483.10, o refuse treatment under §483 | | therapy were reviewe | | |
| | .10(b)(4). | o refuse treatment ander 3400 | | and care plans check | ea | |
| | | · · | | to ensure that they | | |
| | | - | | include goals and | | |
| | | NT is not met as evidenced | | approaches for the | | |
| | by: | | | therapy. | | |
| | | on, staff interviews and | | 3/7/06 | | : |
| | | vo (2) of 10 sampled | | | | |
| | | termined that facility staff | | 3. With respect to measur | | |
| | | care plan for one (1) resident | | put in place or systemic | | |
| | resident based on th | botic therapy and one (1) | | changes made to preve | | |
| | assessment. Resid | • | | this practice; the DON of | T | |
| | | | | designee will perform | | 3/7/06 |
| | The findings include | : | | random audits of charts | of | |
| | | | | residents with | | |
| | | d to care plan for the use of | | antithrombotic therapy t | io . | |
| | an antithrombotic fo | or Resident #6. | | ensure that the therapy | is | |
| | The resident's Dhus | ician Plan of Care (POC) | | included in the care | | |
| | | 2006 included, "Aspirin 325 | | plans. | * | |
| | | (daily) for stroke prevention | | 3/7/06 | | |
| | | | | | | |
| | | | | 4. With respect to how the | • • | 4/13/06 |
| | | v care plan did not include the | | community plans to | | |
| | use of the daily anti | | | monitor performance; th | ne . | |
| | A face-to-face inten | view was conducted with the | | DON or designee will | | |
| | | irses) on February 28, 2006 | | monitor the findings and | t | |
| | | :30 PM who acknowledged | | report to the QA | | 1 |
| | | d not include goals and | | Committee. | | |
| | approaches for antit | · · · · · · | | P | | |

Facility ID: THOMASHOU:

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PRINTED: 03/15/2006

DEPARTME CENTERS F

hygiene and bathing.

| | | AND HUMAN SERVICES | | | | FORM | APPROVED |
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| <u>CENTE</u> | <u>RS FOR MEDICARE</u> | & MEDICAID SERVICES | | | | <u>OMB NO.</u> | <u>0938-0391</u> |
| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A BUILDING | | | (X3) DATE SURVEY COMPLETED | |
| | | 095021 | B. WI | ۹G | | 03/0 | 1/2006 |
| | ROVIDER OR SUPPLIER | | | 1 | REET ADDRESS, CITY, STATE, ZIP CODE 330 MASSACHUSETTS AVENUE NW VASHINGTON, DC 20005 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIÉS MUST BE PRECEÉDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE | BE CROSS- | (X5) COMPLETION DATE |
| F 279 | Continued From pa | ge 7 | F | 279 | F 279 | | |
| | based on the comp Resident #9. | ed to develop a care plan rehensive assessment for | | | 1. With respect to how correct action was accomplished; resident # 9, the care plan revised to reflect a | for | 3/2/06 |
| | annual Minimum Da dated April 1, 2005 assessments dated | nt #9's record revealed an ata Set (MDS) assessment and quarterly MDS July 1, September 28 and . In all MDS assessments | | | comprehensive assessme measurable goals to relate care deficet. 3/2/06 | | |
| | cited above, the res G, "Physical Function Problems" as being | sident was coded in Section oning and Structural totally dependent for all toileting, locomotion on and | | - | With respect to identifying other residents having the potential to be affected; the care plans have been | | 3/7/06 |

Care plan problem #4 dated June 4, 2004, " Self Care Deficit " identified problems in the following areas: feeding, bathing, dressing, toileting and grooming related to "Parkinson disease" and " Alzheimer's/ Dementia " .

off the unit, dressing, eating, toilet use, personal

Goals identified included, "Resident will be able to improve ability to feed self, bathe self, dress self, toilet self, and improve mobility." Under evaluation comments, dated December 12, 2005 "Resident is total assist with all ADLS including feeding."

Facility staff failed to develop a care plan based on the comprehensive assessment of Resident # 9

A face-to-face interview was conducted with the unit manager on March 1, 2006 at 9:30 AM. He/ she acknowledged that the resident was totally dependent for all ADLs and that the care plan did

4/13/06

reviewed for accuracy.

3. With respect to measures

put in place or systemic

changes made to prevent

this practice; the DON or designee will conduct

random audits of care

plans, checking for

4. With respect to how the

community plans to

DON or designee will

monitor the audits and

monitor performance; the

accuracy.

3/7/06

3/7/06

If continuation sheet Page 8 of 25

3/7/06

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4/13/06

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Event ID: G5ML11

Facility ID: THOMASHOU:

report findings to the QA Committee.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 03/15/2006 FORM APPROVED OMB NO. 0938-0391

| | FOF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) M A. BUI | | PLE CONSTRUCTION | (X3) DATE SU COMPLE | |
|--------------------------|---|--|-------------------|-----|--|-----------------------------------|----------------------------|
| | | 095021 | B. WING | | | 03/0 | 1/2006 |
| | ROVIDER OR SUPPLIER | | | 13 | EET ADDRESS, CITY, STATE, ZIP CODE 330 MASSACHUSETTS AVENUE NW (ASHINGTON, DC 20005 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOUL REFERENCED TO THE APPROPRIATE | D BE CROSS- | (X5) COMPLETION DATE |
| F 279 | Continued From pa not reflect the comp record was reviewe | prehensive assessment. The | F | 279 | | | |
| F 280 SS=D | | 0(k)(2) COMPREHENSIVE | F 2 | 280 | | | |
| | The resident has the incompetent or othe incapacitated under participate in planni changes in care and A comprehensive ca within 7 days after t comprehensive ass interdisciplinary tea physician, a register for the resident, and disciplines as detern needs, and, to the e participation of the r or the resident's leg periodically reviewe | the laws of the State, to ng care and treatment or | | | With respect to how conaction was accomplished care plan for resident # updated with new approaches/intervention to subsequent fall. 3/2/06 2. With respect to identifying other resident having the potential to be affected; Residents with fall will have new interventions added to the current interventions to prevent future falls. 3/7/06 | d; the 5 was s related s | 3/2/06 |
| | by: Based on observation review for one (1) of determined that facion care plan to include | sident #5 subsequent to one (| | | With respect to measures put in place or systemic changes made to preven this practice; the DON or designee will monitor incident reports and update care plans after any falls. 3/7/06 | t . | 3/7/06 |
| | A review of Residen | t #5's record revealed a | | | | | 3//100 |

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

Event ID: G5ML11

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Facility ID: THOMASHOU

If continuation sheet Page 9 of 25

| | | HAND HUMAN SERVICES | _ | | | FORM | 03/15/2006 APPROVED 0938-0391 |
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| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | JRVEY TED |
| | | 095021 | B. WH | NG_ | | 03/0 | 1/2006 |
| | PROVIDER OR SUPPLIER | | | 1: | REET ADDRESS, CITY, STATE, ZIP CODE 330 MASSACHUSETTS AVENUE NW | | |
| | | | | <u> </u> | VASHINGTON, DC 20005 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE D | BE CROSS- | (X5) COMPLETION DATE |
| F 280 | Continued From pa | ge 9 | F | 280 | | | a |
| | "At approximately 6 nursing station and #5] was on the floor ROM (range of mot A review of Resider problem, "Fall Prev | January 28, 2006 at 8:25 PM, 5:48 PM [visitor] rushed to the informed writer that [Resident r[Resident] able to perform ion) and follow directions " Int #5's care plan revealed a ention Care Plan." Under | | | With respect to how the community plans to monitor performance; the DON or designee will report findings to the Safety Committee and QA Committee. | 2 | |
| | documented, "Resid with an abrasion me cleansed with NS (r open to air)." There were no appr | elumn, the unit manager dent sustained a fall in room easuring 1 x 1 cm. Area was normal saline) and left OTA (poaches or interventions pove cited fall to prevent the er falls. | | | 4/13/06 | | 4/13/06 |
| | was conducted on F He/she acknowledg initiated after the ab | view with the unit manager February 28, 2006 at 3:30 PM. ed that no interventions were pove cited fall. ewed February 28, 2006. | | | | | |
| | 483.20(k)(3)(i) CON PLANS | IPREHENSIVE CARE | F2 | 281 | | | |
| | | ed or arranged by the facility onal standards of quality. | | ĺ | · · | | |
| | by: | IT is not met as evidenced | | | | | |
| | interview for three (3 was determined that care plans quarterly | 3) of 10 sampled residents, it t facility staff failed to: update for two (2) residents and esident's plan of care with the | | | | | |

Event ID: G5ML11 Facility ID: THOMASHOU:

If continuation sheet Page 10 of 25

| | | | | | FORM | 03/15/2006 APPROVED 0938-0391 |
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| T OF DEFICIENCIES DF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A BUILDING | | | (X3) DATE SURVEY COMPLETED | |
| | 095021 | B. WI | ₩G | · | 03/0 | 1/2006 |
| ROVIDER OR SUPPLIER | · · | | 13 | 30 MASSACHUSETTS AVENUE NW | · | |
| (EACH DEFICIENCY | MUST BE PRECEEDED BY FULL | | | (EACH CORRECTIVE ACTION SHOULD | BE CROSS- | (X5) COMPLETION DATE |
| hospice agency acc Residents #2, 4 and The findings include 1. Facility staff faile care plan quarterly The care plan dated included the followi volume deficit relat Altered mental state diversional activity interest in socializat history of falls and I Noncompliant with to understand plan related to Dementia | cording to the facility policy. d 7. e: e: ed to update Resident #2's according to facility policy. d September 19, 2005 ng problems: "Risk for fluid ed to anticoagulant therapy, us related dementia, Social/ deficit related to loss of tion, Risk for injury related to balance disturbance, plan of care related to inability of care, Self care deficit a, and Alteration in comfort | F | 281 | action was accomplished; resident # 7, the care was obtained from Capital Hos and placed in the chart alk with the care plan initiated facility. A care plan meetir being held. 3/27/06 With respect to identifying | for pice ong by the ig is | 3/27/06 |
| Plan/Interdisciplinar # 8 Policy Interpreta The resident's comp developed within se completion of the re- twenty one (21) day admission, whichev revised as changes dictate. Reviews are There was no evide updated. The record 28, 2006. | y Assessment Team" page ation and Implementation; " brehensive care plan is even (7) days of the esident assessment or within s after the resident er occurs first. Care plans are in the resident's condition e made at least quarterly." Ince that the care plan was a was reviewed on February d to update Resident #4's | | | coordinated plan of care within two days of accepting the referral. 3/2/06 3. With respect to measures put in place or systemic changes made to prevent this practice; the DON or designee will audit the charts within 3 days to insure proper standards are being followed. 3/2/06 | | 3/2/06 3/2/06 |
| | RS FOR MEDICARE TOF DEFICIENCIES OF CORRECTION PROVIDER OR SUPPLIER SHOUSE SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pathospice agency acc Residents #2, 4 and The findings include 1. Facility staff faile care plan quarterly The care plan dated included the followity volume deficit related Altered mental status diversional activity interest in socializat history of falls and I Noncompliant with to understand plan related to Breast Ca A review of the facil Plan/Interdisciplinate # 8 Policy Interpreta The resident's comp developed within se completion of the re- twenty one (21) day admission, whichev revised as changes dictate. Reviews are There was no evide updated. The record 28, 2006. 2. Facility staff failed care plan quarterly a | DF CORRECTION IDENTIFICATION NUMBER: 095021 IDENTIFICATION NUMBER: 095021 IDENTIFICATION NUMBER: SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 10 hospice agency according to the facility policy. Residents #2, 4 and 7. The findings include: 1. Facility staff failed to update Resident #2's care plan quarterly according to facility policy. The care plan dated September 19, 2005 included the following problems: " Risk for fluid volume deficit related to anticoagulant therapy, Altered mental status related dementia, Social/ diversional activity deficit related to loss of interest in socialization, Risk for injury related to history of falls and balance disturbance, Noncompliant with plan of care related to inability to understand plan of care, Self care deficit related to Dementia, and Alteration in comfort related to Breast Cancer. " A review of the facility's policy entitled, "Care Plan/Interdisciplinary Assessment Team" page # 8 Policy Interpretation and Implementation; " The resident's comprehensive care plan is developed within seven (7) days of the completion of the resident assessment or within twenty one (21) days after the resident admission, whichever occurs first. Care plans are revised as changes in the resident's condition dictate. Reviews are made at least quarterly." There was no evidence | RS FOR MEDICARE & MEDICAID SERVICES TOF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA DF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA DF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA DOUDER OR SUPPLIER 095021 SHOUSE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREF TAGE Continued From page 10 F : hospice agency according to the facility policy. Residents #2, 4 and 7. F : The findings include: 1. Facility staff failed to update Resident #2's care plan quarterly according to facility policy. The care plan dated September 19, 2005 included the following problems: "Risk for fluid volume deficit related to anticoagulant therapy, Altered mental status related dementia, Social/ diversional activity deficit related to loss of interest in socialization, Risk for injury related to history of falls and balance disturbance, Noncompliant with plan of care related to inability to understand plan or care, Self care deficit related to Breast Cancer. " A review of the facility's policy entitled, "Care Plan/Interdisciplinary Assessment Team" page # 8 Policy Interpretation and Implementation; " The resident's comprehensive care plan as are revised as changes in the resident's condition dictate. Reviews are made at least quarterly." There was no evidence that the care plan was updated. The record was reviewed on February 28, 2006. 2. Facility staff failed to update Resident #4's care plan quart | RS FOR MEDICARE & MEDICAID SERVICES (22) MULTIR TOF DEFICIENCIES (21) PROVIDER/SUPPLIER/CLA (22) MULTIR DEPOTIFICATION NUMBER: 095021 (22) MULTIR ROVIDER OR SUPPLIER STR STR S HOUSE SUMMARY STATEMENT OF DEFICIENCIES D (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG Continued From page 10 F 281 hospice agency according to the facility policy. F 281 Residents #2, 4 and 7. The findings include: 1. Facility staff failed to update Resident #2's care plan quarterly according to facility policy. F 281 The care plan dated September 19, 2005 included the following problems: " Risk for fluid volume deficit related to anticoagulant therapy, Altered mental status related dementia, Social/ diversional activity deficit related to loss of interest in socialization, Risk for injury related to history of falls and balance disturbance, Noncompliant with plan of care related to inability to understand plan of care, Self care deficit related to Dementia, and Alteration in comfort related to Dementia, and Alteration in comfort related to Breast Cancer. " A review of the facility's policy entitled, "Care Plan/Interdisciplinary Assessment Team" page # 8 Policy Interpretation and Implementation; " The resident's comprehensive care plan is developed within seven (7) days of the completion of the resident assessment or within twenty one (21) days after the resident admission, whichever | RS FOR MEDICARE & MEDICAID SERVICES ICOP DERCENCES ICOP DERCENCES PCORRECTION IDENTIFICATION NUMBER: 095021 REVIDER OR SUPPLIER S HOUSE SUMMARY STATEMENT OF DEFICIENCES (EACH DERCENCY NUST BE PRECEEDED BY FULL REGULATORY OR LISC IDENTIFYING INFORMATION) RESIDUATORY OR LISC IDENTIFYING INFORMATION) Continued From page 10 Instructions The findings include: 1. Facility staff failed to update Resident #2's care plan quarterly according to facility policy. The care plan dated September 19, 2005 included the following problems: "Risk for fluid volume deficit related to anticoagulant therapy, Altered mental status related domental, Social/ diversional activity deficit related to loss of interest in socialization, Risk for injury related to instory of fails and balance disturbance, Noncompliant with plan of care relation in comfort related to Dementia, and Alteration in comfort related to Dementia, and Alteration in comfort related to Breast Cancer." A review of the facility solicy entitled, "Care Plan/Interdisciplinary Assessment Team" page developed within seven (7) days of the completion of the resident assessment or within thervised as changes in the resident's condition dictate. Reviews are made at least quarterly." There was no evidence that the care plan was updated. The record was reviewed on February 28, 2006. With respect on measures put in place or systemic changes made to prevent this practice; | TIMENT OF HEALTH AND HUMAN SERVICES FORM RS FOR MEDICARE & MEDICAID SERVICES OMB NO. PORTORECRAFE & MEDICAID SERVICES OMB NO. PORTORECRES (1) PROVDERSUPPLERCIA (2) MULTIPLE CONSTRUCTION (3) DATES ROVIDER OR SUPPLER STREET ADDRESS, CITY, STATE, ZIP CODE 3300 SHOUSE STREET ADDRESS, CITY, STATE, ZIP CODE 3300 SUMMARY STATEMENT OF DEPICIENCES (EXCH DEPICENCY MUST BE PRECEEDED BY FULL RESULTIONY OR LSC DEDITIFINION MFORMATION) PROVDER'S FLAN OF CORRECTION RESULTION OF CORRECTION STATE SERVICES D Continued From page 10 hospice agency according to the facility policy. F 281 F 281 The findings include: F 281 I. With respect to how corrective action was accomplished; for resident # 7, the care was obtained from Capital Hospice and placed in the chart along with the care plan indiced by the facility. A care plan meting is botomethic and Alteration in comfort related to Derasitization, Risk for injury related to history of falls and balance disturbance, Noncomplain with plan of care. Self care deficit related to Derasit Cancer." 2. With respect to identifying other resident's comprehensive care plan is developed within seven (7) days of the completion of the resident assessment or within Wernty one (21) days after the resident admission, whichever occurs first. Care plan sare revised as changes in the resident scondition dictate. Reviews are made at least quarterly. |

Facility ID: THOMASHOU

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| DEPAR | TMENT OF HEALTH | AND HUMAN SERVICES | | | | | 03/15/2006 APPROVED |
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| CENTE | RS FOR MEDICARE | & MEDICAID SERVICES | | | | OMB NO. | 0938-0391 |
| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
| - | | 095021 | B. WI | 1G_ | | 03/0 | 1/2006 |
| NAME OF P | ROVIDER OR SUPPLIER | | | STF | REET ADDRESS, CITY, STATE, ZIP CODE | | |
| TUOMA | | | | | 330 MASSACHUSETTS AVENUE NW | | |
| THOMAS | S HOUSE | | | ٧ | WASHINGTON, DC 20005 | | |
| (X4) ID PREFIX | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL | ID PREF | 1X: | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD | BE CROSS- | (X5) COMPLETION DATE |
| TAG | REGULATORY OR L | SC IDENTIFYING INFORMATION) | TAG | | REFERENCED TO THE APPROPRIATE D | DEFICIENCY | DATE |
| F 281 | Continued From pa | ge 11 | F | 281 | | <i>y</i> , | ` ; |
| | | | | | 4. With respect to how the | | |
| | | esident # 4 dated September | | | community plans to | | |
| | | he following problems: " | | | monitor performance; the | | |
| | | tegrity related to incontinence | | | DON or designee will | | |
| | | ity, Self care deficit related to ementia, Noncompliant with | | | monitor the audits and | | |
| | | o chronic migraine headache, | | | report findings to the QA | | |
| | | ence of bladder and bowel, | | | | | |
| | | rug use." There was no | | | Committee. | | |
| | | are plan was updated. The | | | 4/13/06 | | 4/13/06 |
| | | d February 28, 2006. | | | <u>N.</u> | | |
| | Director of Nursing 00 A.M. He/she stat plans for Residents was because the co operable for approx | view was conducted with the on February 28, 2006 at 11: red, " The reason the care #2 and 4 were not updated mputers were down and not imately two months." The d on February 28, 2006. | | | 1. With respect to how correction | ive | |
| | 3 Facility staff faile | d to coordinate Resident #7's | | | action was accomplished; for | or | |
| | | hospice agency according to | | | resident # 2 and #4 quarter | у | |
| | the facility's policy. | | | | care plans are updated. 3/ | 2/06 | 3/2/06 |
| | Program, page #33 Implementation stat participates in the h coordinated plan of hospice agency and developed and shall managing pain and symptoms. The care | ity policy titled, "Hospice Policy Interpretation and es, When a resident ospice program, a care between the facility, resident/family will be include directives for other uncomfortable e plan shall be revised and ry to reflect the resident's | | | With respect to identifying other residents having the potential to be affected; the care plans were reviewed to ensure that they are being updated appropriately. 3/7/06 | | 3/7/06 |
| | | 06 Resident #7 was referred the terminal diagnosis of " | | | | · | |
| ORM CMS-256 | | Dbsolete Event ID: G5ML11 | | sility 1 | D: THOMASHOU: If conti | nuction choot | Page 12 of 25 |

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| 095021 B. WING 03/01/2006 NAME OF PROVIDER OR SUPPLIER THOMAS HOUSE STREET ADDRESS, CITY, STATE, 2P CODE 1330 MASSACHUSE TTS AVENUE NW WASHINGTON, DC 20005 Comparing Comparing Comparing PREFIX STREET ADDRESS, CITY, STATE, 2P CODE 1330 MASSACHUSE TTS AVENUE NW WASHINGTON, DC 20005 Comparing Comparing PREFIX D PROVIDER OR NUT OF CORRECTION. NOT CORRECTION. REFERENCED TO THE APPROPRIATE DEPCIENCIES. REFERENCED TO THE APPROPRIATE DEPCIENCIES. REFERENCED TO THE APPROPRIATE DEPCIENCY Comparing Comparing PREFIX D PREFIX REFERENCED TO THE APPROPRIATE DEPCIENCY Comparing Comparing Comparing Protein Comparing Protein Comparing Prot | | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
|---|--------|--|--|--|-----|--|-------------------------------|------------|
| THOMAS HOUSE Tage MASSACHUSETTS AVENUE NW WASHINGTON, DC 20005 (provide the construction of the construction of the construction of the construction of construction of construction of the c | | | 095021 | B. WI | 1G | | 03/0 | 1/2006 |
| PAGE DSUMMARY STATEMENT OF DEPICENCIES REPORT DEPICENCY MUST BE PRECEEDED BY FULL RECOLLTION OF LSC DEPITITING INFORMATIONDPREFX PREFX TAGPREFX PREFX TAGPREFX PREFX TAGPREFX PREFX PREFX TAGPREFX PREFX PREFX TAGPREFX PREFX PREFX TAGPREFX PREFX PREFX TAGPREFX PREFX PREFX TAGPREFX PREFX PREFX TAGPREFX PREFX PREFX PREFX TAGPREFX PREFX PREFX PREFX TAGPREFX PREFX PREFX PREFX PREFX TAGPREFX PREFX PREFX PREFX PREFX TAGPREFX PREFX< | | | | | 13 | 30 MASSACHUSETTS AVENUE NW | | |
| Prostate Cancer /Chronic Renal Failure." There was no evidence of an assessment of Resident #7 by the hospice health care professional since he/she became a hospice or professional since he/she became the facility staff and resident/family since the resident was enrolled in hospice care. A face-to-face interview was conducted on February 28, 2006 11:00 AM with the Director of Nurses. He/she said, "A care plan conference between the facility staff and the hospice agency representative was planed for the near future." The record was reviewed on March 1, 2006. F 284 483.20(0)(3) DISCHARGE SUMMARY F 284 When the facility anticipates discharge a resident must have a discharge plan of care that is developed with the participation of the resident and his or her family, which will assist the resident to adjust | PRÉFIX | (EACH DEFICIENCY | MUST BE PRECEEDED BY FULL | PREF | IX | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD | BE CROSS- | COMPLETION |
| A face-to-face interview was conducted on February 28, 2006 11:00 AM with the Director of Nurses. He/she said, "A care plan conference between the facility staff and the hospice agency | F 281 | Prostate Cancer /C There was no evide Resident #7 by the professional since h patient. A note from February 28, 2006 Hospice nurse visit review chart and co staff. Assessment to comfort, denies pai respiration-24, pulse Assessment to follo A review of the faci Summary " reveale plan conference het the hospice agency | hronic Renal Failure." ence of an assessment of hospice health care ne/she became a hospice in the hospice nurse written on at 12:00 PM indicated, " to assess, promote comfort, bordinate care with facility o follow client repositioned for n vital signs are as follow: e-80, blood pressure - 123/61 w." lity, "Care Plan Conference ed that, there was no care ld between the facility staff, staff and resident/family | F | 281 | put in place or systemic changes made to prevent this practice; the DON or designee will review the care plans and verify that the quarterly care plans are completed. 3/7/06 4. With respect to how the community plans to monitor performance; the DON or designee will monitor the report findings to the QA | | 3/7/06 |
| | SS=D | February 28, 2006 1 Nurses. He/she said between the facility representative was The record was revi 483.20(I)(3) DISCH/ When the facility an must have a dischar post-discharge plan with the participation her family, which wi | 11:00 AM with the Director of 1, "A care plan conference staff and the hospice agency planned for the near future." ewed on March 1, 2006. ARGE SUMMARY ticipates discharge a resident rge summary that includes a of care that is developed n of the resident and his or Il assist the resident to adjust | F2 | 84 | 4/13/06 | | 4/13/06 |

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| | | HAND HUMAN SERVICES | | | | | FORM | 03/15/2006 APPROVED 0938-0391 |
|-------------------|------------------------------------|---|---------------------|----------|---------|--|------------------------|-------------------------------------|
| STATEMEN | T OF DEFICIENCIES DF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MU A. BUILI | | CONST | | (X3) DATE SI COMPLE | URVEY |
| | | 095021 | B. WINC | G | | | 03/0 | 1/2006 |
| NAME OF P | ROVIDER OR SUPPLIER | | [: | | | SS, CITY, STATE, ZIP CODE | | |
| THOMAS | S HOUSE | | | | | CHUSETTS AVENUE NW 'ON, DC 20005 | | |
| (X4) ID PREFIX | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL | ID PREFIX | | (EACH O | ROVIDER'S PLAN OF CORRECTIVE ACTION SHOUL | D BE CROSS- | (X5) COMPLETION DATE |
| TAG | | SC IDENTIFYING INFORMATION) | TAG | r | REFEREN | VCED TO THE APPROPRIATI | | |
| F 284 | Continued From pa | ge 13 | F 28 | 84 | F 284 | | - | |
| | by: | | | | | | | |
| | | w of one (1) of one (1) closed | | | | Nith respect to how correction was accomplished: | ctive | |
| I | | as determined that facility staff | | | | action was accomplished; | | |
| 1 | | at the Transfer/Discharge Plan | Í | · | | esident # 10, was safely lischarged to Assisted Liv | ina | |
| | | t #10's continuing care needs; lent's or responsible party's | 1 | | | 2/24/06 | nıy. | 2/24/06 |
| | | ansfer/Discharge Plan. | 1 | | | 2/24/00 | | 2124100 |
| | _ | - | | | 2. V | Vith respect to identifying | | |
| | The findings include |) | | | | other residents having the | | |
| | | the end and and and | | | | otential to affect; nursing | | |
| | | to ensure that continued dressed on the "Transfer/ | | | - | taff will document an | | |
| | Discharge Plan." | | | | | issessment of continued | | |
| | Distange | | | <u> </u> | - | are needs in the medical | | |
| | | dmitted to the nursing unit on | | | | ecord and will obtain the | | |
| | | m the hospital as the result of | | | | esident or their | | |
| | | living apartment (part of the | | | | esponsible party's | , | |
| | residential commun | ny). | | · | | ignature on all | | |
| | During the review of | f nurses' notes, the resident | | | | ransfers/discharges. | | |
| | | por on January 9, 2006; no | | | | /1//06 | | 414 1100 |
| | | ted and on January 26, 2006 | | | ~ | /1//00 | | 4/1//06 |
| • | was found on the flo | oor with an injury to his/her | | | | | | |
| | nose and was sent of | | | | 2 | Mith manage to measur | 00 | |
| | ampulance) to the h | ospital for evaluation. | | | 3. | With respect to measure put in place or systemic | | |
| | The resident's interc | isciplinary care plan dated | | | | changes made to preve | | |
| | | luded goals and approaches | | | | this practice; the DON of | | |
| | for fails. One (1) of | the interventions was, "place | | | | designee will educate a | | |
| | | ventions program to alert | | | | nursing staff to ensure | 11 | |
| | others to fall risk. " | | • | | | that continued care nee | eds | |
| | The resident was dis | scharged from the nursing | | | | are addressed on the | | |
| | | artment on February 24, 2006 | | | | transfer/discharge | | |
| | | umentation in the record of | | | | summary and signatur | es | |
| | | he resident's continued care | | | | obtained from the | | |
| | | e documentation on the | | | | resident or responsibilit | v | |
| | I ranster/Discharge | Plan of the resident's | | | | | • | |

Facility ID: THOMASHOU

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PAGE 18

| | | HAND HUMAN SERVICES | | 4/19/06 | FORM | : 03/15/2006 APPROVED |
|--------------------------|--|---|-----------------------|---|-----------------------|----------------------------|
| STATEMENT | TOF DEFICIENCIES F CORRECTION | A MEDICAID SERVICES (x1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MU . A, BUILI | LTIPLE CONSTRUCTION | (X3) DATE S COMPLI | |
| | | 095021 | B. WING | · · · · · · · · · · · · · · · · · · · | 03/0 | 1/2006 |
| NAME OF P | ROVIDER OR SUPPLIER | | 5 | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| THOMAS | BHOUSE | | | 1330 MASSACHUSETTS AVENUE NW WASHINGTON, DC 20005 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | NTEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE | BE CROSS- | (X5) COMPLETION DATE |
| F 284 | Continued From pa | age 14 | F 28 | · · · · · · · · · · · · · · · · · · · | | <u> </u> |
| . 201 | continued care nee | • | | party and will audit the process. 4/1/06 | | 4/1/06 |
| | | /her responsible party on the " | | | | |
| | indicated, "Transfe Living) with copies | dated February 23, 2006 r Pt. tomorrow to AL (Assisted of H&P (History and Physical, der Sheet), problem list and ." | - - | 4. With respect to how the community plans to monitor performance; the DON or designee will report and findings to the QA Committee. | | |
| | was dated and sign licensed nurse; how signed by the resid responsible party to | harge Plan" with instructions ed February 24, 2006 by a vever, the form was not ent or the resident's o indicate that instructions ither party. The record was 1, 2006. | | 4/13/06 | | 4/13/06 |
| F 314 | 483.25(c) PRESSU | IRE SORES | F 31 | 4 | | |
| SS=D | resident, the facility who enters the faci | rehensive assessment of a must ensure that a resident lity without pressure sores | | With respect to how correcti action was accomplished; for resident # 8, the pressure u | ńc | |
| | individual's clinical | ressure sores unless the condition demonstrates that able; and a resident having | | has healed/closed. 3/2/06 | | 3/2/06 |
| | pressure sores rece services to promote | eives necessary treatment and healing, prevent infection bres from developing. | | 2. With respect to identifying other residents having the potential to be affected; Residents with wound treatments were observed by the Dir. of | | |
| | by: | NT is not met as evidenced | | Nursing during dressing changes to ensure the proper technique is | | |
| | (1) of one (1) press | on and record review for one sure ulcer treatment, it was illity staff failed to follow the | | followed. 4/1/06 | , | 4/1/06 |

FORM CMS-2557(02-99) Previous Versions Obsolete

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Event ID: G5ML11 Facility ID: THOMASHOU:

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

| PRINTED: | 03/15/2006 |
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| FORM | APPROVED |
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| | | E & MEDICAID SERVICES | _ | · · · · · | . 0938-039 |
|--------------------------|--|--|-----------------------|---|---------------------------|
| | T OF DEFICIENCIES DF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILDI | TIPLE CONSTRUCTION (X3) DATE S NG | |
| | | 095021 | B. WING | 03/0 | 1/2006 |
| | PROVIDER OR SUPPLIER | · | | REET ADDRESS, CITY, STATE, ZIP CODE 1330 MASSACHUSETTS AVENUE NW WASHINGTON, DC 20005 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS- REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETIO DATE |
| F 314 | facility's policy whe treatment for Resid The findings includ Resident #8's press observed on March nurse washed his/h The soiled dressing was cleansed and 2 dressing was applie According to the fac Treatment ", under page 21, " 6. Remo in opened plastic ba and place in the pla Apply gloves. " | n performing a pressure ulcer lent #8. e: sure ulcer treatment was 1, 2006 at 7:05 AM. The er hands and donned gloves. was removed, the wound Keroform and an outer | F 314 | With respect to measures put in place or systemic changes made to prevent this practice; the DON or designee will in-service nursing staff to ensure that proper steps are taken during treatments and will monitor random treatment techniques during wound rounds. 4/1//06 With respect to how the community plans to monitor performance; the DON or designee will report findings to the QA Committee. | 4/1//06 |
| F 329 SS=D | unnecessary drugs. drug when used in e duplicate therapy); without adequate m indications for its us adverse consequen should be reduced o combinations of the | CESSARY DRUGS g regimen must be free from An unnecessary drug is any excessive dose (including or for excessive duration; or onitoring; or without adequate e; or in the presence of ces which indicate the dose or discontinued; or any | F 329 | 4/13/06 | 3/2/06 |

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

Facility ID: THOMASHOU

If continuation sheet Page 16 of 25

| TATEMENT | FOF DEFICIENCIES OF CORRECTION | E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | A BUILDIN | IFLE CONSTRUCTION IG | OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED |
|--------------------------|---|---|---------------------|---|--|
| | | 095021 | B. WING_ | | 03/01/2006 |
| | ROVIDER OR SUPPLIER 8 HOUSE | | 1 | REET ADDRESS, CITY, STATE, ZIP CODE 330 MASSACHUSETTS AVENUE NW VASHINGTON, DC 20005 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL, SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD B REFERENCED TO THE APPROPRIATE DE | E CROSE- COMPLÉTI |
| F 329 | Continued From pa | | F 329 | <u></u> | · . |
| | by: | | 1 020 | | |
| | Based on observat interview for one (1 was determined that consistently monitor | ion, record review and staff) of 10 sampled residents, it at facility staff failed to or the behavior of Resident #4 antipsychotic medication. | | 2. With respect to identifying other residents having the potential to be affected; records of residents receiving antipsychotic | |
| | The findings includ A review of the fac | | | medications were reviewed to ensure Behavior Monitor Records are in place. | |
| | Psychotropic Drug /02 revealed the fo | Use, # 7 page 5 effective 08/1 llowing." " The customer's red using the behavioral | | 3/7/06 | 3/7/06 |
| | record for custome drugs for organic m or psychotic behav problems are track number of episodes pacing, yelling, or s the interdisciplinary | | | With respect to measures put in place or systemic changes made to prevent this practice; the DON or designee will conduct a monthly audit of the Medication Administration Records to verify that | |
| | on July 19, 2005, | nt # 4's physician order written "Seroquel 25mg tablet ½ tab (at bedtime for Delusion/ | | these medications have Behavior Monitoring records. | |
| | A review of the Me Record (MAR) for December, 2005 ar 2006, revealed that | dication Administration October, November and Ind January and February, Resident #4 was Juel 12.5mg by mouth at 7:00 | | 3/7/06 With respect to how the community plans to monitor performance; the DON or designee will report findings to the QA | 3/7/06 |
| | Flow Record" reve monitored for agital | nt #4's "Behavior Monitoring aled that he/she was ted behavior for October 2005 evidence that the resident's | | Committee. 4/13/08 | 4/13/06 |

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 03/15/2006 FORM APPROVED

| (X3) DATE SURVEY COMPLETED 03/01/2006 |
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| ORRECTION (X5) HOULD BE CROSS- RIATE DEFICIENCY) DATE |
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FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: G5ML11 Facility ID: THOMASHOU:

| | | HAND HUMAN SERVICES | | | | FORM | 03/15/2006 APPROVED 0938-0391 |
|--------------------------|--|--|--------------------|----------|--|------------------------|-------------------------------------|
| STATEMEN | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) M A. BUI | | PLE CONSTRUCTION (| (X3) DATE SU COMPLE | JRVEY |
| | | 095021 | B. WIN | IG | | 03/0 | 1/2006 |
| | PROVIDER OR SUPPLIER | | | 13 | REET ADDRESS, CITY, STATE, ZIP CODE 330 MASSACHUSETTS AVENUE NW VASHINGTON, DC 20005 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | x | PROVIDER'S PLAN OF CORRECTIN (EACH CORRECTIVE ACTION SHOULD BI REFERENCED TO THE APPROPRIATE DE | e Cross- | (X5) COMPLETION DATE |
| F 371 SS=E | PREP & SERVICE | FARY CONDITIONS - FOOD ore, prepare, distribute, and anitary conditions. | F 3 | 571 | · · · · · · · · · · · · · · · · · · · | | |
| | by: Based on observati it was determined the adequate to ensure safe and sanitary mexpired chocolate in a soiled can opener gear and cutting sur- counter lacked cover from contamination were not allowed to hotel pans were not not allowed to dry be refrigeration unit was under cooking hood smoke during meal person was observed without hair restrain without gloves; hote and lunch meals we hour period; exhauss the dish machine late secured to the ceiling food storage room fi ceiling; the air suppli- area lacked a cover the dishwasher were | NT is not met as evidenced ons during the survey period, hat dietary services were not that food was served in a hanner as evidenced by: hilk in the walk-in refrigerator; with metal shavings on the faces; a stainless steel ers to protect stored items ; stainless steel plate covers dry before storing for reuse; thoroughly cleaned and were efore storing for reuse; the is inoperative; exhaust fans is failed to remove steam and preparation; a dietary staff d working in the main kitchen ts and handling china ware I pans used during breakfast re not cleaned within a 2 to 3 t fans on the clean side of cked a cover and was not ig; wall surfaces of the dry ailed to terminate at the y louver in the dishwasher ; and ceiling surfaces over e not plastered and painted. observed in the presence of | | | F 371 1. With respect to how corrective action was accomplished; no negative resident outcome. Citations were corrected or will be corrected. 3/3/06 | : • | 3/3/06 |

Event ID: G5ML11

Facility ID: THOMASHOU:

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PRINTED: 03/15/2006

revision 4/ 19/01

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| STATEMEN | OF DEFICIENCIES | E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (XX) MULT A. BUILDIN | IPLE CONSTRUCTION | (X3) DATE S COMPLA | |
|--------------------------|---|--|-------------------------|--|-----------------------------------|----------------------------|
| | | 095021 | B. WING | | 03/0 | 1/2006 |
| NAME OF P | ROVIDER OR SUPPLIER | | 1 | REET ADDRESS, CITY, STATE, ZIP (1330 MASSACHUSETTS AVENUE NASHINGTON, DC 20005 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION S REFERENCED TO THE APPROI | SHOULD BE CROSS- | (X5) COMPLETION DATE |
| F 371 | Continued From p | age 19 | F 371 | | | |
| · • | | rtons of chocolate milk with an | | Milk discar 2/28/06 | ded | |
| | in the walk in refrig observations at ap | February 25, 2006 was stored gerator, in one (1) of three (3) proximately 9:00 AM on | | Can opene cleaned 2/2 | 28/06 | 2/28/06 |
| : | with food residue a surfaces were soil | an opener was observed soiled and the cutting and gear ed with metal shavings in one (| · | Cover to be installed 3// Stainless stee covers will be before storing | 28/06 I plate dried 3 on | 3/28/06 |
| | AM on February 24 3. The stainless st | teel counter in the cook's | · | shelves. Inser on proper pro for drying pri- storage 3/17/(| codure or to 06 | 3/17/06 |
| | would protect china shelves from conta | acked frontal covers which aware and other items on amination in one (1) of one (1) roximately 9:45 AM on | | Pots and pans and dried befor Inservice for cleaning and held. 3/17/06 | ore reuse. | 3/17/06 |
| | shelves for reuse to dry in 37 of 61 obs | plate covers were stored on before allowing covers to fully ervations at approximately 1: | | Refrigerator repaired 3/22 Exhaust fans will be see 2000 | | 3/22/06 |
| | area were not thora and pans were not | d in the pot and pan wash bughly cleaned of food residue allowed to dry before placing | | will be repaire 4/13/06 In-service on gloves and ha nets 3/20/06 | | 4/13/06 |
| | | | | Sufficient help scheduled and in-service | 1 | 3/20/06 |
| | Hotel pans 8 X 12 | X 20 st in four (4) of seven (7) 10 AM on March 1, 2006. | | conducted 3/20/06 Fan repaired | · · · · · | 3/20/06 |
| | | · · · · · · · · · · · · · · · · · · · | | and covered 3/20/06 | | 3/20/06 |

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| PRINTED: | 03/15/2006 |
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| FORM | APPROVED |
| OMB NO. | 0938-0391 |

| | | H AND HUMAN SERVICES | | | RM APPROVEI 10.0938-039 |
|--------------------------|--|--|---------------------|---|----------------------------|
| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | A BUILDII | COM | E SURVEY PLETED |
| | | 095021 | B, WING | | 3/01/2006 |
| NAME OF F | ROVIDER OR SUPPLIER | | | REET ADDRESS, CITY, STATE, ZIP CODE | |
| THOMA | S HOUSE | | | 1330 MASSACHUSETTS AVENUE NW WASHINGTON, DC 20005 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF GORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENC | |
| F 371 | Continued From particular Continued From particular pans 12 X 24 at 10:20 PM on Ma | X 4" in 23 of 24 observations | F 371 | Wall surfaces repaired. 3/20/06 Louver repaired 3/17/06 | 3/20/06 |
| | grill was inoperativ) of one (1) observ 28, 2006. | n unit located under the broiler te in the main kitchen in one (1 ation at 9:45 AM on February | | Ceiling repaired 3/17/06 With respect to identifying other residents having the potential to be affected; | 3/17/06 |
| | the main kitchen w remove smoke and | cated under cooking hoods in tere not operating efficiently to I steam while the lunch meal oproximately 10:00 AM on | | the Food Service Director monitored food areas to determine that no other similar conditions exist. 3/3/06 | 3/3/06 |
| | with preparation of kitchen without hai chinaware without (1) observation at a February 28,2006. 9. Hotel pans used lunch meals were r period as evidence pans that remained the pot and pan wa | erson was observed assisting the dinner meal in the main r restraints and was handling using gloves in one (1) of one approximately 1:20 PM on to prepare the breakfast and not washed within a 2 to 3 hour d by observation of soiled in the sink and on counters in sh areas at 4:00 PM. Staff gh help was not available to before 4:00 PM. | | With respect to measures put in place or systemic changes made to prevent this practice; areas sited will be monitored by the Food Service Director or designee to ensure that these items are not repeated, 3/3/06 | 3/3/06 |
| | clean side of the di and was not secure one (1) observation on February 28, 20 11. Wall surfaces in adjacent to the wall | n located in the ceiling on the sh machine lacked a cover ed to the ceiling in one (1) of a at approximately 10:25 AM 05. In the dry food storage room k-in refrigerator was not intact a ceiling to prevent the | | With respect to how the community plans to monitor performance; the Food Service Director or designee will monitor and report findings to the QA Committee. 4/13/08 | 4/13/06 |

FORM CMS-2567(02-89) Previous Versions Obsolete $\mathbf{\hat{z}}$

If continuation sheet Page 21 of 25

| | | HAND HUMAN SERVICES | | For 4/19 | | NO, 0938-039 |
|--------------------------|--|--|----------------------|----------------------------------|--|----------------------|
| TATEMEN | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A, BUILD | TIPLE CONSTRUCTIONS | XN (2(3) DA | TE SURVEY MPLETED |
| | | 095021 | B, WING | . <u> </u> | | 3/01/2006 |
| NAME OF P | ROVIDER OR SUPPLIER | | s | REET ADDRESS, CIT | | |
| THOMA | S HOUSE | . : | | 1330 MASSACHUSI WASHINGTON, I | ETTS AVENUE NW | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH CORREC | R'S PLAN OF CORRECTION TIVE ACTION SHOULD BE CROS O THE APPROPRIATE DEFICIEN | |
| F 371 | Continued From pa | | F 37 | 1 | | |
| | | and pest infestation in one (1) ion at 9:00 AM on February | | F 456 | | |
| | 28, 2006. | ION AL 9.00 ANI ON FEDIDALY | | | respect to how corrective | Ì |
| | 12 The stroupply | ouver which disperses air | | | n was accomplished; the en concentration filter was | |
| | from the ceiling in t | the dishwasher area lacked a one (1) observation at 9:48 | | | ced. 3/2/06 | 3/2/06 |
| | AM on February 28 | , 2006. | | 2 10/775 | respect to identifying | |
| | 12 Coilles surface | s on the clean side of the dish | | | residents having the | |
| | | plastered and painted and | | | ntial to be affected; | |
| | openings were obs | erved around the exhaust fan | | resid | ents with oxygen | í í |
| | |) observation at 10:50 AM | | conci | entration tanks were | |
| | on February 28, 20 | 06. | | | cted to ensure a | , |
| F 456 | 483 70(c)(2) SPAC | E AND EQUIPMENT | F 456 | ı E | s in place. | |
| SS≍D | | | 1 400 | 3/2/0 | 5 | 3/2/06 |
| | | aintaín all essential | | | | |
| | mechanical, electri equipment in safe o | cal, and patient care | | | respect to measures | |
| | equipment in sale t | perating condition. | | | place or systemic es made to prevent | |
| | | | | | actice; the DON or | |
| | | NT is not met as evidenced | | | ace will monitor | |
| | by: Biased on an observe | rotion during the suprov | | | ncentrators each time put into use and weekly, | |
| | | vation during the survey mined that proper procedures | | and w | ill in-service staff to | |
| | were not followed to | ensure that oxygen | | | e that oxygen concentrated filtered. | |
| | | s filtered. This finding was | | 4/1/06 | | 4/1/06 |
| | Nursing and Mainte | sence of Housekeeping, and a nance Staff. | | | | 1700 |
| | The findings include | 3: | | 1 | espect to how the | |
| | | | | | unity plans to | |
| Í | | rator was observed operating | | | or performance; the or designee will | |
| | | a filter, allowing unfiltered | | | findings to the QA | |
| | | ne (1) of one (1) observation | | Comm | - | |
| | at 3:10 PM on Febr | | | 4/13/0 | | 4/13/06 |

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| | | AND HUMAN SERVICES | | | | FORM | 03/15/2006 APPROVED 0938-0391 |
|--------------------------|---|---|------------------|------|---|------------------------|-------------------------------------|
| STATEMEN | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) M A. BUI | | TIPLE CONSTRUCTION | (X3) DATE SU COMPLE | JRVEY |
| | | 095021 | B. WI | NG _ | · | 03/0 | 1/2006 |
| | PROVIDER OR SUPPLIER | | | · · | REET ADDRESS, CITY, STATE, ZIP CODE 1330 MASSACHUSETTS AVENUE NW | | |
| | | TEMENT OF DEFICIENCIES | D | | PROVIDER'S PLAN OF CORREC | | (X5) |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION) | PREF TAG | | (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE D | BE CROSS- | COMPLETION DATE |
| F 492 SS=D | 483.75(b) ADMINIS | TRATION | F4 | 192 | 2 | | |
| 33-D | compliance with all and local laws, regu accepted profession | erate and provide services in applicable Federal, State, lations, and codes, and with nal standards and principles sionals providing services in | | | · · · | | • |
| | by: Based on record rev was determined tha with 22 DCMR 3211 (1) registered nurse | | | | | · | |
| | night shift according According to 22 DC shall have at least th At least one (1) regi- hour basis, seven (7 The facility's "Skilled schedules were revi- through 28, 2006. It licensed practical nu- worked the night shi on the following date 27 and 28. A registe | d Nursing Daily Staffing" ewed from February 21 was observed that a urse was assigned and ft (11:00 PM until 7:30 AM) es: February 21, 22, 23, 24, ered nurse was scheduled t shift Saturday and Sunday, | | | F 492 1. With respect to how correct action was accomplished; HR Director has hired an F night shift . The RN will be employment on 3/31/06. | the RN for | 3/31/06 |

Event ID: G5ML11 Facility ID: THOMASHOU:

If continuation sheet Page 23 of 25

| STATEMEN | T OF DEFICIENCIES OF CORRECTION | E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILDI | TIPLE CONSTRUCTIONS | м | (X3) DATE SU COMPLE | |
|--------------------------|---|--|-----------------------|---------------------|--|------------------------|---------------------------|
| | | 095021 | B. WING | | | 03/0 | 1/2006 |
| | ROVIDER OR SUPPLIER | | 1 | 1330 MASSACHUS | TY, STATE, ZIP CODE ETTS AVENUE NW | | |
| | | | | WASHINGTON, I | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES / MUST BE PRECEEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH CORREC | ER'S PLAN OF CORREC CTIVE ACTION SHOULD TO THE APPROPRIATE [| BE CROSS- | (X5) COMPLETIO DATE |
| F 492 | Continued From pa | age 23 | F 492 | 2. With | respect to identifying | | |
| | Care Managers" d | ster Schedule for Resident ated March 10 through April 6, | | poter | residents having the tial to be affected; | | |
| | schedule was "revi | d. Hand written on the sed 2/18/06". The projected | | contir | R Director will nuously recruit/hire | | |
| | nurse for Monday t | eduled a licensed practical hrough Friday. A registered d for the night shift on | | no ga | sure that there are aps in coverage. | | |
| | Saturday and Sund | | | 4/1/0 | | | 4/1/06 |
| | face- to- face interv | at approximately 2:00 PM a view was conducted with the | | put ir | respect to measures a place or systemic | 1 | |
| | acknowledged that | ome administrator who a registered nurse was not ed for the night shift. He/she | | this p | ges made to prevent practice; the HR | | |
| | | luman Resource Department | | sche | tor will monitor the dule to determine no | | |
| | | to provide 24 hour nursing | | will in | slots are vacant. DON mmediately report | | |
| | facility. | stered nurse for the nursing were reviewed on February | | any 4/1/0 | RN vacancies. 16 | | |
| | 28, 2006. | nore reviewed on replacing | | | respect to how the | | |
| | | I to ensure that the Minimum ordinator had a District of d nurse license. | | mon | munity plans to itor performance; the Director and DON will | | |
| | | s revealed that the RN, DS coordinator for the facility, | | weel | rt to ED during kly stand-up | | |
| | began working at th . There was no Dist nurse license maint | ne facility on February 6, 2006 rict of Columbia registered ained by the Human | | 4/13 | tings. /06 | | 4/1/06 |
| | Resources departm | | | | •• | | • |
| | resident's record, da | a quarterly assessment in a ated March 1, 2006 and e and the state that issued the | | | | | |

| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MU A. BUILI | JLTIPLE CONSTRUCTION DING | (X3) DATE SI COMPLE | |
|--------------------------|--|---|---------------------|---|---|---------------------------|
| | | 095021 | B. WING | G | 03/0 | 1/2006 |
| | ROVIDER OR SUPPLIER | | : | STREET ADDRESS, CITY, STATE, ZIP C 1330 MASSACHUSETTS AVENUE WASHINGTON, DC 20005 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION S REFERENCED TO THE APPROP | HOULD BE CROSS- | (X5) COMPLETIC DATE |
| F 492 | RN license. This n Director of Nursing Upon interview with 10:30 AM, he/she a not have a District and showed the sur of Columbia RN lic stated, "I thought signed my notes an okay." According to Chapt Columbia Municipa Registered Nurses, applicant for license authorized to engag registered nursing i without a District of applicant:(c) Has for licensure by end | ote was co-signed by the | F 4 | With respect to how action was accomplise RAC-C (Resident As Coordinator- Credent been hired and is now responsible for the M is currently working u supervised practice of for 90 days (per the I Nursing Regulations 5411.9) 2/11/06 With respect to ident other residents havin potential to be affected an audit has been conducted to ensure all nurses have Distric Columbia licenses. 3/14/06 | shed; an sessment tialed) has w DSs. She inder of the DON Registered Section ifying ng the ed; that | 2/11/06 3/14/06 |
| | Facilities of Title Medicine DCMR, employees, with the or certification num facility and available The facility employe (3) weeks without a registered nurse lice | ed a registered nurse for three District of Columbia | | 3. With respect to mease put in place or system changes made to preact this practice; the HR Director or designee periodically audit to ensure compliance. 3/14/06 4. With respect to how community plans to monitor performance DON or HR Director report to the ED at the weekly stand-up mease 4/13/06 | nic event will the e; the r will the | 3/14/06 |

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| 04, | /19/2006 00:20 | 2026282249 | | RISE THOMAS CIRCL | PAG | E 29 |
|--------------------------|--|---|-------------------------|--|------------------------|----------------------------------|
| | | HAND HUMAN SERVICES | ſ | enter 4/19/20 | FORM | 03/15/200 APPROVE 0938-039 |
| STATEMEN | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER: | (2) MULTI A, BLILDIN | PLE CONSTRUCTION G 01 - MAIN BUILDING 01 | (X3) DATE SI COMPLE | JRVEY |
| | | 095021 | B. WING | | 03/0 | 1/2006 |
| NAME OF P | ROVIDER OR SUPPLIER | | | EET ADDRESS, CITY, STATE, ZIP CODE | | |
| THOMAS | B HOUSE | · | | 330 MASSACHUSETTS AVENUE NW VASHINGTON, DC 20005 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE | BE CROSS- | (XS) COMPLETION DATE |
| K 000 | conducted on Marc | TS Ifety Code survey was th 1, 2006. The following d based on observations and | K 000 | Responses to the cited deficiencies do not constitute an admission or agreement by the Community of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is | | |
| K 050 SS=E | Fire drills are held varying conditions, shift. The staff is f aware that drills are Responsibility for p is assigned only to | AFETY CODE STANDARD at unexpected times under at least quarterly on each amiliar with procedures and is e part of established routine. lanning and conducting drills competent persons who are | K 050 | prepared solely as a matter of compliance with federal and/or state law. K 050 1. With respect to how correcting action was accomplished; findrills were submitted but were subm | re TC | • |
| | conducted betweer announcement ma alarms. 19.7.1.2 This STANDARD i Based on observat | e leadership. Where drills are a 9 PM and 6 AM a coded y be used instead of audible s not met as evidenced by: ions and record review during le inspection, it was | | not quarterly. They will be h quarterly. 3/6/06 With respect to identifying other residents having the potential to be affected; an audit of all fire drills found drills were not held quarterly or were not properly documented | cld | 3/6/06 |
| | determined that fire quarterly as require | e drills were not conducted d. These findings were sence of the maintenance | | in '05. They will be conducted at least one time per shift quarterly. And will be properly documented 3/23/06 | • | 3/2 3/06 |
| | fire drills were cond third shifts of the th and third shifts of th 2005 in five (5) of 1 30 and 4:00 PM on | not available to support that ucted during the second and ird quarter and first, second le fourth quarter for the year 2 observations between 11: March 1, 2006. ERSUPPLIER REPRESENTATIVE'S SIGN | | | | S) DATE |

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.

| TATEMENT | S FOR MEDICARE OF DEFICIENCIES CORRECTION | E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (22) MU A. BUILI | ULTIPLE CONSTRUCTION DING 01 - MAIN BUILDING 01 | OMB NO (X3) DATE S COMPLI | <u>, 0936-039</u> URVEY ITED |
|--|---|---|---------------------|--|---------------------------------|------------------------------------|
| | | 095021 | B. WING | ; | 03/0 | 1/2006 |
| NAME OF PROVIDER OR SUPPLIER THOMAS HOUSE | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1330 MASSACHUSETTS AVENUE NW WASHINGTON, DC 20005 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION) | iD PREFIX TAG | PROVIDER'S PLAN OF CORRI | LD BE CROSS- | 0(5) COMPLETION DATE |
| | | | | With respect to measures pin in place or systemic changes made to prevent this practice; Safety Committee chairperson will ensure all drills are conducted at least one time per shift quarterly and that paperwork is properly completed. 3/31/06 With respect to how the community plans to monitor performance; Safety Committee chair person will submit each drill to QA Committee in '06. 4/13/06 | | 3/31/06 |

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Health Regulation Administration STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IND PLAN OF CORRECTION COMPLETED **IDENTIFICATION NUMBER:** A. BUILDING B. WING 095021 03/01/2006 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **1330 MASSACHUSETTS AVENUE NW** THOMAS HOUSE WASHINGTON, DC 20005 SUMMARY STATEMENT OF DERCIENCIES PROVIDER'S PLAN OF CORRECTION (XA) ID **D** (X5) COMPLETE (EACH DEFICIENCY MUST BE FRECEEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG L 000 Initial Comments L 000 Responses to the ciled deficiencies do not constitute An annual licensure survey was conducted on an admission or agreement February 28 through March 1, 2006. On March by the Community of the 9, 2006, a follow up licensure inspection was truth of the facts alleged or conducted of the dietary services at your facility. conclusions set forth in the Statement of Deficiencies. The following deficiencies were based on The Plan of Correction is observations, staff interviews and record review. prepared solely as a matter The sample included 10 residents based on a of compliance with federal census of 29 on the first day of the survey. and/or state law. L 012 3203.2 Nursing Facilities L 012 A list of all employees, with the appropriate current license or certification numbers, shall be on file at the facility and available to the Director. L 012 This Statute is not met as evidenced by: Based on record review and staff interview, it was determined that facility staff failed to ensure With respect to how corrective that the Minimum Data Set (MDS) coordinator action was accomplished; an had a District of Columbia registered nurse RAC-C (Resident Assessment license. Coordinator- Credentialed) has been hired and is now The findings include: responsible for the MDSs. She A review of licenses revealed that the RN, is currently working under employed as the MDS coordinator for the facility supervised practice of the DON began working at the facility on February 6, 2006 for 90 days (per the Registered . There was no District of Columbia registered Nursing Regulations Section nurse license maintained by the Human 5411.9) 2/11/06 Resources department at the facility. 2/11/06 The MDS RN wrote a quarterly assessment in a 2. With respect to identifying resident's record, dated March 1, 2006 and other residents having the signed his/her name and the state that issued the potential to be affected: RN license. This note was co-signed by the an audit has been Director of Nursing. conducted to ensure that all nurses have District of Upon Interview with the RN on March 1, 2006 at Columbia licenses. 10:30 AM, he/she acknowledged that he/she did not have a District of Columbia nursing license 3/14/06 3/14/06 Health Regulation Administration VH4 Or I LABORATORY DIRECTON SICK PROVIDER SHE LIEP REPORTSENTATIVE'S SIGNATURE

STATE FORM

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If continuation heat 1 of 18

PRINTED: 03/15/2006 FORM APPROVED

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUM 095021 | | | | (X3) DATE SURVEY COMPLETED 03/01/2006 | | | | |
|--|---|--|--|---|------------|--|--|--|
| ······································ | | | TREET ADDRESS, CITY, | | 03/01/2006 | | | |
| | | | | SSACHUSETTS AVENUE NW | | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENC (EACH DEFICIENCY MUST BE PRECEEDED REGULATORY OR LSC IDENTIFYING INFORM | | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CRO REFERENCED TO THE APPROPRIATE DEFICIEN | | | | |
| L 051 | Continued From page 1 and showed the surveyor an incomplete Dist of Columbia RN license application. The nu stated, " I thought if the Director of Nursing signed my notes and supervised me, it would okay." According to Chapter 54 DCMR, " District of Columbia Municipal Regulations [DCMR] for Registered Nurses, " Section 54.13.2, " An applicant for licensure by endorsement may authorized to engage in supervised practice registered nursing In the District of Columbia without a District of Columbia license If the applicant:(c) Has an initial application pen for licensure by endorsement In the District of Columbia." | | nurse ig co- build be t of for An ay be ce of bia e lending ct of | 3. With respect to measures put in place or systemic changes made to prevent this practice; the HR Director or designee will periodically audit to ensure compliance. 3/14/06 4. With respect to how the community plans to monitor performance; the DON or HR Director will report to the ED at the | 3/14/06 | | | |
| | DCMR, 3203.2, "A appropriate current numbers, shall be o available to the Dir The facility employ (3) weeks without a registered nurse lic The licenses were n 2006. 3210.4 Nursing Fac A charge nurse sha following: (a)Making daily resi | list of all employees, we license or certification on file at the facility and ector." ed a registered nurse for District of Columbia ense. reviewed on February 2 silities If be responsible for the ident visits to assess phase and implementing an | or three 28, L 051 | weekly stand-up meeting. 4/13/06 | 4/13/06 | | | |

Health Regulation Administration

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G5ML11

If continuation sheet 2 of 18

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| Health H | Regulation Administ | ration | | | <u> </u> | | | | |
|--------------------------|--|--|---------|---|---|--|---|---------------|--|
| | | (X1) PROVIDER/SUPPLIE IDENTIFICATION NU | | | (X3) DATE SURVEY COMPLETED 03/01/2006 | | | | |
| | | | | | | | STATE 710 COL | | |
| 1330 M | | | 1330 MA | ADDRESS, CITY, STATE, ZIP CODE ASSACHUSETTS AVENUE NW NGTON, DC 20005 | | | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | Y FULL | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD B REFERENCED TO THE APPROPRIATE DE | | LD BE CROSS- | ECROSS COMPLE | |
| L 051 | Continued From pa | age 2 | ·, · | L 051 | | | | | |
| | | - ication records for curacy in the transcrip and adherences to sto | | | L 051 | | | 1 | |
| | c)Reviewing residents' plans of care for appropriate goals and approaches, and revising them as needed; | | | | With respect to how action was accomp resident # 2 and #4 care plans are upda | | plished; fo r 4 quarterl y | | |
| | for direct resident i residents; | onsibility to the nursi nursing care of speci | fic | | 2. | other residents havin potential to be affected | gthe | · . | |
| | (e)Supervising and employee on the u | l evaluating each nur nit; and | sing | | | the care plans were reviewed to ensure the they are being update | | | |
| | or her designee inf residents. | ector of Nursing Serv formed about the stat | lus of | | | appropriately. 3/7/06 | | 3/7/06 | |
| | This Statute is not met as evidenced by: Based on observation, staff interviews and record review for six (6) of 10 sampled residents, it was determined that the charge nurse failed to develop and/or review and revise care plans for: two (2) residents quarterly; one (1) resident after a fail; one (1) resident receiving antithrombotic therapy: one (1) resident receiving hospice care; and one (1) resident based on the comprehensive assessment. Residents # 2, 4, 5 | | | | 3. | With respect to measu put in place or system changes made to prev this practice; the DON designee will review th care plans and verify the the quarterly care plan are completed. 3/7/06 | ic rent ne nat | 3/7/06 | |
| | ,6, 7 and 9. The findings include: | | | | With respect to how the | e l | | | |
| | 1. Facility staff fails care plan quarterly. | ed to update Residen | ıt #2's | | | community plans to monitor performance; th DON or designee will monitor the report | he | | |
| | The care plan dated September 19, 2005 included the following problems: "Risk for fluid volume deficit related to anticoagulant therapy, Altered mental status related dementia, Social/ | | | | i | monitor the report findings to the QA Committee, 4/13/06 | • | 4/13/06 | |

STATE FORM

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If continuation sheet 3 of 18

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SUNRISE THOMAS CIRCL

PRINTED: 03/15/2006 FORM APPROVED

| TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 095021 | | | (X2) MULT A. BUILDIN B. WING _ | | (X3) DATE SURVEY COMPLETED 03/01/2006 | | | | |
|---|--|--|--|---|---|--------------------------|--------|--|--|
| | | | | DRESS CITY | STATE, ZIP CODE | | 1/2000 | | |
| THOMAS | | | 1330 MAS | SSACHUSETTS AVENUE NW GTON, DC 20005 | | | | | |
| (X4) ID Prefix Tag | ((EACH DEFICIENCY MUST BE PRECEEDED | | FULL | ID PREFIX TAG | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION S REFERENCED TO THE APPROP | (X5) COMPLETE DATE | | | |
| | interest in socialize history of falls and Noncompliant with inability to understa deficit related to Di comfort related to Di comfort related to Di comfort related to Di A review of the fac Plan/Interdisciplina # 8 Policy Interpret The resident's com developed within s completion of the n twenty one (21) day admission, whichever revised as changes dictate. Reviews and There was no evide updated. The recor 28, 2006. 2. Facility staff failed care plan quarterly. The care plan for R 19, 2005 included to Alteration in skin in and impalred mobil Osteoporosis and E care, Pain related to Occasional Incontir and Psychotropic d evidence that the c record was reviewe | deficit related to loss tion, Risk for injury r balance disturbance plan of care related and plan of care, Self ementia, and Alterati Breast Cancer. " ility's policy entitled, ry Assessment Team ation and Implement prehensive care plan even (7) days of the esident assessment of safter the resident ver occurs first. Care in the resident's con- e made at least quar ence that the care plan d was reviewed on F ed to update Residen tegrity related to inco- ity, Self care deficit r bernentia. Noncompli o chronic migraine he ence of bladder and rug use." There was are plan was updated d February 28, 2006. | elated to to f care on in "Care n" page ation; " n is or within plans are ndition terty." an was ebruary t #4's ptember s: " ontinence elated to ant with eadache, bowel, no d. The | L 051 | | | | | |
| | Director of Nursing | view was conducted on February 28, 200 led, " The reason the | 6 at 11: | | | | | | |

If continuation sheet 4 of 18

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SUNRISE THOMAS CIRCL

PRINTED: 03/15/2006 FORM APPROVED

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SL IDENTIFICATIO | | (X1) PROVIDER/SUPPLIE IDENTIFICATION NUT | ERICLIA (X2) MULTIPLE CONSTRUCTION IMBER: A BUILDING B. WING | | | | (X3) DATE SURVEY COMPLETED 03/01/2006 | | |
|---|---|--|--|---|--|--|--|----------------------------|--|
| | | | STREET AD | DRESS, CITY, | | | | | |
| 1330 MA | | | | ASSACHUSETTS AVENUE NW NGTON, DC 20005 | | | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | | ID PROVIDER'S PLAN OF CORR PREFIX (EACH CORRECTIVE ACTION SHOU TAG REFERENCED TO THE APPROPEDAT | | | D BE CROSS- | (X3) COMPLET DATE | |
| L 051 | was because the operable for approvidence of the operable for approaches a solution of the operable of the | ts #2 and 4 were not a computers were down oximately two months yed on February 28, 2 lied to update a care p as and interventions for equent to one (1) fall. ent #5's record reveal d January 28, 2006 at 6:48 PM [visitor] rush d informed writer that or[Resident] able to otion) and follow direct ent #5's care plan rev revention Care Plan. ' column, the unit mana esident sustained a fall neasuring 1 x 1 cm. / (normal saline) and le proaches or interventia above cited fall to pre- ner falls. erview with the unit m February 28, 2006 at liged that no interventia above cited fall. viewed February 28, 2006 at liged that no interventian above cited fall. | and not "The 2006. plan to or led a 8:25 PM, hed to the 1 [Resident o perform ctions " realed a "Under ager II in room Area was eft OTA (lons vent the hanager 1 3:30 PM. ions were 2006. | L 051 | | put in place or systemic changes made to preve this practice; the DON designee will monitor incident reports and update care plans after any falls. 3/7/06 With respect to how the community plans to monitor performance; DON or designee will report findings to the | d; the 5 was s related ng he he ent or r f the | 3/2/06 3/7/06 3/7/06 | |
| | dated February 16 | /sician Plan of Care (F , 2006 included, " As qd (daily) for stroke pr | pinin 325 | | | Safety Committee and QA Committee. 4/13/06 | • | 4/13/06 | |

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If continuation sheet 5 of 18

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| | | ation | | | | | |
|--------------------------|--|--|---|--------------------------------------|---|--|--------|
| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIE IDENTIFICATION NUM 095021 | | (X2) MULT A. BUILDIN B. WING _ | | (X3) DATE SI COMPLE | |
| | PROVIDER OR SUPPLIER | | | OPESS CITY | STATE, ZIP CODE | | 1/2000 |
| | S HOUSE | | 1330 MA | | TTS AVENUE NW | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIE MUST BE PRECEEDED BY SC IDENTIFYING INFORMA | r FULL | ID PREFIX TAG | (EACH CORRECTIVE ACTION S | OVIDER'S PLAN OF CORRECTION DRRECTIVE ACTION SHOULD BE CROSS- CED TO THE APPROPRIATE DEFICIENCY) | |
| L 051 | L 051 Continued From page 5 The interdisciplinary care plan dated December 15, 2005 was not updated to include the use of the daily antithrombotic. A face-to-face interview was conducted with the DON (Director of Nurses) on February 28, 2006 at approximately 12:30 PM who acknowledged that the care plan did not include goals and approaches for antithrombotic therapy. 5. Facility staff failed to coordinate Resident #7's | | e use of 3 with the 28, 2008 viedged | L 051 | With respect to h action was accor resident # 6, the updated to includ usage. 3/2/06 With respect to in other residents h potential to be affi | nplished; for ; care plan was le antithrombotic dentifying aving the fected; | 3/2/06 |
| | 5. Facility staff faile plan of care with the to the facility's police A review of the facil Program, page #33 Implementation state participates in the facil coordinated plan of hospice agency and developed and shate managing pain and symptoms. The care updates as necessate current status." On February 15, 20 to Hospice care with Prostate Cancer /Cl There was no evide Resident #7 by the patient. A note from February 28, 2006 a Hospice nurse visit review chart and co | ed to coordinate Resi e hospice agency ac cy. lilty policy titled, "Ho Policy interpretation tes, When a resident nospice program, a care between the fa d resident/family will include directives f other uncomfortable e plan shall be revise ry to reflect the resident (06 Resident #7 was h the terminal diagnon hronic Renal Failure. | cording ospice a and t cility, be or ed and dent's referred osis of " " nt of spice written on ed, " comfort, cility | | the records of respectiving antithrouth therapy were reviand care plans of to ensure that the include goals and approaches for the therapy. 3/7/08 With respect to mput in place or synchanges made to this practice; the indesignee will perform audits of residents with antithrombotic the ensure that the the included in the care plans. 3/7/06 | mbotic lewed hecked ey d ne neasures sternic prevent DON or form charts of erapy to herapy Is | 3/7/06 |

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| | n t of deficiencies of correction | (X1) PROVIDERSUPPLIE IDENTIFICATION NUM | R/OLIA MEIER: | (XZ) MULT A. BUILDH B. WING | IPLE CONSTRUCTION IG | | 03/D1/2006 | | | |
|---------------------------|--|--|---|---|--|--|------------------------|--|--|--|
| | NOVIDER OR SUPPLIER | | STREET ADD | RESS. CITY | STATE, ZIP CODE | | | | | |
| | 8 HOUSE | | 1330 MAS | 330 MASSACHUSETTS AVENUE NW VASHINGTON, DC 20005 | | | | | | |
| (CA) ID PRAIPIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY SC DENTIFYING INFORMA | FULL | ic) Prefix Tag | PROVIDER'S PLAN C (EACH CORRECTIVE ACTIC REFERENCED TO THE APP | N SHOULD BE CROSS- | (25) COMPLE DATE | | | |
| | The Interdisciplinar 15, 2005 was not up the daily antithrom A face-to-face Inter DON (Director of Ni at approximately 12 that the care plan di approaches for antit 5. Facility staff failed plan of care with the | y care plan dated Dec pdated to include the polic. (view was conducted (urses) on February 28 (30 PM who acknown d not include goals a hrombotic therapy. d to coordinate Reside (hospice agency acc | cember use of with the 3, 2006 edged rid ent #7's | L 051 | 4. With respect 1 community pl monitor perfor DON or desig monitor the fir report to the C Committee. 4/13/06 | ans to mance; the nee will ndings and | 4/13/06 | | | |
| | Program, page #33 I mplementation state participates in the ho poordinated plan of c pospice agency and eveloped and shall panaging pain and o ymptoms. The care polates as necessary urrent status." In February 15, 2006 Hospice care with t postate Cancer /Chro polates #7 by the ho ofessional since he/ filent. A note from the bruary 28, 2008 at | ty policy titled, "Hosp Policy Interpretation a so, When a resident sploe program, a are between the facil resident/family will be include directives for ther uncomfortable plan shall be revised to reflect the resider B Resident #7 was ref the terminal diagnosts onic Renal Failure." are of an assessment of spice health care she became a hospice to hospice nurse writt 12:00 PM Indicated, | and lity, and nf's ferred a of " of a and s and and s and s and s and s and s and s and s and s and s and s and and and and and and and and and and | | action was accordinated from a coordinated from a conduct of the care placed in the coordinated placed in the care pla | Capital Hospice he chart along lan initiated by the blan meeting is 27/06 identifying having the lifected; was uture ave a to of care | 3/27/06 | | | |
| Ho | spice nurse visit to New chart and coord | assess, promote com linate care with facilit blow client reposition | ifort, ly | | 3/2/06 | | 3/2/06 | | | |

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| | nt of derciencies of correction | (1) PROVIDER/SUPPLE IDENT/PICATION NU 095021 | | (CC) MUL A, BUILDI B. WING | TIPLE CONSTRUCTION | (CC) DATE S COMPLI | URVEY ETID | | |
|--------------------------|--|---|---------------------|---|-----------------------------|-----------------------|---------------|--|--|
| VAME OF | PROVIDER OR SUPPLIER | | STREET ADD | RESS, CITY | STATE, 2P CODE | | | | |
| THOMA | s house | | 1330 MAS WASHING | ASBACHUSETTS AVENUE NW NGTON, DC 20005 | | | | | |
| (74) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCE MUST BE PRECEDED SY BC DENTIFYING INFORM | FUL | PREFIX TAG | BACH CORRECTIVE ACTION # 11 | | | | |
| L 051 | Continued From pa | ge 5 | | L 061 | | | | | |
| | .* | | 1 | | 3 10 000 | | | | |
| Í | The interficulties | care plan dated De | onghar | | 3. With respect to measure | Tes | | | |
| | 15. 2005 was not un | dated to include the | | | put in place or systemi | D | | | |
| ļ | the daily antithromb | ofic. | | | changes made to preve | ent | L | | |
| | | , | 1 | | this practice; the DON | or | | | |
| | | view was conducted | | | designee will audit the | | | | |
| | | ises) on February 2 30 PM who acknow | | | charts within 3 days to | | | | |
| | | i not include geals a | | | insure proper standards | | | | |
| | approaches for antith | | | 1 | are being followed. | | | | |
| · [| | | | | 3/2/06 | - | 3/2/08 | | |
| | | to coordinate Resid | | · · | · | , | | | |
| | o the facility's policy. | hospice agancy acc | oraing | - (| | | | | |
| {" | o me racing a poiloy. | • | · [| | 4. With respect to thow the | A | | | |
| P | review of the facility | y policy titled, "Hos | pice | 1. | community, plans to | ř I | | | |
| F | rogram, page #33 P | olicy Interpretation | and | | monitor performance; | the l | | | |
| 1 | nplementation states | B, When a resident | 1 | 1 | DON or designee will | | | | |
| | articipates in the hos | pice program, a are between the fact | 14. | · | monitor the findings ar | nd l | | | |
| - (h | ospice egency and re | esident/family will be | 114 y , | • | report to the QA | | . | | |
| de | eveloped and shall in | clude directives for | | . (| Committee. | | 4/13/06 | | |
| i co | anaging pain and ot | her uncomfortable | | | | } | ł | | |
| Sy | mptoms. The care p | lan shall be revised | and | 1 | | 1 | - 1 | | |
| | noni staius." | to reflect the resider | πσ | | | | ĺ | | |
| Or | February 15, 2008 | Resident #7 was ref | bried | | | | | | |
| 10 Pn | Hospice care with th ostate Cancer /Chron | e terminal diegnost: nic Renal Fallure." | sof " | | · . | | | | |
| Th | ere was no avidence | of an assessment (| of I | | · · · · | · | | | |
| Re | sident #7 by the hos | pice health care | . | l | | | ļ | | |
| pro | fossional since he/s | he became a hospic | 8 | ŀ | | l | } | | |
| per per | IBITL A NOTO TIOM the | incepice nurse with | en on a | l | | Į | | | |
| Ho | numy 60, 2000 at 12 Dice aurse visit to m | 2:00 PM Indicated, ssess, promote com | Fort | | · · · · | | | | |
| | | | | | | 1 · | · } | | |
| | ow chart and coordi | hate care with facilit | ý í | 1 | | · · | | | |
| revistat | | nate care with facilit low client reposition | | ł | | | | | |

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| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIE IDENTIFICATION NUM | | (X2) MULT A. BUILDIN B. WING _ | KG | E SURVEY IPLETED 3/01/2006 | | |
|--------------------------|---|---|--|---|--|----------------------------------|--|--|
| | ROVIDER OR SUPPLIER | | STREET ADD | RESS. CITY. | STATE, ZIP CODE | 0,0,1,2000 | | |
| | S HOUSE | | 1330 MAS | ASSACHUSETTS AVENUE NW IGTON, DC 20005 | | | | |
| (X4) ID PREFIX TAG | | | DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX BACH CORRECTIVE ACTIVE ACTIVE ACTIVE BE CROS | | | | | |
| L 051 | respiration-24, puls Assessment to folk A review of the fac Summary " reveal plan conference he the hospice agency since the resident of A face-to-face inter February 28, 2006 Nurses. He/she sal between the facility representative was The record was rev 8. Facility staff faile based on the comp Resident #9. A review of Reside annual Minimum D dated April 1, 2005 assessments dated December 28, 2009 cited above, the res G, " Physical Fund Problems " as beir ADLs: bed mobility off the unit, dressin hygiene and bathin | in vital signs are as fe se-80, blood pressure ow." wility, "Care Plan Con- led that, there was no eld between the facility y staff and resident/fa was enrolled in hospic rview was conducted 11:00 AM with the Di d, "A care plan confe y staff and the hospic planned for the near viewed on March 1, 20 ed to develop a care p prehensive assessment ata Set (MDS) assess and quarterly MDS I July 1, September 2 5. In all MDS assess sident was coded in S stioning and Structura of totally dependent ff , toileting, locomotion og, eating, tollet use, p g. #4 dated June 4, 200 | a - 123/61 aference care ty staff, amily ce care. on irector of erence e agency future." 006. plan ant for ed an sment Section i or all on and personal 4, " Self | L 051 | L 051 1. With respect to how corrective action was accomplished; for resident # 9, the care plan was revised to reflect a comprehensive assessment with measurable goals to related self-care deficit. 3/2/06 2. With respect to identifying other residents having the potential to be affected; the care plans have been reviewed for accuracy. 3/7/06 3. With respect to measures put in place or systemic changes made to prevent this practice; the DON or designee will conduct random audits of care plans, checking for accuracy. 3/7/06 4. With respect to how the community plans to monitor performance; the DON or designee will | 3/2/06 | | |
| | following areas: fee toileting and groom | tified problems in the eding, bathing, dressir ing related to "Parkir heimer's/ Dementia " | ng, nson | | monitor the audits and report findings to the QA Committee. | | | |
| | Goals identified inc | luded, "Resident will | be able | | 4/13/06 | 4/13/08 | | |

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| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIE IDENTIFICATION NU 095021 | | (X2) MULT A. BUILDIN B. WING _ | | (X3) DATE SI COMPLE | | | |
|--------------------------|---|---|-------------------------------------|--|------------------|--------------------------|----|--|--|
| | ROVIDER OR SUPPLIER | | STREET AD | DRESS, CITY, | STATE, ZIP CODE | | | | |
| | S HOUSE | | | ASSACHUSETTS AVENUE NW NGTON, DC 20005 | | | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | id Prefix Tag | PROVIDER'S PLAN OF (EACH CORRECTIVE ACTION REFERENCED TO THE APPRO | SHOULD BE CROSS- | (XS) COMPLETE DATE | | | |
| L 051 | Continued From pa | age 7 | | L 051 | | | La | | |
| | self, toilet self, and evaluation comme | o feed self, bathe se i improve mobility." nts, dated December assist with all ADLS | Under r 12, 2005 | · | | • | | | |
| | Facility staff failed to develop a care plan b on the comprehensive assessment of Resid 9. | | | | | | | | |
| | unit manager on M she acknowledged dependent for all A | rview was conducted arch 1, 2006 at 9:30 that the resident was DLs and that the car prehensive assessm of March 1, 2006. | AM. He/ s totally re plan did | | · · · | | | | |
| L 052 | 3211.1 Nursing Fac | cilities | | L 052 | | | | | |
| | Sufficient nursing the resident to ensure to receives the following the | | each | | | | | | |
| | | ications, diet and nut uids as prescribed, a ng care as needed; | | , | | | | | |
| | | inimize pressure uld promote the healing | | | | | | | |
| | the resident is comi evidenced by freed | y personal grooming fortable, clean, and r om from body odor, and clean, neat and | neat as cleaned | | | | | | |
| | (d) Protection from infection; | accident, injury, and | | | | | | | |

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| | T OF DEFICIENCIES DF CORRECTION | (X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUMB 095021 | | (X2) MULT A. BUILDIN B. WING _ | | (X3) DATE SURVEY COMPLETED | | |
|-----------------------------|---|--|---------------------|---|---|-------------------------------|-------------------------|--|
| NAME OF P | ROVIDER OR SUPPLIER | | STREET ADDR | RESS, CITY, | STATE, ZIP CODE | <u> </u> | | |
| THOMAS | HOUSE | | | ASSACHUSETTS AVENUE NW NGTON, DC 20005 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY F SC IDENTIFYING INFORMATI | ULL (ON) | ID PREFIX TAG | PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SHO REFERENCED TO THE APPROPRIA | ULD BE CROSS- | (X5) COMPLET DATE | |
| L 052 Continued From page 8 | | nge 8 | | L 052 | 1. With respect to how con action was accomplishe | | | |
| | (e)Encouragement, assistance, and training self-care and group activities; (f)Encouragement and assistance to: | | ing in | | resident # 8, the pressu has healed/closed. 3/2 | re ulcer | 270.000 | |
| | | | | | | | 3/2/06 | |
| | his or her own cloth | ed and dress or be dre ning; and shoes or slip n and in good repair; | | | 2. With respect to identifyin other residents having the potential to be affected; Residents with wound treatments were | ie | | |
| | (2)Use the dining ro | oom if he or she is able | e; and | | observed by the Dir. of Nursing during dressing | 1 | | |
| | (3)Participate in me recreational activiti | eaningful social and es; with eating; | · . | | changes to ensure the proper technique is followed. | | | |
| | (g)Prompt, unhurrie requires or request | ed assistance if he or s help with eating; | ihe | | 4/1/063. With respect to measure: | - | 4/1/08 | |
| | him or her in eating | tive self-help devices t | to assist | | put in place or systemic changes made to prevent | | | |
| | Independently; (DAssistance if per | eded, with daily hygien | A | | this practice; the DON or designee will in-service | | | |
| , , , | including oral acre; | | | | nursing staff to ensure that proper steps are | | | |
| |))Prompt response t for help. | to an activated call be | I or call | | taken during treatments and will monitor random treatment techniques | | | |
| | Based on observati (1) of one (1) press | met as evidenced by: on and record review f sure ulcer treatment, it | was | | during wound rounds. 4/1//06 | | 4/1//06 | |
| | given to Resident # | ficient nursing time wa 8 to ensure proper can orming a pressure ulce | e was | ſ | With respect to how the community plans to monitor performance; the | | | |
| | The findings include | ð: | | | DON or designee will report findings to the QA | | | |
| | | ure ulcer treatment wa 1, 2006 at 7:05 AM. T | | | Committee. 4/13/06 | | 4/13/06 | |

If continuation sheet 9 of 18

PRINTED: 03/15/2006 FORM APPROVED

Health Regulation Administration (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING 8. WING 095021 03/01/2006 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **1330 MASSACHUSETTS AVENUE NW** THOMAS HOUSE WASHINGTON, DC 20005 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID D (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEEDED BY FULL EACH CORRECTIVE ACTION SHOULD BE CROSS-PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) DATE REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG TAG L 052 L 052 Continued From page 9 nurse washed his/her hands and donned gloves. The soiled dressing was removed, the wound was cleansed and Xeroform and an outer dressing was applied. According to the facility's policy " Pressure Ulcer Treatment ", under " Steps in the Procedure, " page 21, " 6. Remove soiled dressing and place in opened plastic bag. Also remove soiled gloves and place in the plastic bag. 7. Wash hands. 8, Apply gloves. " The nurse failed to remove the soiled gloves, wash his/her hands and apply clean gloves according to the facility's policy while performing a pressure ulcer treatment. L 053 3211.2 Nursing Facilities L 053 Each facility shall have at least the following employees: (a)At least one (1) registered nurse on a twentyfour (24) hour basis, seven (7) days a week; (b)Twenty-four (24) hour licensed nursing staff sufficient to meet nursing needs of all residents; (c)At least one practical or registered nurse, serving as charge nurse, on each unit at all times: (d)A minimum of two (2) nursing employees per nursing unit, per shift. This Statute is not met as evidenced by: Based on record review and staff interview, it was determined that facility staff failed to comply with 22 DCMR 3211.2 by not having at least one (1) registered nurse (RN) on a 24 hour basis.

Health Regulation Administration STATE FORM

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| | T of deficiencies of correction | (X1) PROVIDER/SUPPLIE IDENTIFICATION NUM 095021 | | (X2) MULT A. BUILDIN B. WING | IPLE CONSTRUCTION NG | (X3) DATE S COMPLI | | |
|--------------------------|---|---|---|---|---|-------------------------|-----------------|--|
| | ROVIDER OR SUPPLIER | | STREET AD | DRESS, CITY, | STATE, ZIP CODE | | | |
| | B HOUSE | | 1330 MAS | ASSACHUSETTS AVENUE NW IGTON, DC 20005 | | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOUL | | HOULD BE CROSS- | (X5) COMPLET DATE | | |
| L 053 | Continued From page 10 | | | L 053 | L 053 | — <u> </u> | | |
| | The findings includ | le: to provide a RN on tl | se night | | 1. With respect to hov action was accomp HR Director has hir | lished; the | | |
| | shift according to li | icensure regulations. | | | night shift. The RN employment on 3/3 | • | 3/31/06. | |
| | shall have at least | CMR 3211.2, "Each fa the following employ gistered nurse on a tw (7) days a week" | ees: (a) | | 2. With respect to ider other residents hav | ing the | | |
| | schedules were rev through 28, 2006. licensed practical re worked the night sh | ed Nursing Daily Staff viewed from February It was observed that nurse was assigned an hift (11:00 PM until 7: tes: February 21, 22 | 21 a nd 30 AM) | | potential to be affect the HR Director will continuously recruit to ensure that there no gaps in coverage 4/1/06 | /hire are | 4/1/06 | |
| | | itered nurse was sche ht shift Saturday and 6, 2006. | | | 3. With respect to mea put in place or syste | emic | | |
| | Care Managers" d 2006 was reviewed schedule was "revis four (4) weeks, sch nurse for Monday t | ster Schedule for Res ated March 10 throug I. Hand written on the sed 2/18/06". The pro eduled a licensed pra hrough Friday. A reg I for the night shift on | h April 6, bjected ctical istered | | changes made to pi this practice; the HF Director will monitor schedule to datermi RN slots are vacant will immediately rep any RN vacancies. | the ine no DON | | |
| | Saturday and Sund | - | DMA | | 4/1/06 | | 4/1/06 | |
| | face- to- face interv licensed nursing ho acknowledged that consistently assigned | at approximately 2:00 view was conducted w orne administrator who a registered nurse wa ed for the night shift. luman Resource Dep dditional staff. | rith the) as not He/she | | With respect to how community plans to monitor performance HR Director and DO report to ED during weekly stand-up | e; the | | |
| | | to provide 24 hour nu stered nurse for the nu | | | meetings. 4/13/06 | | 4/13/0 6 | |

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| Health F | Regulation Administr | ation | | | <u></u> | | |
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| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIE IDENTIFICATION NUM | | (X2) MUL1 A. BUILDIN B. WING_ | IPLE CONSTRUCTION | (X3) DATE S COMPLI 03/0 | |
| NAME OF F | PROVIDER OR SUPPLIER | | STREET ADD | RESS, CITY, | STATE, ZIP CODE | | |
| THOMAS | S HOUSE | | | SACHUSE TON, DC | TTS AVENUE NW 20005 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY SC IDENTIFYING INFORMA | FUL | id Prefix Tag | PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SHK REFERENCED TO THE APPROPRI | WILD BE CROSS- | (XS) COMPLETE DATE |
| L 053 L 098 | facility. The staffing sheets 28, 2006. 3218.4 Nursing Fac The facility shall er accordance with th | were reviewed on F | re fed in sessment | L 053 L 098 | With respect to how c action was accomplis residents were adverse tray card with the men portion sizes was avai each resident on each tray. 2/28/96 Spreadsheets v sizes will be added as back-up to current sys 3/27/06 | shed; No ely affected. A ou and ilable for resident's with portion | 2/28/06 |
| | This Statute is not Based on observati the survey period, is staff failed to prepa- portion sizes and tr observed preparing specific serving size | met as evidenced by ions and record revie t was determined that re menus (spreadsho ayilne dietary staff wa entrees without dire es. These findings w sence of the dietary | w during at dietary ests) with ere ctions for rere | | With respect to identify residents having the put to be affected; The Div will audit the system to it's effectiveness and y monthly assessments to the types of foods and amounts are served, 3/29/06 | otential etician o evaluate will perform o ensure | 3/29/06 |
| |) of one (1) observa 2. Trayline dietary s and serving meals March 1, 2006 with to monitor and cont residents on therap no concentrated sw mechanical and ren | e: nclude portion sizes, ation on February 28, staff were observed p on February 28, 2006 out access to spread rol the portion sizes s eutic diets, such as n eets, low cholesterol, ial, in six (6) of six (6 en February 28, 2006 | 2006. Teparing and sheets served to egular, pureed, | | With respect to measurput in place or systemic changes made to prevision this practice; dietary supervisory will ensure staff is trained/reminder to follow system and Dietician will periodical monitor compliance. 3/29/06 With respect to how the community plans to monitor performance; the system and community plane community plane to monitor performance; the system and community plane to monitor performance; the system and | c ent ed lly | 3729/05 |
| | from spoilage, safe | ilities Il be clean, wholesom for human consumpt se with the requireme | ne, free ion, and | L 099 | Distary manager or distician will report findings to the QA Committee. 4/13/08 | | 4/13/06 |

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SUNRISE THOMAS CIRCL

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| | t of deficiencies of correction | (X1) PROVIDER/SUPPL IDENTIFICATION N 095021 | | (X2) MULT A. BUILDIN B. WING _ | IPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED 03/01/2006 | | | |
|--------------------------|--|--|--|--|--|---|--------------------------|--|--|
| | | 005021 | | | | | 11/2000 | | |
| | ROVIDER OR SUPPLIER | | 1330 MA | DDRESS, CITY, STATE, ZIP CODE ASSACHUSETTS AVENUE NW IGTON, DC 20005 | | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENC MUST BE PRECEEDED SC IDENTIFYING INFORM | BY FULL | ID PREFIX TAG | PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTION S REFERENCED TO THE APPRO | SHOULD BE CROSS- | (XS) COMPLETI DATE | | |
| L 099 | Regulations (DCMI This Statute is not Based on observati it was determined t adequate to ensure safe and sanitary m expired chocolate r a soiled can opened | age 12 btitle B, D. C. Muni R), Chapter 24 throu met as evidenced ions during the surv hat dietary services that food was serv nanner as evidence nilk in the walk in re r with metal shaving rfaces; a stainless | ugh 40. by: /ey period, 3 were not /ed in a id by: efrigerator; gs on the | L 099 | | | | | |
| · · · · · | counter lacked covi from contamination were not allowed to hotel pans were not not allowed to dry b refrigeration unit wa under cooking hood smoke during meal person was observe without hair restrain without gloves; hote and lunch meals we | ers to protect stored s; stainless steel plat dry before storing t thoroughly cleaned before storing for re- as inoperative; exha is failed to remove preparation; a diet ed working in the m its and handling chi el pans used during ere not cleaned with | d items the covers for reuse; d and were use; the aust fans steam and ary staff ain kitchen ina ware breakfast hin a 2 to 3 | | | · . | | | |
| | the dish machine la secured to the ceilin food storage room to ceiling; the air supp | ng; wall surfaces of falled to terminate a ly louver in the dish r; ceiling surfaces o ot plastered and pair on intenor of bins, is were soiled and o These findings wer | vas not the dry at the washer ver the nted; drip wells chinaware re | | L 099 1. With respect to how o action was accomplis negative resident out | hed; no | | | |
| | The findings include 1. A crate of 25 carl expiration date of F in the walk in refrige | tons of chocolate m ebruary 25, 2006 w | as stored | | Citations were corrected. 3/3/06 • Milk discarde 2/28/06 | led or will | 3/3/06 | | |

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| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIEF IDENITIFICATION NUM 095021 | | (X2) MULT A. BUILDIN B. WING _ | IPLE CONSTRUCTION | ON 04 | (X3) DATE SURVEY COMPLETED 03/01/2006 | |
|--|---|---|------------|--------------------------------------|--|--|---|--------------------------|
| | | 1202021 | | | STATE, ZIP CODE | | 03/0 | 172000 |
| | ROVIDER OR SUPPLIER 3 HOUSE | | 1330 MAS | | ITS AVENUE N | N | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY SCIDENTIFYING INFORMA | FULL | id Prefix Tag | (EACH CORREC | ER'S PLAN OF CORRECTIO CTIVE ACTION SHOULD BE TO THE APPROPRIATE DEF | CROSS- | (XS) COMPLETE DATE |
| L 099 | Continued From pa | nge 13 | | L 099 | • | Can opener | | |
| | February 28, 2006. | | | | | cleaned 2/28/06 | .] | |
| repluary 20, 2000. | | Í | | • | Cover to be | | | |
| | 2, A mechanical can opener was obser | | ed solled | | | installed 3/28/06 | | |
| with food residue and the cutting and gear surfaces were solled with metal shavings 1) of one (1) observation at approximately | | ar s in one (| | • | Stainless steel plate covers will be dried | | 2/28/08 3/28/06 | |
| ÁM oi 3. Th prepa | 1) of one (1) observ AM on February 28 | | ely 9:30 | | | before storing on shelves. Inservice | | |
| | preparation area la | eel counter in the coo cked frontal covers w | hich | | | on proper procedure for drying prior to | | |
| | | ware and other item | | | | storage 3/17/06 | | 3/17/06 |
| shelves from contamination in one (1) of observation at approximately 9:45 AM on February 28, 2006. | | | | - | Pots and pans cleaned and dried before reuse. | | | |
| | 4. Stainless steel plate covers were sto | | ed on | | | Inservice for proper cleaning and storage | , | |
| | | before allowing cover ervations at approxim | | | • | held. 3/17/06 Refrigerator | | 3/17/06 |
| | 05 PM on February | 28, 2008. | | | | repaired 3/22/06 | | 3/22/06 |
| | | d in the pot and pan v | | | • | Exhaust fans | | |
| | | oughly cleaned of foor allowed to dry before | | · | | will be repaired | | |
| | | in the following instan | | | • | 4/13/06 In-service on | | 4/13/06 |
| | | N OHGE AL AS IS AL | A 66 -2-14 | | | gloves and hair | | |
| | Hotel pans 10 X 12 (8) observations on | X 6"(inches) in six (6 March 1, 2006 at | or eignt | | | nets 3/20/06 | | 200-0- |
| | approximately 10:0 | - | • | | - | Sufficient help | : | 3/20/06 |
| | | | | | - | scheduled and | : | |
| | | < 20" in four (4) of sev | | | | in-service | • | • • |
| | observations at 10: | 10 AM on March 1, 2 | 006. | | | conducted | | |
| | Hotel pars 12 X 24 | X 4" in 23 of 24 obse | rvations | | | 3/20/06 | | 3/20/06 |
| | at 10:20 PM on Ma | | | | • | Fan repaired | | W20/00 |
| ļ | | | | | | and covered | • | |
| . | | unit located under the in the main kitchen | | | | 3/20/08 | | 3/20/06 |
| | | ation at 9:45 AM on F | | | 4 | Wall surfaces repaired. 3/20/06 | | 3/20/06 |

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SUNRISE THOMAS CIRCL

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| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIE IDENTIFICATION NU | | (X2) MULT A. BUILDIN B. WING | | (X3) DATE S COMPLE | |
|--------------------------|------------------------------------|--|-----------|------------------------------------|---|-----------------------|-------------------------|
| | | 095021 | | | | 03/0 | 1/2006 |
| IAME OF P | ROVIDER OR SUPPLIER | R | STREET AD | DRESS, CITY, | STATE, ZIP CODE | | |
| THOMAS | B HOUSE | | | BSACHUSE STON, DC 2 | TTS AVENUE NW 20005 | · . | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIE CY MUST BE PRECEEDED B' LSC IDENTIFYING INFORM | YFULL | id Prefix Tag | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION S REFERENCED TO THE APPROP | HOULD BE CROSS- | (X5) COMPLET DATE |
| L 099 | Continued From | page 14 | | L 099 | Louver repaire | a | 3/17/06 |
| | 7 Exhaust fors lo | - nested under conicina | hoods in | | 3/17/08 | | 1.2.1.100 |
| | | aust fans located under cooking hoods in in kitchen were not operating efficiently to | | | · Genny Aspense | 1 | 3/17/06 |
| 1 | | nd steam while the lun | | | 3/17/06 | | |
| | | approximately 10:00 A | | | Scoops | | [|
| | February 28, 200 | 6. | | | removed from | | 1 |
| | 8. A dietary staff | person was observed | assisting | | bins and stored in new scoop | !. | |
| | | of the dinner meal in the | | | holders 3/21/06 | , | 3/21/06 |
| | | chinaware without usir | ng gloves | | Drip wells | | |
| | in one (1) of one (| | 2008 | | cleaned | | 3/17/06 |
| | approximately 1.2 | 20 PM on February 28 | ,2000. | | Plates cleaned | 1 | 3/9/06 |
| | 9. Hotel pans use | d to prepare the break | dast and | | and In-service | | |
| | | not washed within a 2 | | | on cleaning | | |
| | period as evidenc | ed by observation of s | soiled | | plates help | | 3/20/06 |
| | | ed in the sink and on c | | | | · | , |
| | | ash areas at 4:00 PM | | | 2. With respect to identifying | 1 | • |
| | | ugh help was not ava | Hadle to | | other residents having the | 9 | 1 |
| | complete the task | Delote 4,00 PM. | Í | | potential to be affected: | | |
| | 10. The exhaust f | an located in the cellin | na on the | | the Food Service Director | <u>.</u> | |
| | | lish machine lacked a | | | monitored food areas to | | |
| | | red to the ceiling in on | | | determine that no other | | |
| | | on at approximately 10 |):25 AM | | similar conditions exist. | | • |
| | on February 28, 2 | 005. | | i | 3/3/06 | | 3/3/06 |
| | 11. Wall surfaces | in the dry food storag | e room | | 1 | | |
| ĺ | | alk in refrigerator, was | | | | | |
| | | he ceiling to prevent th | | | With respect to measures | | |
| | | and pest infestation in ation at 9:00 AM on Fe | | 1 | put in place or systemic | | |
| | 28, 2006. | | | | changes made to prevent | | |
| | , 2000. | | · [| | this practice; areas sited | | |
| ł | | louver which disperse | | | will be monitored by the | | |
| | | the dishwasher area | | | Food Service Director or | | |
| | | of one (1) observation | at 9:48 | | designee to ensure that | | |
| | AM on February 2 | 8, 2008. | | , | these items are not | | |
| | | es on the clean side of plastered and painted | | | repeated, 3/3/06 | | 3/3/06 |

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| | | (X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUMB 095021 | | | (X3) DATE SURVEY COMPLETED 03/01/2006 | |
|--------------------------|---|--|-----------------------------------|---|---|-------------------------|
| IAME OF P | IAME OF PROVIDER OR SUPPLIER STREET ADD | | | STATE, ZIP CODE | | |
| THOMAS | B HOUSE | | 1330 MASSACHUSE VASHINGTON, DC | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION S REFERENCED TO THE APPROP | HOULD BE CROSS- | (X3) COMPLET DATE |
| L 099 | Continued From page 15 | | L 099 | · · · · · · · · · · · · · · · · · · · | , | |
| | in one (1) of one (on February 28, 20 14. Scoops used t rice were stored in 3) observations at | to dispense flour, sugar the bins in three (3) of 10:50 AM on March 9, 1 | and three (2006, | 4. With respect to h community plans monitor performa Food Service Din designee will mor report findings to | to nce; the ector or nitor and | |
| | with accumulated | er cooking hoods were grease on the inner well of two (2) observations , 2006. | | Committee. 4/13/06 | | 4/13/06 |
| | warmer were not the washing as eviden | lates) stored in the plate noroughly cleaned after ced by food particles or faces in 11 of 16 obser arch 9, 2008. | the | | | · . |
| L 104 | 3219.6 Nursing Fa | cilities | L 104 | L 104 | | |
| | hair net or other he This Statute is not Based on observat it was determined to observed working it | met as evidenced by: ions during the survey p hat a dietary staff perso n the main kitchen with s finding was observed | period, on was put | With respect to how or action was accomplish negative resident outo Citations were corrected be corrected. 3/3/06 | ned; no ome. | 3/3/06 |
| | with preparation of kitchen without hair | e: on was observed assist the dinner meal in the r restraints in one (1) of proximately 1:20 PM on | nain one (1 | In-service on hair nets 3/20/06 Sufficient help scheduled an in-service conducted | p | 3/20/06 |
| 1 | | | | conducted | . | 3/20/06 |

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| 1330 MAS | | BENTIFICATION NUI | | (22) MULTIFLE CONSTRUCTION A. BUILDING B. WING | | | DC3) DATE BURNEY COMPLETED | |
|--------------------------|--|--|------------------------------|--|------|--|-------------------------------|------------------------|
| | | STREET AND | | 03/01/2006 | | | | |
| | | XOREDO, CITY, STATE, ZP CODE SSACHUSETTS AVENUE NW GTON, DC 20005 | | | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIE MUST BE PRECEEDED BY SCIDENTIFYING INFORMA | FUL | id PREPX TAG | EACH | PROVIDER'S PLAN ()F CORRE CORRECTIVE ACTION SHOUL ENCED TO THE APP ROPRIATE | BE CROSS- | (25) Comple Date |
| L 099 | | - | | L 099 | | | | |
| | | erved around the exi) observation at 10 06. | | | | | · · | |
| | nice were stored in 3) observations at | o dispense flour, sug the bins in three (3) o 10:50 AM on March E er cooking noods wer | of three (), 2006. | | 2. | With respect to identifying other residents having the potential to be affected; | | |
| | with accumulated g surfaces in one (1) 55 AM on March 9, | rease on the inner w of two (2) observatio 2006, | ell ns et 10: | | | the Food Service Director monitored food areas to determine that no other similar conditions exist. | | |
| | warmer were not the washing as evidence | ates) stored in the pla oroughly cleaned after ed by food particles aces in 11 of 16 observed by 2009 | ər on the | | 3 | 3/3/06 With respect to measures | | 3/3/08 |
| L 104 | 3219.6 Nursing Fac | - | 1 | L 104 | . 0. | put in place or systemic changes made to prevent | | |
| 1 | hair not or other hea | employee shall wear o ad covering. met as evidenced by: | 4 | | | this practice; areas sited will be monitored by the Food Service Director or | | |
| | Based on observation it was determined the observed working in | ons during the survey bat a dictary staff pen the main kitchen wit finding was observe | r period, son was hout | | | designee to ensure that these items are not repeated. 3/3/06 | | 3/3/06 |
| . | The findings include | : |). | | 4. | With respect to how the community plans to | | |
| | with preparation of the | n wasiobserved assis to dinner meal in the restraints in one (1) o roximately 1:20 PM o | main f one (1 | | | monitor performance; the Food Service Director or designee will monitor and report findings to the QA Committee. | | |
| ļ | | | ľ | 4 | | 4/13/06 | } | 4/13/06 |

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SUNRISE THOMAS CIRCL

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Health Regulation Administration

| TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLI IND PLAN OF CORRECTION IDENTIFICATION NUMBER 095021 | | | (XC2) MULT A. BUILDIN B, WING _ | | COMPLETED 03/01/2006 | | |
|---|---|---|---------------------------------------|---------------------|--|-----|------------------------|
| MAME OF P | ROVIDER OR SUPPLIER | | STREET AD | DRESS, CITY, | STATE, ZIP CODE | | |
| THOMAS | HOUSE | | | SACHUSE | TTS AVENUE NW 20005 | · · | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | FULL | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS- REFERENCED TO THE APPROPRIATE DEFICIENCY) | | (X5) COMPLE DATE |
| L 442 L 442 | Continued From page 16 3258.13 Nursing Facilities | | | L 442 L 442 | L 442 | | |
| | mechanical, electri equipment in safe This Statute is not Based on an obser | aintain all essential ical, and patient care operating condition. met as evidenced by vation during the sur | y: vey | | 1. With respect to how corre- action was accomplished; oxygen concentration filter replaced. 3/2/06 | the | 3/2/06 |
| | period, it was determined that proper procedures were not followed to ensure that oxygen concentrated air was filtered. This finding was observed in the presence of Housekeeping, Nursing and Maintenance Staff. | | | | With respect to identifying other residents having the potential to be affected; residents with oxygen concentration tanks were | | |
| | The findings include: An oxygen concentrator was observed operating | | | | inspected to ensure a filter is in place. | | |
| | in room 221 withou atmospheric air to | t a filter, allowing uni enter the machine du one (1) of one (1) obs | filtered inng | | 3/2/063. With respect to measures put in place or systemic changes made to prevent | | 3/2/06 |
| L 446 | fire plan shall be co four (4) times a yea This Statute Is not | ting the effectiveness anducted for each shi | ft at least | L 446 | this practice; the DON or designee will monitor the concentrators each time one is put into use and week and will in-service staff to cusure that oxygen concentr air is filtered. | | |
| | the Life Safety Cod determined that fire quarterly as require | le inspection, it was a drills were not condu- d. These findings was sence of the mainten | ucted | | 4/1/06 4. With respect to how the community plans to monitor performance; the | | 4/1 /06 |
| | The findings include | | | | DON or designee will report findings to the QA | | |
| | fire drills were cond | s not available to sup lucted during the seco ird quarter and first, s | ond and | | Committee, 4/13/06 | | 4/13/06 |

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SUNRISE THOMAS CIRCL

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION 095021 | | | (X2) MULT A. BUILDIN B. WING _ | IG | SURVEY LETED | |
|---|--|----------------------|--------------------------------------|----------------------|--|---------|
| | | | | DRESS, CITY, | | |
| HOMAS | HOUSE | | | SSACHUSE GTON, DC | TTS AVENUE NW 20005 | · |
| (X4) ID PRÉFIX TAG | FIX (EACH DEFICIENCY MUST BE PRECEEDED | | SY FULL | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY | |
| L 448 | Continued From pa | age 17 | | L 446 | | |
| | and third shifts of t | he fourth quarter fo | r the year | | L 446 | |
| | | 12 observations bet | | | 1. With respect to how corrective action was accomplished; fire drills were submitted but were not quarterly. They will be held | |
| | | • | | | quarterly. 3/6/06 | 3/6/06 |
| | | | | | 2. With respect to identifying other residents having the potential to be affected; an audit of all fire drills | |
| ., | | | | | found drills were not held quarterly or were not properly documented | |
| | | | | | in '05. They will be conducted at least one time per shift quarterly. And | |
| | | | | | will be properly documented. 3/23/06 3. With respect to measures | 3/23/06 |
| | | • • | | | put in place or systemic changes made to prevent this practice; Safety | |
| i - | • | | | | Committee chairperson will cnsure all drills are conducted at least one time | |
| | • • | | | | per shift quarterly and that paperwork is properly | |
| | | | | | completed. 3/31/06 | 3/31/06 |
| | | | | | With respect to how the community plans to | |
| | | | | | monitor performance; Safety Committee chair | |
| | | | | | person will submit each drill to QA Committee in | |
| | | | | | '06. - 4/13/06 | 4/13/06 |