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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE AT THOMAS CIRCLE	1330 MASSACHUSETTS AVENUE NW WASHINGTON, DC 20005

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 000	Initial Comments A licensure survey was conducted February 20 though February 22, 2008. The following deficiencies were based on record review, observations and interviews with staff and residents. The sample included 10 residents based on a census of 21 residents on the first day of survey.	L 000		
L 010	3202.4 Nursing Faculties Each employee or person hired under contract who requires licensure, registration or certification in order to provide resident care shall be licensed, registered or certified under the laws and regulations of the District. This Statute is not met as evidenced by: Based on observations, review of employee licenses, and staff interviews, it was determined that the facility failed to have a license on file for a dietitian. The findings include: According to Tile 22 DCMR 3202.4, "Each employee or person hired under contract who requires licensure, registration or certification in order to provide resident care shall be licensed, registered or certified under the laws and regulations of the District." A review of a spreadsheet dated January 16, 2007 used to prepare resident meals and the menus dated August 10, 2007 that are posted for residents to review, revealed a signature of a RD [registered dietitian]. The facility lacked evidence that the dietitian was licensed in the District of Columbia. A face-to-face interview was conducted with	L 010	L010 1. The facility has contracted with a registered dietitian who is licensed in the District of Columbia as of 02/22/2008. This RD will sign off on menus. 03/01/2008. 2. The credentials of all staff that require licensure, registration or certification in order to provide care in the District of Columbia was checked for current status by the Human Resources department. No other issues were found. 3. All licensed and certified staff has been informed that they are required to keep their credentials current. The Director of Human Resources or designee will audit for compliance monthly as of 04/2008. 4. The Director of H.R. or designee will report the findings of these audits to the Quality Assurance Committee monthly X 3, April, May and June 2008. **Completion Date 04/06/2008**	

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE AT THOMAS CIRCLE	1330 MASSACHUSETTS AVENUE NW WASHINGTON, DC 20005

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 010	Continued From page 1 Employee #2 on February 21, 2008 at 3:45 PM. He/she acknowledged that the facility did not have a license on file for the dietitian.	L 010		
L 052	3211.1 Nursing Facilities Sufficient nursing time shall be given to each resident to ensure that the resident receives the following: (a)Treatment, medications, diet and nutritional supplements and fluids as prescribed, and rehabilitative nursing care as needed; (b)Proper care to minimize pressure ulcers and contractures and to promote the healing of ulcers: (c)Assistants in daily personal grooming so that the resident is comfortable, clean, and neat as evidenced by freedom from body odor, cleaned and trimmed nails, and clean, neat and well-groomed hair; (d) Protection from accident, injury, and infection; (e)Encouragement, assistance, and training in self-care and group activities; (f)Encouragement and assistance to: (1)Get out of the bed and dress or be dressed in his or her own clothing; and shoes or slippers, which shall be clean and in good repair; (2)Use the dining room if he or she is able; and (3)Participate in meaningful social and recreational activities; with eating; (g)Prompt, unhurried assistance if he or she	L 052	**L052** A.) 1. Tylenol for resident #1: Order corrected on 02/22/08 and carried thru to MAR. The Licensed Staff was in- serviced on 02/22/03. 2. DON, Unit Manager and MDS RN audited all resident charts on 02/25/08 thru 02/28/08. All physician orders were audited also. Corrections made where made applicable to physician orders, MAR's and TAR's. 3. DON, Unit Manager and MDS RN will audit and reconcile when necessary all resident's physician orders, MAR's and TAR's monthly. 4. Results from monthly audits will drive in-services and individual teaching to licensed team members. Results / trends will be reported at monthly Quality Assurance Committee meetings. A. 1. Resident #4 hand mittens were documented in care plan as resident choice (not assistive device) as of 02/22/08. 2.All residents were evaluated for personal choice of wearing outside clothes inside. Notation was made in care plan where applicable as of 02/22/08 3.In service to care plan to notes personal choices in care plan as of 03/06/2008. 4.Quarterly audit by DON/unit manager will be reported at quarterly Quality Assurance Committee meetings starting 03/20/2008.	

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE AT THOMAS CIRCLE	1330 MASSACHUSETTS AVENUE NW WASHINGTON, DC 20005

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 2 requires or request help with eating; (h)Prescribed adaptive self-help devices to assist him or her in eating independently; (i)Assistance, if needed, with daily hygiene, including oral acre; and j)Prompt response to an activated call bell or call for help. This Statute is not met as evidenced by: Based on observation, staff interview and record review for three (3) of 10 sampled residents, it was determined that facility staff failed to: administer Tylenol as per physician's orders; obtain a physician's order for use of hand mittens for one (1) resident; and follow physician's orders for a Vigilon monitor and administration of Ativan and reschedule a MRI for one(1) resident. Residents #1, 4 and 5. The findings include: 1. Facility staff failed to administer Tylenol according to the current physician's order for Resident #1. A physician's Interim Order Form dated and signed January 29, 2008 revealed, "Order clarification: [change] Tylenol to 1gm BID PO [1gram twice daily by mouth] for pain. A review of the February 2008 Physician's Orders dated and signed by the physician on February 8, 2008, revealed, "Tylenol 325 mg tablet 2 tabs PO [by mouth] 2 times daily for Osteoarthritis ..." This was the current order for Tylenol.	L 052	A) 1. Tylenol for resident #1: order corrected on 02/22/08. 2. DON, Unit Manager and MDS RN audited all residents' charts on 02/25/08 thru 02/28/08. All physician orders were audited. Corrections were made when applicable to physician orders, MAR's & TAR's. 3. Staff was in-serviced on 02/26/08, 02/27/08 and 03/20/08 with procedure for carrying orders thru from origin by MD to MAR, TAR for both current and the next month. 4. Monthly audits by RN's will be assessed; patterns and trends will drive both individual and unit education. Resultant findings will be reviewed at QAA meeting.	

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE AT THOMAS CIRCLE	1330 MASSACHUSETTS AVENUE NW WASHINGTON, DC 20005

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 3 A review of the February 2008 Medication Administration Record revealed,"[change] Tylenol to 1gm BID P.O. for pain". According to the February 2008 MAR, Tylenol was administered as evidenced by the entry of nurses' initials A face-to-face interview was conducted with Employees # 3 and 5 on February 21, 2008 at approximately 2:30 PM. They both acknowledged that the January 29, 2008 Physician's Order for Tylenol was not transcribed to the February 2008 Physician's Order Form. However, the resident was receiving the correct amount of Tylenol. The record was reviewed February 21, 2008. 2. The facility staff failed to obtain a physician's order for the use of hand mittens for Resident # 4. Resident # 4 was observed at 12:20 PM on February 20, 2008 with a blue hand mitten on his/her left hand. The resident was also observed at 3:00 PM on February 20, 2008, and 1:00 PM on February 21, 2008 wearing blue hand mittens on both hands. A review of the resident's record lacked evidence of a physician's order for the use of hand mittens. A face-to-face interview was conducted with Employee #3 at approximately 12:00 PM on February 21, 2008. He/she acknowledged that a physician's order was never obtained for the use of the hand mittens. He/she added, "He/she has neuropathy and he/she used to complain that his/her hands were cold. We [the facility] decided to put the mittens on his/her hands to keep them	L 052	1. The hand mittens are the residents' preference, this is not an assistive device. Residents' choice was addressed in resident's care plan meeting 02/25/08. 2. DON. Unit Manager reviewed all other residents. Residents with clothes preferences had preference addressed in care plan. 3. DON, Unit Manager in-serviced care plan team on 02/28/08, 03/06/08 and 03/13/08. Preferences found noted on CAN daily assignment sheets should information need to be conveyed to agency staff. 4. Unit manager will audit care plans for completeness. Results of monthly audits will be reported @ QAA meetings and used to determine in-services on an as needed basis.	

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE AT THOMAS CIRCLE	1330 MASSACHUSETTS AVENUE NW WASHINGTON, DC 20005

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 4 warm. He/she does not complain of the pain in his/her hands any more." The record was reviewed on February 21, 2008. 3. Facility staff failed to follow physician's orders for the use of a Vigilon monitor and administration of Ativan and reschedule a brain MRI for Resident #5. A. Facility staff failed to follow physician's orders for the use of a Vigilon monitor Review of the physician's notes for Resident # 5's record revealed the following: September 17, 2007 " Pt. [patient] fell out of bed 9/13/07 and lacerated [his/her] (L) ear. Went to [hospital] and had sutures placed ..." October 9, 2007 " Pt. fell 10/6/07 around 10:15 AM, per nursing report, pt. was found on the floor between the wheelchair and bed ...unable to explain why ..was sitting on the floor...C/O [complaint of] low back pain ..." December 21, 2007 " ...attempting to transfer from bed to wheelchair unassisted when [he/she] fell ... was found on the floor by staff ...hit the floor and head on wheelchair. No loss of consciousness ..." A review of the nurses' notes for Resident # 5's record revealed the following: September 15, 2007 at 4:55 PM: "Resident was sitting on the commode on the bathroom when [he/she] fell off the commode to the floor ..." September 26, 2007 at 10:00 AM: "Resident observed on the floor in room close to bed,	L 052	1. Resident #5 received a safety monitor on 03/11/08 2.Charts and PT notes were audited by the unit manager and PT staff. Chair and / or bed alarms initiated when indicated. 3. At weekly care plan meetings, nursing, PT and OT staff will assess all new admits, residents with change in condition and the weeks falls for appropriate interventions. Staff was in-serviced on 02/25/08, 03/06/08 and 03/13/08 on safety monitors. Residents with safety monitors had device added to CAN flow sheet for dispersal of information to both facility staff and agency. 4. Information gathered will be analyzed and reported at QAA meetings. Audited information will be used to alter policy and procedure as indicated and generate in-services.	

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE AT THOMAS CIRCLE	1330 MASSACHUSETTS AVENUE NW WASHINGTON, DC 20005

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 5 resident observed with no sign of distress ..." October 6, 2007 at 9:45:"...found resident sitting in front of the W/C [wheelchair] on the floor beside the bed ...I tried to get in the bed ..." October 9, 2007 at 3:00 PM: "Resident was observed in ...bathroom on the floor close to the commode..." December 21, 2007 at 14:30 (2:30 PM): "Resident was observed on the floor in ...room while trying to move from bed to chair. Did not complain of pain and no injury observed ..." A review of the Occupational Therapy Daily Documentation notes for Resident # 5's record revealed the following: October 10, 2007, "Resident had a fall from toilet yesterday per nursing report while attempting to get up from toilet. Recommend alarm for toilet, bed and W/C. Also pt. [patient] should not be left unaccompanied. Discussed with nursing supervisor who is in agreement. Also discussed need for tall back..." A review of Resident # 5's physician's "Interim Order Form" revealed the following: December 21, 2007, "Vigilon monitor. Fall Precaution" The review of Resident #5's care plan revealed the following problem initiated April 7, 2007, "Resident is at risk for falls related to dementia, h/o [history of] CVA, anxiety, h/o back surgery, antidepressant use." Approaches identified included, October 6, 2007: "Alarm as ordered, avoid leaving alone in room" and December 21, 2007: "Frequent safety checks by staff."	L 052		

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE AT THOMAS CIRCLE	1330 MASSACHUSETTS AVENUE NW WASHINGTON, DC 20005

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 6 The resident was observed in the dining room on February 21, 2008 at about 11:00 AM and 1:00 PM. There was no chair alarm on the resident's chair. The resident was observed by the surveyor and Employee #3 in bed on February 22, 2008 at approximately 7:35 AM. There was no bed alarm on the resident's bed. A face-to-face interview was conducted with Employee # 3 on February 22, 2008 at approximately 8:00 AM. He / she acknowledged that the order for the Vigilon monitor was not followed up on. He/She said, "There is no bed/chair or bathroom alarm for use by the resident. We do not have a record for frequent safety checks by staff." Facility staff failed to follow up on the recommendation to provide Resident # 5, who had a history of multiple falls, with an alarm for the bed, wheelchair and toilet. B. Facility staff failed to administer Ativan as per the physician's order and reschedule a MRI. A review of the resident's Interim Order Form revealed the following: November 7, 2007, "Reschedule MRI brain with contrast - open MRI please. Ativan 1mg P.O. (orally) prior (1 hour) to MRI ..." A review of the resident's record revealed the following from a MRI provider: "... [Resident] was here 12/27/07 at 2:45 PM to have MRI of the brain ...Scan was unsuccessful due to patient being uncomfortable lying down. "	L 052	1. Resident # 5 MRI was completed on 03/17/08. 2. All charts audited by the DON, Unit Manager and MDS RN week of 02/25/08 thru 02/28/08 for consults not followed thru and medications not administered. No further findings. 3. DON, Unit Manager and MDS RN will audit the charts for follow thru on consults and / or MD orders for procedures for 90 days. The Unit Secretary was in-serviced on 02/21/08 with regards to auditing that information from point of service is returned to facility after all consults. Nursing staff in-serviced on 02/26/08. 4.Information will be analyzed and reported at monthly QAA meeting. Audited information will be used to alter policy and procedure as indicated. **Completion Date 04/06/08**	

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE AT THOMAS CIRCLE	1330 MASSACHUSETTS AVENUE NW WASHINGTON, DC 20005

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 7 The resident's MAR lacked evidence that Ativan 1mg P.O. prior (1hour) to MRI was administered as per the physician's order on December 27, 2007 as evidenced by the lack of a nurse's initials. A face-to-face interview was conducted with Employee # 4 on February 22, 2008 at 9:30 AM. He / she acknowledged that there was no evidence in the record that the resident received Ativan as ordered and that the facility did not reschedule the resident's MRI after the unsuccessful attempt of December 27, 2007. The record was reviewed on February 22, 2008.	L 052		
L 099	3219.1 Nursing Facilities Food and drink shall be clean, wholesome, free from spoilage, safe for human consumption, and served in accordance with the requirements set forth in Title 23, Subtitle B, D. C. Municipal Regulations (DCMR), Chapter 24 through 40. This Statute is not met as evidenced by: Based on observations and staff interview during the survey period, it was determined that dietary services were not adequate to ensure that foods were prepared and served in a safe and sanitary manner as evidenced by: water (condensation) dripping from the ceiling above the automatic dish machine area, soiled cooking hoods, grill surfaces, ovens, deep fryer, mixer stand, shelves, fruit juice machine and floors; food items stored in refrigerators beyond expiration date and/or spoiled, burner with a non-functional pilot light, chicken thawed in standing water and boxes stacked outside the dumpster. The findings were observed and acknowledged in the presence of Employee #5 on February 20, 2008 between 8:20 AM and 9:30 AM and at 12:20 PM - 12:50 PM.	L 099		

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE AT THOMAS CIRCLE	1330 MASSACHUSETTS AVENUE NW WASHINGTON, DC 20005

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 099	Continued From page 8 The findings include: 1. On February 21, 2008 at 12:20 PM water (condensation) was observed dripping from a damaged ceiling above the automatic dish machine area onto chinaware ready for reuse. [Mold, rust, peeling paint and a hole was observed on the damaged ceiling]. A face-to-face interview was conducted with Employee #5 on February 20, 2008 at 12:21 PM. He/she stated, "There have been several attempts to fix the exhaust fan that is the cause of the condensation build up. It has been this way on and off for about a month." A face-to-face interview was conducted with Employee #2 on February 21, 2008 at 11:45 AM. He/she stated, "We [the facility] have not had any residents within the last month with Gastrointestinal upset or diarrhea." Additionally, a review of information gathered for the Infection Control Program revealed that there were no incidents of gastrointestinal issues. 2. Soiled interior surfaces of the cooking hoods and filters in the main kitchen were soiled with grease in two (2) of two (2) observations of cooking hoods. Soiled cooking surfaces on two (2) of two (2) ovens, one (1) of one (1) deep fryer, one (1) of one (1) stove, and one (1) of one (1) grill were observed soiled with grease. Soiled - One (1) of one (1) mixer stand, one (1) of one (1) juice machine, and shelves in the food preparation area were observed soiled. Soiled floors were observed in the main kitchen	L 099	**L099** 1. The following findings have been corrected: • Damaged ceiling above the automatic dish machine area repaired as 02/21/2008. • Soiled interior surfaces of the cooking hoods and filters in the main kitchen that were soiled with grease were cleaned as of 03/22/08. • Soiled cook surfaces on ovens, stove, deep fryer and grill were cleaned as of 03/01/2008. • Soiled mixer stand, juice machine and sheves in the food preparation area were cleaned as of 03/01/2008. • Soiled floors in the main kitchen and the hallway area near the walk-in refrigerator, the service door and the dry goods pantry were cleaned as of 03/01/2008. • All expired foods observed in the refrigerators were discarded at the time of the survey 02/20/2008. • Frozen chicken observed being thawed in a compartmental sink full of water was discarded on 02/20/2008. Staff was in serviced on the proper way to thaw foods as of 3/2008.	

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE AT THOMAS CIRCLE	1330 MASSACHUSETTS AVENUE NW WASHINGTON, DC 20005

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 099	Continued From page 9 and the hallway area near the walk-in refrigerator, the service door and the dry goods panty. 3. Expired foods were observed in the refrigerators as follows: A hotel pan with plastic covering contained cranberry sauce dated February 6, 2008. Beef dated February 14, 2008 and stored on a meet rack was observed to have an odor and brown areas. A box of lettuce dated January 20, 2008 was observed to be withered. 5. On February 20, 2008 at 8:20 AM, frozen chicken was observed being thawed in a compartmental sink full of water. 6. On February 20, 2008 at 11:10 AM approximately 20 labeled boxes with produce and/or food and one (1) bag of trash were observed stored outside on the ground of the service area.	L 099	• 20 labeled boxes with produce and /or food and one bag of trash observed stored outside on the ground of the service area was discarded at the time of the survey 02/20/2008. 2. All other areas in the kitchen were checked for soiled surfaces, expired food items, food thawing techniques and trash removal for compliance. No other issues were found. 03/01/2008. 3. The dinning service staff was in serviced on keeping Food and drink clean, wholesome, free from spoilage, safe for human consumption, and served in accordance with the requirements as of 03/31/2008. The Director of Dinning services or designee will audit for soiled surfaces, expired food items, food thawing techniques and trash removal for compliance monthly as of 04/2008. 4. The Director of Dinning Services or designee will report the findings of these audits to the Quality Assurance Committee monthly X 3, April, May and June 2008.	
L 214	3234.1 Nursing Facilities Each facility shall be designed, constructed, located, equipped, and maintained to provide a functional, healthful, safe, comfortable, and supportive environment for each resident, employee and the visiting public. This Statute is not met as evidenced by: Based on observation, staff interview it was determined that the facility staff failed to maintain a safe and hazard free environment as evidenced by extension cords in resident areas and unsecured oxygen tanks. The findings observed during the environmental tour were	L 214	**Completion Date 04/06/2008**	

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE AT THOMAS CIRCLE	1330 MASSACHUSETTS AVENUE NW WASHINGTON, DC 20005

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 214	Continued From page 10 acknowledged in the presence of Employee #1 on February 20, 2008 between 9:35 AM and 11:30 AM. The findings include: A. Extension cords were observed in the general living/activities area connected to lamps. B. Oxygen tanks were unsecured in three (3) of 17 tanks observed in the oxygen closet. The findings observed during the environmental tour were acknowledged in the presence of Employee #1 on February 20, 2008 between 9:35 AM and 11:30 AM.	L 214	**L214** 1. The following was corrected: • Extension cords observed in general living /activities area connected to lamps were removed as of 03/01/2008. • The oxygen tanks were secured in the oxygen closet. 03/01/2008 2. All other resident general living/ act ivies areas were check foe extension cords and unsecured oxygen tanks. No other issues were found. 03/01/2008. 3. The Housekeeping/maintenance\ nursing staff were reeducated on maintaining a safe and hazard free environment 03/31/2008. The Director of Housekeeping/ maintenance or designee will audit for extension cords and unsecured oxygen tanks for compliance monthly as of 03/2008. 4. The Director of Housekeeping /Maintenance or designee will report the findings of these audits to the Quality Assurance Committee monthly X 3, April, May and June 2008. **Completion Date 04/06/2008**	
L 410	3256.1 Nursing Facilities Each facility shall provide housekeeping and maintenance services necessary to maintain the exterior and the interior of the facility in a safe, sanitary, orderly, comfortable and attractive manner. This Statute is not met as evidenced by: Based on observations during the survey period, it was determined that maintenance and housekeeping services were not adequate to ensure that the facility was maintained in a safe manner as evidenced by: soiled window sills, floors, blinds and over-the-bed lights and marred/scarred chairs. These findings were observed and acknowledged in the presence of Employee #1 on February 20, 2008 between 9:35 AM and 11:30 AM. The findings include: 1. Soiled window sills in four (4) of eight (8) rooms observed 205, 208, 209 and 216.	L 410		

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE AT THOMAS CIRCLE	1330 MASSACHUSETTS AVENUE NW WASHINGTON, DC 20005

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 410	Continued From page 11 Soiled floors in one (1) of (1) biohazard closet observed and in one (1) of one (1) stairwell observed between the lobby and first floors. Soiled blinds in seven (7) of eight (8) rooms observed 203, 205, 208, 209, 214, 216 and 217. Soiled over-the-bed lights in six (6) of eight (8) rooms observed 205, 208, 209, 211, 214 and 216. 2. Marred/scarred dining room chairs in 17 of 17 chairs observed.	L 410	**L410** 1. Soiled window sills observed in rooms 205, 208, 209 and 216 were cleaned as of 03\22\2008. • Soiled floors were cleaned in the biohazard closet, the stairwell between the lobby and first floor. 03\22\2008 • Soiled blinds were cleaned in rooms 203, 205, 208, 214, 216 and 217 as of 03\22\2008. • Soiled over the bed light in rooms 205, 208, 209, 214, 216 and 217 were cleaned as of 03/22/2008. • Marred/scarred dinning room chairs were repaired as of 04\06\2008. 2. All other resident rooms were checked for soiled floors, soiled blinds, soiled light fixtures and marred and scarred chairs. 03/01/2008. Corrections were done as needed. 03/01/2008 3. All housekeeping and maintenance staff were reeducated on provide housekeeping and maintenance services necessary to maintain the exterior and the interior of the facility in a safe, sanitary, orderly, comfortable and attractive manner. The Director of Housekeeping/ maintenance or designee will audit soiled window sills , floors, blinds, lights and marred and scared dining room chairs for compliance monthly as of 04/2008. 4. The Director of Housekeeping /Maintenance or designee will report the findings of these audits to the Quality Assurance Committee monthly X 3, April, May and June 2008. **Completion Date 04/06/2008**	