STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	10/20/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARROLL MANOR NURSING & REHAB	725 BUCHANAN ST., NE WASHINGTON, DC 20017

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION 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 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 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 tiles. These findings were observed in the presence of the Maintenance Director. The findings include: Penetrations were observed in wall surfaces	K 017	K017 NFPA 101 Life Safety Code Standard 1. All identified areas of penetration have been sealed. 2. The facility will conduct another facility inspection to insure that all areas have been treated by 11/30/06. 3. A preventative maintenance program will be implemented to survey one unit monthly to identify any new areas of penetration. 4. Findings of the surveys will be reported to the facility's Safety Committee.	11/30/06

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

Carol Pallara — Acting Administrator — 11/6

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

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K 017	Continued From page 1 around electrical wires, cables and pipes, in the following areas: Ground Level a 3 to 4 inch opening was observed in wall surfaces over stairwell door # 3 in one (1) of five (5) observations at 10:41 AM on October 20, 2006. Penetrations were observed in wall surfaces over the laundry storage room and the laundry entrance doors in two (2) of five (5) observations at 10:45 AM on October 20, 2006. Second Floor a 4 to 6 inch penetration was observed around the heat and cooling pipes in the wall surfaces near the conference center in two (2) of six (6) observations at approximately 12 :10 PM on October 20, 2006. Third Floor an opening was observed around a group of telecommunications wires that passed through the floor in one (1) of five (5) observations 12:55 PM on October 20, 2006.	K 017		

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K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observations during the Life Safety Code inspection, it was determined that double and single swinging doors failed to close and latch. These findings were observed in the presence of the Maintenance Director. The findings include: Third Floor the pantry room entrance door failed to close and latch in one (1) of one (1) observation at 11:47 AM on October 20, 2006. The storage room and personal laundry room doors failed to close and latch in two (2) of two (2)	K 018	K018 NFPA 101 Life Safety Code Standard 1. The identified doors will be repaired by 11/30/06 to insure proper closure. 2. All fire doors will again be inspected by 11/30/06. 3. Semi-annually all fire doors will be tested and the supervisor will perform random tests weekly. 4. Findings will be reported to the Safety Committee and the department director for review on a monthly basis.	11/30/06

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K 018	Continued From page 3 observations at 12:25 AM on October 20, 2006. Fourth Floor the pantry door failed to close and latch in one (1) of five (5) observations at 12:30 PM on October 20, 2006. Fifth Floor the pantry and storage room doors failed to close and latch in two (2) of five (5) observations at 12:35 PM on October 20, 2006.	K 018		
K 130 SS=D	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Based on observations during the survey period, it was determined that the fire gate was damaged and separated from stairwell walls. The findings include: Hinges were damaged and separated from the wall on the stairwell fire gate between the ground and first floor stairwells in one (1) of 15 observations at 10:40 AM on October 20, 2006.	K 130	K 130 NFPA 101 Miscellaneous 1. The hinge in the stairwell between the first and ground floor will be replaced by 11/30/06 2. All other fire gates will be inspected to insure that they are in good working order and repaired as needed by 11/30/06. 3. The supervisor will perform monthly checks of all gates to determine functional adequacy. 4. Findings will be reported to the Safety Committee and the department director for review on a monthly basis.	11/30/06

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	095021	A. BUILDING _____ B. WING _____	03/01/2006

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F 000	INITIAL COMMENTS An annual recertification survey was conducted February 28 through March 1, 2006. The following deficiencies were based on observations, staff interviews and record review. The sample included 10 residents based on a census of 29 on the first day of survey.	F 000	F 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 prepared solely as a matter of compliance with federal and/or state law.	
F 272 SS=D	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information	F 272		

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

[signature] | VHA | 3/24/06

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

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F 272	Continued From page 1 regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview for one (1) of 10 sampled residents, it was determined that facility staff failed to complete an admission Minimum Data Set (MDS). Resident #7. The findings include: A review of resident #7's record revealed that he /she was admitted to the facility on January 30, 2006. There was no evidence that a comprehensive admission MDS assessment was completed. According to the MDS manual page 2-3, " Admission Assessment must be completed by the 14th day of the resident's stay. The admission assessment is a comprehensive assessment for a new resident that must be completed within 14 calendar days of admission to the facility. " A face-to-face interview was conducted on March 1, 2006 at 9:00 AM with the MDS coordinator. The surveyor requested the MDS from the MDS coordinator." He/she stated, "the computers were down and the MDS could not be printed." A comprehensive MDS was not completed within 14 days upon admission to the facility. The	F 272	F 272 1. With respect to how corrective action was accomplished; the MDS has been retrieved, printed and placed in the resident medical record. 3/31/06 2. With respect to identifying other residents having the potential to be affected; the MDS Coordinator will audit current MDSs (since 2/11/06) to determine that they have been completed within 14 days of admission. 4/7/06 3. With respect to measures put in place or systemic changes made to prevent this practice; the DON will perform random audits of MDSs for timely completion. 4/13/06 4. With respect to how the community plans to monitor performance; the DON will monitor the audits and report to the QA Committee. 4/13/06	3/31/06 4/7/06 4/13/06 4/13/06

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F 272	Continued From page 2 record was reviewed on March 1, 2006.	F 272		
F 278 SS=E	483.20(g) - (j) RESIDENT ASSESSMENT The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and record review for four (4) of 10 sampled residents, it was determined that facility staff	F 278	F 278 1. With respect to how corrective action was accomplished; an RAC-C (Resident Assessment Coordinator- Credentialed) has been hired and is now responsible for the MDSs. She is currently working under supervised practice of the DON for 90 days (per the Registered Nursing Regulations Section 5411.9) 2/11/06	2/11/06

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F 278	Continued From page 3 failed to accurately code the Minimum Data Set (MDS) as evidenced by: two (2) residents coded for monitoring intake and output without clinical record support; Section I not inclusive of all active diagnoses for one (1) resident; and the Registered Nurse (RN) signed that the MDS was complete prior to other disciplines entering information for one (1) resident. Residents #1, 3, 5 and 8. The findings include: 1. Facility staff coded Resident #1 as being monitored for intake and output without clinical record support. A review of Resident #1's record revealed that a quarterly MDS dated January 6, 2006 and a significant change MDS dated October 9, 2005 was coded in Section P "Special Treatments and Procedures" for monitoring intake and output (P 1d). There was no evidence in the record that a physician's order or a nursing intervention was initiated to monitor intake and output. A face-to-face interview with the unit manager was conducted on February 28, 2006 at 2:30 PM. He/she acknowledged that the resident was not monitored for intake and output for the above cited dates. The record was reviewed February 28, 2006. 2. Facility staff coded Resident #3 as being monitored for intake and output without clinical record support. A review of Resident #3's record revealed that an annual MDS completed August 24, 2005 was	F 278	Resident # 1: The next MDS and future MDSs will be coded properly for intake and output. Resident # 3: as of 2/11/06, the MDSs will be coded properly for intake and output. Resident # 5: as of 2/11/06 the MDS and future MDSs will include all diagnoses appropriate to that review period. Resident # 8: The next MDS and future MDSs will be reviewed and signed by the RN after all other disciplines have completed their sections. 4/13/06 2. With respect to identifying other residents having the potential to be affected; the MDS Coordinator will review MDSs to determine that they are coded properly for intake and output, that they have all diagnoses and other disciplines have signed	4/13/06

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F 278	Continued From page 4 coded in Section P "Special Treatments and Procedures" for monitoring intake and output (P1 d). There was no evidence in the clinical record that a physician's order or a nursing intervention was initiated to monitor intake and output. A face-to-face interview with the unit manager was conducted on February 28, 2006 at 2:30 PM. He/she acknowledged that the resident was not monitored for intake and output for the above cited date. The record was reviewed February 28, 2006. 3. Facility staff failed to include all active diagnoses on the annual MDS for Resident #5. A review of Resident #5's record revealed that an annual MDS was completed on November 2, 2005. Section I, "Disease Diagnoses" did not include pancreatic insufficiency or Gastroesophageal Reflux Disease (GERD). A physician's order initiated December 23, 1998 and subsequently renewed every 30 to 60 days since that date directed, "Lipram 3 caps (13500 units) by mouth before meals three times daily - for pancreatic insufficiency." Additionally, a physician's order initiated July 13, 2004 and renewed every 30 to 60 days since that date directed, " Prevacid solutab 15 mg, [and give] one tab by mouth every day for GERD. " A face-to-face interview was conducted with the unit manager on February 28, 2006 at 2:30 PM. He/she acknowledged that the diagnoses were not coded on the resident's annual MDS. The record was reviewed February 28, 2006.	F 278	them prior to the RN review and signature. 4/13/06 3. With respect to measures put in place or systemic changes made to prevent this practice; the DON will perform random audits of MDSs for proper coding, diagnoses and signatures. 4/13/06 and ongoing 4. With respect to how the community plans to monitor performance; the DON will monitor the audits and report to the QA Committee. 4/13/06 and ongoing	4/13/06 4/13/06 and ongoing 4/13/06 and ongoing

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F 278	Continued From page 5 4. The RN failed to ensure that other disciplines had entered information on the admission MDS prior to signing under Section AA9 for Resident # 8. A review of Resident #8's record revealed an admission MDS signed by the RN coordinating the assessment (Section R2b) dated January 2, 2006. In Section AA9, "Signatures of persons who completed a portion of the accompanying assessment or tracking form" the physical therapist, dietician, and social worker's signatures were dated January 3, 2006, and the activity therapist's signature was completed January 4, 2006. According to the directions in the "MDS 2.0 Manual " , page 212, "The RN Assessment Coordinator must not sign and attest to completion of the assessment until all other assessors have finished their portions of the MDS." The record was reviewed March 1, 2006.	F 278		
F 279 SS=D	483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that	F 279	F 279 1. With respect to how corrective action was accomplished; for resident # 6, the care plan was updated to include antithrombotic usage. 3/2/06	3/2/06

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F 279	Continued From page 6 are to be fumished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under § 483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483 .10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and record review for two (2) of 10 sampled residents, it was determined that facility staff failed to develop a care plan for one (1) resident receiving antithrombotic therapy and one (1) resident based on the comprehensive assessment. Residents #6 and 9. The findings include: 1. Facility staff failed to care plan for the use of an antithrombotic for Resident #6. The resident's Physician Plan of Care (POC) dated February 16, 2006 included, " Aspirin 325 mg (one) 1 tablet qd (daily) for stroke prevention ." The interdisciplinary care plan did not 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.	F 279	2. With respect to identifying other residents having the potential to be affected; the records of residents receiving antithrombotic therapy were reviewed and care plans checked to ensure that they include goals and approaches for the therapy. 3/7/06 3. With respect to measures put in place or systemic changes made to prevent this practice; the DON or designee will perform random audits of charts of residents with antithrombotic therapy to ensure that the therapy is included in the care plans. 3/7/06 4. With respect to how the community plans to monitor performance; the DON or designee will monitor the findings and report to the QA Committee. 4/13/06	3/7/06 3/7/06 4/13/06

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F 279	Continued From page 7 2. Facility staff failed to develop a care plan based on the comprehensive assessment for Resident #9. A review of Resident #9's record revealed an annual Minimum Data Set (MDS) assessment dated April 1, 2005 and quarterly MDS assessments dated July 1, September 28 and December 28, 2005. In all MDS assessments cited above, the resident was coded in Section G, "Physical Functioning and Structural Problems" as being totally dependent for all ADLs: bed mobility, toileting, locomotion on and off the unit, dressing, eating, toilet use, personal hygiene and bathing. 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 " . 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	F 279	F 279 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 deficet. 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 monitor the audits and report findings to the QA Committee. 4/13/06	3/2/06 3/7/06 3/7/06 4/13/06

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F 279	Continued From page 8 not reflect the comprehensive assessment. The record was reviewed March 1, 2006.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review for one (1) of 10 sampled residents, it was determined that facility staff failed to update a care plan to include approaches and interventions for Resident #5 subsequent to one (1) fall. The findings include: A review of Resident #5's record revealed a	F 280	1. With respect to how corrective action was accomplished; the care plan for resident # 5 was updated with new approaches/interventions related to subsequent fall. 3/2/06 2. 2. With respect to identifying other residents 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 3. With respect to measures put in place or systemic changes made to prevent this practice; the DON or designee will monitor incident reports and update care plans after any falls. 3/7/06	3/2/06 3/7/06 3/7/06

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F 280	Continued From page 9 nurse's note dated January 28, 2006 at 8:25 PM, "At approximately 6:48 PM [visitor] rushed to the nursing station and informed writer that [Resident #5] was on the floor ...[Resident] able to perform ROM (range of motion) and follow directions ... " A review of Resident #5's care plan revealed a problem, "Fall Prevention Care Plan." Under the "Evaluation" column, the unit manager documented, "Resident sustained a fall in room with an abrasion measuring 1 x 1 cm. Area was cleansed with NS (normal saline) and left OTA (open to air)." There were no approaches or interventions initiated after the above cited fall to prevent the resident from further falls. A face-to-face interview with the unit manager was conducted on February 28, 2006 at 3:30 PM. He/she acknowledged that no interventions were initiated after the above cited fall. The record was reviewed February 28, 2006.	F 280	4. With respect to how the community plans to monitor performance; the DON or designee will report findings to the Safety Committee and QA Committee. 4/13/06	4/13/06
F 281 SS=D	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview for three (3) of 10 sampled residents, it was determined that facility staff failed to: update care plans quarterly for two (2) residents and coordinate one (1) resident's plan of care with the	F 281		

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F 281	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 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 quarterly according to the facility's policy.	F 281	F 281 1. 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 initiated by the facility. A care plan meeting is being held. 3/27/06 2. With respect to identifying other residents having the potential to be affected; Capital Hospice was notified that all future referrals must have a 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	3/27/06 3/2/06 3/2/06

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F 281	Continued From page 11 The care plan for Resident # 4 dated September 19, 2005 included the following problems: " Alteration in skin integrity related to incontinence and impaired mobility, Self care deficit related to Osteoporosis and Dementia, Noncompliant with care, Pain related to chronic migraine headache, Occasional incontinence of bladder and bowel, and Psychotropic drug use." There was no evidence that the care plan was updated. The record was reviewed February 28, 2006. A face-to-face interview was conducted with the Director of Nursing on February 28, 2006 at 11: 00 A.M. He/she stated, " The reason the care plans for Residents #2 and 4 were not updated was because the computers were down and not operable for approximately two months." The record was reviewed on February 28, 2006. 3. Facility staff failed to coordinate Resident #7's plan of care with the hospice agency according to the facility's policy. A review of the facility policy titled, "Hospice Program, page #33 Policy Interpretation and Implementation states, When a resident participates in the hospice program, a coordinated plan of care between the facility, hospice agency and resident/family will be developed and shall include directives for managing pain and other uncomfortable symptoms. The care plan shall be revised and updates as necessary to reflect the resident's current status." On February 15, 2006 Resident #7 was referred to Hospice care with the terminal diagnosis of "	F 281	4. With respect to how the community plans to monitor performance; the DON or designee will monitor the audits and report findings to the QA Committee. 4/13/06 1. With respect to how corrective action was accomplished; for resident # 2 and #4 quarterly care plans are updated. 3/2/06 2. 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	4/13/06 3/2/06 3/7/06

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F 281	Continued From page 12 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 patient. A note from the hospice nurse written on February 28, 2006 at 12:00 PM indicated, " Hospice nurse visit to assess, promote comfort, review chart and coordinate care with facility staff. Assessment to follow client repositioned for comfort, denies pain vital signs are as follow: respiration-24, pulse-80, blood pressure - 123/61 Assessment to follow." A review of the facility, "Care Plan Conference Summary " revealed that, there was no care plan conference held between the facility staff, the hospice agency 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 planned for the near future." The record was reviewed on March 1, 2006.	F 281	3. With respect to measures 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 Committee. 4/13/06	3/7/06 4/13/06
F 284 SS=D	483.20(l)(3) DISCHARGE SUMMARY When the facility anticipates discharge a resident must have a discharge summary that includes a post-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 to his or her new living environment. This REQUIREMENT is not met as evidenced	F 284		

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F 284	Continued From page 13 by: Based on the review of one (1) of one (1) closed clinical record, it was determined that facility staff failed to: ensure that the Transfer/Discharge Plan addressed Resident #10's continuing care needs; and obtain the resident's or responsible party's signature on the Transfer/Discharge Plan. The findings include: A. The facility failed to ensure that continued care needs were addressed on the "Transfer/ Discharge Plan." Resident #10 was admitted to the nursing unit on January 4, 2006 from the hospital as the result of a fall in an assisted living apartment (part of the residential community). During the review of nurses' notes, the resident was found on the floor on January 9, 2006; no injury was documented and on January 26, 2006 was found on the floor with an injury to his/her nose and was sent out 911 (emergency ambulance) to the hospital for evaluation. The resident's interdisciplinary care plan dated January 6, 2006 included goals and approaches for falls. One (1) of the interventions was, "place resident in falls preventions program to alert others to fall risk. " The resident was discharged from the nursing facility to his/her apartment on February 24, 2006 . There was no documentation in the record of an assessment for the resident's continued care needs, nor was there documentation on the Transfer/Discharge Plan of the resident's	F 284	F 284 1. With respect to how corrective action was accomplished; resident # 10, was safely discharged to Assisted Living. 2/24/06 2. With respect to identifying other residents having the potential to affect; nursing staff will document an assessment of continued care needs in the medical record and will obtain the resident or their responsible party's signature on all transfers/discharges. 4/1//06 3. With respect to measures put in place or systemic changes made to prevent this practice; the DON or designee will educate all nursing staff to ensure that continued care needs are addressed on the transfer/discharge summary and signatures obtained from the resident or responsibility	2/24/06 4/1//06

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F 284	Continued From page 14 continued care needs. B. Facility staff failed to obtain a signature from Resident #10 or his/her responsible party on the " Transfer/Discharge Plan". A physician's order dated February 23, 2006 indicated, "Transfer Pt. tomorrow to AL (Assisted Living) with copies of H&P (History and Physical, POS (Physician Order Sheet), problem list and advance directives." The "Transfer/Discharge Plan" with instructions was dated and signed February 24, 2006 by a licensed nurse; however, the form was not signed by the resident or the resident's responsible party to indicate that instructions were received by either party. The record was reviewed on March 1, 2006.	F 284	party and will audit the process. 4/1/06 4. With respect to how the community plans to monitor performance; the DON or designee will report and findings to the QA Committee. 4/13/06	4/1/06 4/13/06
F 314 SS=D	483.25(c) PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation and record review for one (1) of one (1) pressure ulcer treatment, it was determined that facility staff failed to follow the	F 314	1. With respect to how corrective action was accomplished; for resident # 8, the pressure ulcer has healed/closed. 3/2/06 2. With respect to identifying other residents having the potential to be affected; Residents with wound treatments were observed by the Dir. of Nursing during dressing changes to ensure the proper technique is followed. 4/1/06	3/2/06 4/1/06

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F 314	Continued From page 15 facility's policy when performing a pressure ulcer treatment for Resident #8. The findings include: Resident #8's pressure ulcer treatment was observed on March 1, 2006 at 7:05 AM. The 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.	F 314	3. 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 4. With respect to how the community plans to monitor performance; the DON or designee will report findings to the QA Committee. 4/13/06	4/1//06 4/13/06
F 329 SS=D	483.25(l)(1) UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. This REQUIREMENT is not met as evidenced	F 329	F 329 1. With respect to how corrective action was accomplished; for resident # 4; the behavior monitor record for antipsychotic medications was documented in the medical record as prescribed. 3/2/06	3/2/06

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F 329	Continued From page 16 by: Based on observation, record review and staff interview for one (1) of 10 sampled residents, it was determined that facility staff failed to consistently monitor the behavior of Resident #4 who was receiving antipsychotic medication. The findings include: A review of the facility policy titled, " Psychotropic Drug Use, # 7 page 5 effective 08/1 /02 revealed the following." " The customer's behavior is monitored using the behavioral monitoring chart or behavioral assessment record for customers receiving antipsychotic drugs for organic mental syndrome with agitated or psychotic behavior. The specific behavioral problems are tracked and documented as to the number of episodes or number of hours (if for pacing, yelling, or screaming) as determined by the interdisciplinary team care plan A review of Resident # 4's physician order written on July 19, 2005, "Seroquel 25mg tablet ½ tab (12.5mg) by mouth at bedtime for Delusion/ Agitation." A review of the Medication Administration Record (MAR) for October, November and December, 2005 and January and February, 2006, revealed that Resident #4 was administered Seroquel 12.5mg by mouth at 7:00 PM. A review of Resident #4's "Behavior Monitoring Flow Record" revealed that he/she was monitored for agitated behavior for October 2005 only. There was no evidence that the resident's	F 329	2. With respect to identifying other residents having the potential to be affected; records of residents receiving antipsychotic medications were reviewed to ensure Behavior Monitor Records are in place. 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 a monthly audit of the Medication Administration Records to verify that these medications have Behavior Monitoring records. 3/7/06 4. With respect to how the community plans to monitor performance; the DON or designee will report findings to the QA Committee. 4/13/06	3/7/06 3/7/06 4/13/06

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F 329	Continued From page 17 behavior was monitored for November and December 2005 and January and February 2006.	F 329	F 363 1. With respect to how corrective action was accomplished; No residents adversely affected. A tray card with the menu and portion sizes was available for each resident on each resident's tray. 2/28/06	2/28/06
F 363 SS=F	483.35(c) MENUS AND NUTRITIONAL ADEQUACY Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. This REQUIREMENT is not met as evidenced by: Based on observations and record review during the survey period, it was determined that dietary staff failed to prepare menus (spreadsheets) with portion sizes and trayline dietary staff were observed preparing entrees without directions for specific serving sizes. These findings were observed in the presence of the dietary manager. The findings include: 1. Menus failed to include portion sizes, in one (1) of one (1) observation on February 28, 2006. 2. Trayline dietary staff were observed preparing and serving meals on February 28, 2006 and March 1, 2006 without access to spread sheets to monitor and control the portion sizes served to residents on therapeutic diets, such as regular, no concentrated sweets, low cholesterol, pureed, mechanical and renal, in six (6) of six (6) observations between February 28, 2006 and March 1, 2006.	F 363	2. With respect to identifying other residents having the potential to be affected; spreadsheets with portion sizes will be added as back-up to current system. 3/27/06 3. With respect to measures put in place or systemic changes made to prevent this practice; dietary supervisory will ensure staff are trained/reminded to follow system and Dietician will periodically monitor compliance. 3/29/06 4. With respect to how the community plans to monitor performance; the Dietary manager or dietician will report findings to the QA Committee. 4/13/06	3/27/06 3/29/06 4/13/06

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F 371 SS=E	483.35(h)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by: Based on observations during the survey period, it was determined that dietary services were not adequate to ensure that food was served in a safe and sanitary manner as evidenced by: expired chocolate milk in the walk-in refrigerator; a soiled can opener with metal shavings on the gear and cutting surfaces; a stainless steel counter lacked covers to protect stored items from contamination; stainless steel plate covers were not allowed to dry before storing for reuse; hotel pans were not thoroughly cleaned and were not allowed to dry before storing for reuse; the refrigeration unit was inoperative; exhaust fans under cooking hoods failed to remove steam and smoke during meal preparation; a dietary staff person was observed working in the main kitchen without hair restraints and handling china ware without gloves; hotel pans used during breakfast and lunch meals were not cleaned within a 2 to 3 hour period; exhaust fans on the clean side of the dish machine lacked a cover and was not secured to the ceiling; wall surfaces of the dry food storage room failed to terminate at the ceiling; the air supply louver in the dishwasher area lacked a cover; and ceiling surfaces over the dishwasher were not plastered and painted. These findings were observed in the presence of the dietary manager.	F 371	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

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F 371	Continued From page 19 The findings include: 1. A crate of 25 cartons of chocolate milk with an expiration date of February 25, 2006 was stored in the walk in refrigerator, in one (1) of three (3) observations at approximately 9:00 AM on February 28, 2006. 2. A mechanical can opener was observed soiled with food residue and the cutting and gear surfaces were soiled with metal shavings in one (1) of one (1) observation at approximately 9:30 AM on February 28, 2006. 3. The stainless steel counter in the cook's preparation area lacked frontal covers which would protect chinaware and other items on shelves from contamination in one (1) of one (1) observation at approximately 9:45 AM on February 28, 2006. 4. Stainless steel plate covers were stored on shelves for reuse before allowing covers to fully dry in 37 of 61 observations at approximately 1: 05 PM on February 28, 2006. 5. Hotel pans stored in the pot and pan wash area were not thoroughly cleaned of food residue and pans were not allowed to dry before placing on racks for reuse in the following instances: Hotel pans 10 X 12 X 6"(inches) in six (6) of eight (8) observations on March 1, 2006 at approximately 10:00 AM. Hotel pans 8 X 12 X 20" in four (4) of seven (7) observations at 10:10 AM on March 1, 2006.	F 371	• Milk discarded 2/28/06 • Can opener cleaned 2/28/06 • Cover to be installed 3/28/06 • Stainless steel plate covers will be dried before storing on shelves. Inservice on proper procedure for drying prior to storage 3/17/06 • Pots and pans cleaned and dried before reuse. Inservice for proper cleaning and storage held. 3/17/06 • Refrigerator repaired 3/22/06 • Exhaust fans will be repaired 4/13/06 • In-service on gloves and hair nets 3/20/06 • Sufficient help scheduled and in-service conducted 3/20/06 • Fan repaired and covered 3/20/06	2/28/06 2/28/06 3/28/06 3/17/06 3/17/06 3/22/06 4/13/06 3/20/06 3/20/06 3/20/06

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OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID 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 _____	03/01/2006

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

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F 371	Continued From page 20 Hotel pans 12 X 24 X 4" in 23 of 24 observations at 10:20 PM on March 1, 2006. 6. The refrigeration unit located under the broiler grill was inoperative in the main kitchen in one (1) of one (1) observation at 9:45 AM on February 28, 2006. 7. Exhaust fans located under cooking hoods in the main kitchen were not operating efficiently to remove smoke and steam while the lunch meal was prepared at approximately 10:00 AM on February 28, 2006. 8. A dietary staff person was observed assisting with preparation of the dinner meal in the main kitchen without hair restraints and was handling chinaware without using gloves in one (1) of one (1) observation at approximately 1:20 PM on February 28,2006. 9. Hotel pans used to prepare the breakfast and lunch meals were not washed within a 2 to 3 hour period as evidenced by observation of soiled pans that remained in the sink and on counters in the pot and pan wash areas at 4:00 PM. Staff indicated that enough help was not available to complete the task before 4:00 PM. 10. The exhaust fan located in the ceiling on the clean side of the dish machine lacked a cover and was not secured to the ceiling in one (1) of one (1) observation at approximately 10:25 AM on February 28, 2005. 11. Wall surfaces in the dry food storage room adjacent to the walk-in refrigerator was not intact from the floor to the ceiling to prevent the	F 371	• Wall surfaces repaired. 3/20/06 • Louver repaired 3/17/06 • Ceiling repaired 3/17/06 2. With respect to identifying other residents having the potential to be affected; the Food Service Director monitored food areas to determine that no other similar conditions exist. 3/3/06 3. 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 4. 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. 4/13/06	3/20/06 3/17/06 3/17/06 3/3/06 3/3/06 4/13/06

revised 4/19/06

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F 371	Continued From page 21 transfer of smoke and pest infestation in one (1) of one (1) observation at 9:00 AM on February 28, 2006. 12. The air supply louver which disperses air from the ceiling in the dishwasher area lacked a cover in one (1) of one (1) observation at 9:48 AM on February 28, 2006. 13. Ceiling surfaces on the clean side of the dish machine were not plastered and painted and openings were observed around the exhaust fan in one (1) of one (1) observation at 10:50 AM on February 28, 2006.	F 371		
F 456 SS=D	483.70(c)(2) SPACE AND EQUIPMENT The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on an observation during the survey 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. The findings include: An oxygen concentrator was observed operating in room 221 without a filter, allowing unfiltered atmospheric air to enter the machine during oxygen therapy in one (1) of one (1) observation at 3:10 PM on February 28, 2006.	F 456	F 456 1. With respect to how corrective action was accomplished; the oxygen concentration filter was replaced. 3/2/06 2. With respect to identifying other residents having the potential to be affected; residents with oxygen concentration tanks were inspected to ensure a filter is in place. 3/2/06 3. With respect to measures put in place or systemic changes made to prevent this practice; the DON or designee will monitor the concentrators each time one is put into use and weekly, and will in-service staff to ensure that oxygen concentrated air is filtered. 4/1/06 4. With respect to how the community plans to monitor performance; the DON or designee will report findings to the QA Committee. 4/13/06	3/2/06 3/2/06 4/1/06 4/13/06

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F 492 SS=D	483.75(b) ADMINISTRATION The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. This REQUIREMENT is not met as evidenced by: Based on 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 and 22 DCMR 3203.2 by employing one (1) RN without a District of Columbia license. The findings include: 1. Facility staff failed to provide a RN on the night shift according to licensure regulations. According to 22 DCMR 3211.2, "Each facility shall have at least the following employees: (a) At least one (1) registered nurse on a twenty-four hour basis, seven (7) days a week ..." The facility's "Skilled Nursing Daily Staffing" schedules were reviewed from February 21 through 28, 2006. It was observed that a licensed practical nurse was assigned and worked the night shift (11:00 PM until 7:30 AM) on the following dates: February 21, 22, 23, 24, 27 and 28. A registered nurse was scheduled and worked the night shift Saturday and Sunday, February 25 and 26, 2006.	F 492	F 492 1. With respect to how corrective action was accomplished; the HR Director has hired an RN for night shift . The RN will begin employment on 3/31/06.	3/31/06

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F 492	Continued From page 23 Additionally, a "Master Schedule for Resident Care Managers" dated March 10 through April 6, 2006 was reviewed. Hand written on the schedule was "revised 2/18/06". The projected four (4) weeks, scheduled a licensed practical nurse for Monday through Friday. A registered nurse was assigned for the night shift on Saturday and Sunday. On March 1, 2006 at approximately 2:00 PM a face- to- face interview was conducted with the licensed nursing home administrator who acknowledged that a registered nurse was not consistently assigned for the night shift. He/she indicated that the Human Resource Department was recruiting for additional staff. Facility staff failed to provide 24 hour nursing coverage by a registered nurse for the nursing facility. The staffing sheets were reviewed on February 28, 2006. 2. The facility failed to ensure that the Minimum Data Set (MDS) coordinator had a District of Columbia registered nurse license. A review of licenses revealed that the RN, employed as the MDS coordinator for the facility, began working at the facility on February 6, 2006 . There was no District of Columbia registered nurse license maintained by the Human Resources department at the facility. The MDS RN wrote a quarterly assessment in a resident's record, dated March 1, 2006 and signed his/her name and the state that issued the	F 492	2. With respect to identifying other residents having the potential to be affected; the HR Director will continuously recruit/hire to ensure that there are no gaps in coverage. 4/1/06 3. With respect to measures put in place or systemic changes made to prevent this practice; the HR Director will monitor the schedule to determine no RN slots are vacant. DON will immediately report any RN vacancies. 4/1/06 4. With respect to how the community plans to monitor performance; the HR Director and DON will report to ED during weekly stand-up meetings. 4/13/06	4/1/06 4/1/06

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F 492	Continued From page 24 RN license. This note was co-signed by the Director of Nursing. Upon interview with the RN on March 1, 2006 at 10:30 AM, he/she acknowledged that he/she did not have a District of Columbia nursing license and showed the surveyor an incomplete District of Columbia RN license application. The nurse stated, " I thought if the Director of Nursing co-signed my notes and supervised me, it would be 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 be authorized to engage in supervised practice of registered nursing in the District of Columbia without a District of Columbia license if the applicant: ...(c) Has an initial application pending for licensure by endorsement in the District of Columbia. " According to Chapter 32, " Skilled Care Facilities " of Title 22, " Public Health and Medicine" DCMR, 3203.2, " 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." The facility employed a registered nurse for three (3) weeks without a District of Columbia registered nurse license. The licenses were reviewed on February 28, 2006.	F 492	1. With respect to how corrective action was accomplished; an RAC-C (Resident Assessment Coordinator- Credentialed) has been hired and is now responsible for the MDSs. She is currently working under supervised practice of the DON for 90 days (per the Registered Nursing Regulations Section 5411.9) 2/11/06 2. With respect to identifying other residents having the potential to be affected; an audit has been conducted to ensure that all nurses have District of Columbia licenses. 3/14/06 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 weekly stand-up meeting. 4/13/06	2/11/06 3/14/06 3/14/06 4/13/06

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K 000	INITIAL COMMENTS The annual Life Safety Code survey was conducted on March 1, 2006. The following deficiency was cited based on observations and record review.	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 prepared solely as a matter of compliance with federal and/or state law.	
K 050 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on observations and record review during the Life Safety Code inspection, it was determined that fire drills were not conducted quarterly as required. These findings were observed in the presence of the maintenance director. The findings include: Documentation was not available to support that fire drills were conducted during the second and third shifts of the third quarter and first, second and third shifts of the fourth quarter for the year 2005 in five (5) of 12 observations between 11:30 and 4:00 PM on March 1, 2006.	K 050	K 050 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 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	3/6/06 3/23/06

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

HSA 3/24/06

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

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			3. With respect to measures put 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	3/31/06
			4. 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