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

PRINTED: 05/31/2
FORM APPROV
OMB NO. 0938-0

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 ______	R 05/21/2007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS A follow-up survey to the annual re-certification survey (March 20 through 22, 2007) was conducted on May 21, 2007. An Immediate Jeopardy (IJ) in the area of CFR 483.25 (h) (1), F323 was identified on May 21, 2007 at 11:19 AM. The facility Executive Director and Corporate Representative were informed of the IJ and a plan of action to address the issue of resident safety was received. The IJ remained in effect until approximately 1:30 PM. The following deficiencies were based on record review, observations and staff interviews. The sample included six (6) residents based on 60% of the annual re-certification survey and three (3) supplemental residents.	{F 000}	Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusion set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with federal and state law.	All completion dates as state in original POC and/or June 22, 2007 [handwritten initials]
F 253 SS=D	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview during the tour of the main kitchen, it was determined that the facility staff failed to provide maintenance services necessary to maintain a safe environment as evidenced by the absence of tile on the floor of the janitorial closet and a hole in the ceiling. The findings include: On May 21, 2007 at approximately 2:30 PM, in the presence of Employee #5; the following was observed:	F 253	F253 1. Janitorial closet will be replaced by June 22, 2007. In addition, the water pipes located in the closet will be sealed by June 22, 2007 and the hole in the ceiling will be repaired by June 22, 2007. 2. Kitchen rounds have been conducted to identify any other areas that need tiling or sealing. All ceiling areas in the Kitchen were also inspected to identify any open areas. No other areas were identified that are in need of tiling, sealing or hole repairs.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: N. Casey Lady, RN 6/28/07 TITLE: Dir of Nursing (X6) 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.

Revised POC Rec'vd 6/28/07

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

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F 253	Continued From page 1 1. The janitorial closet, located at the back of the main kitchen, had no tile on the floor. There was no closure around the water pipes located in the closet. Employee #5 stated, "That should have been done last year." 2. A one (1) foot by two (2) foot hole in the ceiling tile, was observed above an exit door near the entrance to the kitchen. Employee #5 stated, "I don't know why there is a hole there. They need to fix that." Employee #5 acknowledged the aforementioned findings at the time of the observations.	F 253	~~3.~~ In-services will be provided to kitchen staff on the need to ensure a safe kitchen environment as related to floor and ceiling tiling and sealing of water pipes in closets. Kitchen rounds will be completely on a daily basis by Dining Service Coordinator and/or their designee. If areas are identified to be in need of repair, the Maintenance department will be contacted and repairs completed promptly. 4. Dining Service Coordinator or designee will monitor the kitchen daily for compliance. Rounds will be completed and deficient practices will be documented and analyzed. ~~Immediate action will be taken, if~~ indicated. On a monthly basis, the findings of the kitchen rounds and corrective actions will be reported at the Quality Assurance meeting. The Quality Assurance report will drive staff education, changes in practice and/or procedure, if indicated.	6/22/07
{F 279} SS=D	483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	{F 279}	**F279** 1. Interim care plans for residents number 6 and T1 were completed by the Director of Health Services during survey, May 21, 2007 to reflect needed services to obtain or maintain the resident's highest practicable, physical, mental, and psycho-social well being.	

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{F 279} SS=D	483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	{F 279}		6/22/07

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{F 279}	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of six (6) sampled residents and one (1) supplemental resident, it was determined that facility staff failed to initiate a care plan with appropriate goals and approaches for the assessment and care for: one (1) resident with back pain, receiving antibiotic therapy and a history of constipation and Hypertension; and one (1) resident receiving anticoagulant and antibiotic therapy and a history of Atrial Fibrillation, Hyperlipidemia and Hypertension. Resident #6 and T1. The findings include: 1. Facility staff failed to initiate care plans with goals, approaches and interventions to address pain management, antibiotic therapy for an Urinary Tract Infection (UTI), constipation and Hypertension for Resident #6. Resident #6 was admitted to the facility on May 14, 2007. Physician's orders signed and dated May 14, 2007 included OxyContin for pain, Senna for constipation, Linezolid for the UTI and two (2) medications for Hypertension. During the review of the clinical record, a hospital discharge summary dated May 14, 2006 was reviewed and indicated that the resident was treated for back pain, an UTI, constipation and Hypertension. The record failed to include initial care plans to address the resident's pain, UTI, constipation and Hypertension. A face-to-face interview was conducted with Employee #13 on May 21, 2007 at approximately	{F 279}	2. All recent admissions care plans will be audited by Director of Health Services or designee to determine if an interim care plan has been developed to address needed services to obtain or maintain the resident's highest practicable, physical, mental, and psycho-social well being. If an interim care plan is needed, one will be developed promptly. 3. Current nursing staff will be in-serviced by Director of Health Services or designee on the need to develop an interim care plan that addresses the immediate needs at time of admission. In-servicing will be included during the new hire orientation process. DNS or designee will review random admission health information files to ensure that interim care plans are in place. 4. On a continuing basis, the Director of Nursing, or their designee will audit recent admission care plans to determine if an interim care plan has been developed. Immediate action will be taken when indicated. The results of this audit and corrective action taken, will be reported at the Quality Assurance monthly meetings. Data collected will be analyzed and drive staff development. During quarterly Quality Assurance meetings, all community data will be reviewed and discussed with practice and/or procedural changes made as indicated.	6/22/07

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{F 279}	Continued From page 3 11:00 AM who acknowledged that the resident lacked initial care plans. The record was reviewed on May 21, 2007. 2. Facility staff failed to initiate care plans with goals and approaches to address anticoagulant and antibiotic therapy, atrial fibrillation, Hyperlipidemia and Hypertension for Resident T1. According to the admission orders signed by the physician on May 18, 2007, the resident was receiving the following medications: Lovenox (anticoagulant) Amiodarone (antiarrhythmic) Lopressor and Lasix (antihypertensive), Lovastatin (Hyperlipidemia) and Cipro (antibiotic).	{F 279}		
	According to the History and Physical form completed by the physician on May 18, 2007, diagnoses included: Pulmonary Embolism, Hypertension, Atrial Fibrillation and Hyperlipidemia. A review of Resident T1's record revealed no evidence that care plans were initiated with goals and approaches for anticoagulant and antibiotic therapy, atrial fibrillation, Hyperlipidemia and Hypertension. A face-to-face interview was conducted with Employee #13 on May 21, 2007 at approximately 4:20 PM. He/she acknowledged that the care plans were not initiated. The record was reviewed on May 21, 2007.			
{F 314} SS=E	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	{F 314}		

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{F 314}	Continued From page 4 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 observations and staff interviews for two (2) of three (3) residents with pressure ulcers, it was determined that proper infection control procedures were not followed to prevent infection during pressure ulcer treatments. Residents #5 and H2.	{F 314}	F314 1. Current nursing staff have been in-serviced on maintaining a protective barrier / clean field when placing supplies on an over bed table prior to beginning pressure ulcer treatment. In addition, current nursing staff has been in-serviced on proper disposal of biohazard soiled dressing materials and cleaning of over bed table upon completion of the treatment. 2. Current nursing staff providing wound care has been observed to determine if proper clean protective barriers and proper infection control practices are followed. If deficient practice is	
	The findings include: Facility staff failed to follow proper infection control procedures during pressure ulcer treatments for Resident #5 and H2. On May 21, 2007 at approximately 9:25 AM a pressure ulcer treatment was observed for Resident #5 and at approximately 10:50 AM a pressure ulcer treatment was observed for Resident H2. Employee #3 rolled the treatment cart with a plastic bag attached to the side of the cart outside of Resident #5 ' s room. He/she entered the room with a container of supplies and a bottle of liquid hand cleanser. The container of supplies and the hand cleanser were placed on the resident's over bed table without cleaning or the use of a protective barrier to open supplies. He/she proceeded to administer the treatment with the use of a liquid hand cleanser between		observed, 1:1 in-servicing will occur and corrective actions will be implemented. 3. All supplies in treatment cart have been individually bagged, and now include biohazard trash bags for disposal of biohazard dressing materials and disinfectant wipes to wipe down over bed tables. Licensed staff in-serviced on proper wound care techniques to include infection control practices and disposal of biohazardous waste. New licensed team members will be trained on proper wound care techniques. 4. DNS and/or designee will complete random observations of wound care weekly for a month and then quarterly to ensure proper technique is followed. Immediate action will be taken when indicated. The results of these observations and corrective action taken will be reported at the Quality Assurance monthly meeting. Data collected will be used to drive staff development.	6/22/07

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{F 314}	Continued From page 5 glove changes. At the completion of the treatment, the soiled dressing was discarded in a plastic bag which was closed, removed from the resident's room and placed in a non-biohazardous plastic bag that was attached to the treatment cart. Employee #3 failed to clean the over bed table after the treatment. The treatment cart was then rolled to Resident H2's doorway who was scheduled for the next treatment. Employee #3 failed to clean the over bed table prior to and after the pressure ulcer treatment for Resident H2. The same supply container and hand cleanser bottle were placed on Resident H2's over bed table without a protective barrier. The soiled dressing was contained in a plastic bag and disposed of in a non-biohazardous bag attached to the treatment cart. A face-to-face interview was conducted on May 21, 2007 at approximately 4:35 PM with Employee #3 who acknowledged that he/she was unaware that the over bed table required cleaning prior to and after the pressure ulcer treatment and that the soiled dressings should have been disposed of immediately. A face-to-face interview was conducted with Employee #1 on May 21, 2007 at 5:30 PM. He/she stated, "Once the dressing change is done, the trash should be immediately taken to the trash room and disposed of in a bio-hazardous container."	{F 314}		
F 323 SS=J	483.25(h)(1) ACCIDENTS The facility must ensure that the resident environment remains as free of accident hazards as is possible.	F 323	F323 1. The stove with gas burners was repaired at the time of the survey on May 21, 2007. The burners were cleaned by kitchen staff and an outside company inspected the gas burners to ensure proper igniting. The open area in the service area floor has been repaired.	

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F 323	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observations, staff interview and review of a maintenance request form, it was determined that facility staff failed to maintain an environment free of possible accident hazards as evidenced by: facility staff lighting the burners on the gas stove with paper. This resulted in Immediate Jeopardy (IJ). In addition, an unsecured covering was observed over a hole near the janitorial closet in the main kitchen. The findings include: 1. Facility staff failed to ensure the safety of residents and staff from a possible accident hazard by lighting the burners on the gas stove in the main kitchen with paper. During a tour of the main kitchen at 8:20 AM on May 21, 2007, a white residue was observed on two (2) of the eight (8) burners on the gas stove. When asked what the white residue was, Employee #6 stated, "The burners don't ignite so the staff lights the stove with paper. That's the leftover paper." Each burner was tested and five (5) of the eight (8) burners failed to ignite. Employee #7 who prepared the breakfast meal and was beginning to prepare the soup for dinner was asked if he/she had used any burners on the stove this morning at approximately 8:30 AM on May 21, 2007. Employee #7 answered, "I only use the burners that work. Some of them don't work so I don't use those." Employee #7 turned	F 323	2. All stoves with gas burners where inspected to determine if they properly ignited. In addition, the service area floor was inspected to determine if there are additional holes in the flooring. No issues were identified with regard to the gas burners and service area flooring. 3. In-services will be provided to the kitchen staff on proper lighting of gas burners. On a weekly basis, the gas burner will be inspected and cleaned as needed. In addition, the maintenance employees will be in-serviced on the need to secure service area flooring covers during repairs. Kitchen rounds will be completed on a daily basis by Dining Services Coordinator or their designee, utilizing the attached rounds sheet. If areas are identified to be in need of repair, the Maintenance department will be contacted and a work order will be submitted to address any identified areas. 4. Dining Service Coordinator or their designee will monitor the kitchen daily for compliance. Rounds will be completed and deficient practices will be documented and analyzed. Immediate action will be taken, if indicated. On a monthly basis, the findings of the kitchen rounds and corrective actions will be reported at the Quality Assurance meeting. The Quality Assurance report will drive staff education, changes in practice and/or procedure, if indicated.	review received 6/28/07 TB 6/22/07

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F 323	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observations, staff interview and review of a maintenance request form, it was determined that facility staff failed to maintain an environment free of possible accident hazards as evidenced by: facility staff lighting the burners on the gas stove with paper. This resulted in Immediate Jeopardy (IJ). In addition, an unsecured covering was observed over a hole near the janitorial closet in the main kitchen. The findings include: 1. Facility staff failed to ensure the safety of residents and staff from a possible accident hazard by lighting the burners on the gas stove in the main kitchen with paper. During a tour of the main kitchen at 8:20 AM on May 21, 2007, a white residue was observed on two (2) of the eight (8) burners on the gas stove. When asked what the white residue was, Employee #6 stated, "The burners don't ignite so the staff lights the stove with paper. That's the leftover paper." Each burner was tested and five (5) of the eight (8) burners failed to ignite. Employee #7 who prepared the breakfast meal and was beginning to prepare the soup for dinner was asked if he/she had used any burners on the stove this morning at approximately 8:30 AM on May 21, 2007. Employee #7 answered, "I only use the burners that work. Some of them don't work so I don't use those." Employee #7 turned	F 323	F323 1. The stove with gas burners was repaired at the time of the survey on May 21, 2007. The burners were cleaned by kitchen staff and an outside company inspected the gas burners to ensure proper igniting. The open area in the service area floor has been repaired. 2. All stoves with gas burners where inspected to determine if they properly ignited. In addition, the service area floor was inspected to determine if there are additional holes in the flooring. No issues were identified with regard to the gas burners and service area flooring. 3. In-services will be provided to the kitchen staff on proper lighting of gas burners. On a weekly basis, the gas burner will be inspected and cleaned as needed. In addition, the maintenance employees will be in-serviced on the need to secure service area flooring covers during repairs. Kitchen rounds will be completed on a daily basis by Dining Services Coordinator or their designee, utilizing the attached rounds sheet. If areas are identified to be in need of repair, the Maintenance department will be contacted and a work order will be submitted to address any identified areas. 4. Over the next 8 weeks, Dining Service Coordinator or their designee will monitor the daily kitchen rounds for compliance. On a monthly basis, the findings of the kitchen rounds and any necessary corrective action taken will be reported at the Quality Assurance.	6/22/07 revision requested [illegible] 6/22/07

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 ____	R 05/21/2007

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

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F 323	Continued From page 7 on the two (2) burners used for the breakfast meal and both ignited. A face-to-face interview was conducted with Employee #6 on May 21, 2007 at 8:35 AM. He/She stated that the burners had not been working for more than a week. He/she presented a copy of a maintenance request to repair the stove dated May 11, 2007 at 9:00 AM. The work order noted that six (6) parts were on order for the burners. At 9:45 AM on May 21, 2007, Employee #5 was queried if he/she was aware of any problems with the stove. Employee #5 replied, "Some of the burners don't ignite when turned on. There was a work order put in about a week or so ago. We are waiting for the parts to arrive. The injectors are clogged and need to be cleaned." Employee #5 was asked if he/she was aware that staff were lighting the burners with paper. Employee #5 stated, "Yes, I know. They shouldn't do that. It's not safe." 2. Facility staff failed to ensure that a covering over a hole in the main kitchen was secure. During a tour of the main kitchen, an unsecured covering over a hole near the janitorial closet was observed in the presence of Employee #5 at 1:30 PM on May 21, 2007. There was an area of flooring across from the janitorial closet, currently under repair, approximately 2 x 4 feet, covered by two (2) pieces of metal supporting a yellow safety cone that was attached to the walls with electrical wire. The metal plates were not secured to the floor and easily moved to expose the hole in the floor.	F 323		

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F 323	Continued From page 8 At the time of the observation, Employee #5 stated, "Maintenance was just working there yesterday, but they should secure the covering so no one falls through the hole or hurts themselves."	F 323		
{F 333} SS=D	483.25(m)(2) MEDICATION ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview for two (2) supplemental residents, it was determined that licensed staff failed to ensure that one (1) resident correctly administered an inhaler and one (1) resident received medication as ordered by the physician. Residents JH1 and T1. The findings include: 1. Licensed staff failed to ensure that Resident JH1 correctly administered an inhaler. The annual MDS (Minimum Data Set) dated December 25, 2006, Section I (Disease Diagnoses) included Asthma. According to the facility's policy "Oral Inhalation Administration Procedure", Section: III B: 9, Page:1 of 2, " Purpose: To allow correct administration of oral inhaler to resident, and for instruction in proper technique for those residents able to administer the medication to themselves... Procedures: Shake the inhaler. Attach the aerochamber or spacer device, if indicated...	{F 333}	F333 1. Residents # JH1 and T1 have had their medications properly administered. 2. All residents that are prescribed inhalers will have their orders reviewed, ensure medications are available, and the nursing staff / residents will be in-service/educated for proper administering of inhalers. Licensed nurse will observe residents for return demonstration of proper use of inhaler. If after education and training, resident refuses to follow established administration protocols, attending MD will notified and care plan/health information record will reflect resident's decision. 3. The nursing staff will be in serviced on proper inhaler administration and proper return demonstration by residents who self-administer inhalers, as ordered by their physicians. Resident health information record will reflect training and outcome of return demonstration. If resident refuses to follow established protocols, attending MD will be called and care plan/health information record will reflect resident's decision. 4. Director of Nursing or their designee will conduct observation rounds to monitor inhaler administration compliance. The findings and any necessary corrective action taken will be reported at the Quality Assurance monthly meetings. Data collected will be used to drive staff development and patient education.	6/22/07

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

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F 323	Continued From page 8 At the time of the observation, Employee #5 stated, "Maintenance was just working there yesterday, but they should secure the covering so no one falls through the hole or hurts themselves."	F 323	F333 1. Residents # JH1 and T1 have had their medications properly administered. 2. All resident that are prescribed inhalers will have their orders reviewed, ensure medications are available, and the nursing staff / residents will be in-service/educated for proper administering of inhalers. Residents and licensed nurse observe for return demonstrations. If after education and training, resident refuses to follow established administration protocols, attending MD will notified and care plan/health information record will reflect resident's decision. 3. The nursing staff will be in serviced on proper inhaler administration and proper observation of residents who assist in the administration of the inhaler. Resident health information record will reflect training and outcome of return demonstration. If resident refuses to follow established protocols, attending MD will be called and care plan/health information record will reflect resident's decision. 4. Over the next 8 weeks, Director of Nursing or their designee will conduct observation rounds to monitor for inhaler administration compliance. The findings and any necessary corrective action taken will be reported at the Quality Assurance monthly meetings	6/22/07 revised [illegible] TEI 6/22/07
{F 333} SS=D	483.25(m)(2) MEDICATION ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview for two (2) supplemental residents, it was determined that licensed staff failed to ensure that one (1) resident correctly administered an inhaler and one (1) resident received medication as ordered by the physician. Residents JH1 and T1. The findings include: 1. Licensed staff failed to ensure that Resident JH1 correctly administered an inhaler. The annual MDS (Minimum Data Set) dated December 25, 2006, Section I (Disease Diagnoses) included Asthma. According to the facility's policy "Oral Inhalation Administration Procedure", Section: III B: 9, Page:1 of 2, " Purpose: To allow correct administration of oral inhaler to resident, and for instruction in proper technique for those residents able to administer the medication to themselves... Procedures: Shake the inhaler. Attach the aerochamber or spacer device, if indicated...	{F 333}		

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{F 333}	Continued From page 9 Have the resident rinse his/her mouth and spit out the rinse water..." On May 21, 2007, at approximately 10:00 AM, during medication pass, Resident JH1 administered both of his/her inhalers, Adair 500/50 mg and ProAir HFC, in the presence of Employee #3. The resident did not follow the correct procedure for administering the inhalers. The resident did not shake the inhaler, did not space the inhaler properly nor did he/she rinse his/her mouth after use. Employee #3 did not stop the resident at any time and instruct him/her in the proper technique. A face-to-face interview was conducted with the Employee #3, on May 21, 2007 at 1:00 PM. He/She stated, "The resident likes to administer [his/her] own inhaler". 2. Licensed staff failed to administer two (2) inhalant medications to Resident T1 as ordered by the physician. According to the physician's order signed and dated May 19, 2007 at 10:20 PM " ...Advair discus 250/50 inhalation bid [twice a day] COPD, Spiriva inhalation PO [by mouth] Q [every day] - COPD (Chronic Obstructive Pulmonary Disease)..." A review of the Medication Administration Record for May 2007 revealed that Advair and Spiriva were not administered on May 20, 2007 as ordered by the physician. On May 21, 2007 at 10:35 AM an observation of Resident T1's medication revealed that a box of Advair and Spiriva was present. The boxes were	{F 333}		

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

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{F 333}	Continued From page 10 unopened. A face-to-face interview was conducted with Employee #3 at approximately 10:35 AM. He/she stated, "The medication must have arrived sometime yesterday (Sunday, May 20, 2007). It was here when I got to work this morning (Monday, May 21, 2007). I don't know why they didn't give it at least once yesterday. I am going to give them to [him/her] now." The resident was observed on May 21, 2007 at 8:30 AM, 1:00 PM and 3:45 PM. [Resident] was not observed to be in any distress at the time of the observations. The record was reviewed on May 21, 2007.	{F 333}		
F 363 SS=D	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 observation, staff interview, record review and review of menus for three (3) of 22 residents, it was determined that facility staff failed to prepare diets as ordered by the physician for three (3) residents with special nutritional needs and offer substitutions for certain foods that one (1) resident disliked. Residents #2, 4 and T1. The findings include:	F 363	F363 1. Dietician in serviced staff regarding Renal diet. Dietician reviewed and approved all diets ordered within the community. Residents #2 and T1 have received diets as prescribed by the physician. Resident # 4 has received the proper textured modified diet as prescribed by the physician. In addition, Resident #T1 has been interviewed to determine her likes / dislikes. 2. An audit will be completed for all residents to confirm diet that is served is the diet that is prescribed. If any discrepancies are identified, proper orders will be obtained and proper diets will be served. In addition, residents will be re-interviewed to confirm their likes and dislikes. The resident's likes and dislikes will be noted in resident's health information record and diet card in dietary.	

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

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F 363	Continued From page 11 A face-to-face interview was conducted with Employee #5 at 9:45 AM on May 23, 2007. He/she stated, "I only prepare a regular diet meal. I don't cook any special diets like renal, low fat or diabetic. I puree foods for those residents needing a pureed diet and I chop the food up for the mechanical diets." A review of the recipe book for "Week 4" (menus for the current week) revealed menus for a regular diet. There were no menus in the recipe book for those residents with special nutritional needs. The nursing facility unit is located on the second floor of the facility. A face-to-face interview with Employee #14, assigned to the second floor kitchen, was conducted on May 21, 2007 at 10:30 AM. He/she stated, "The hot food comes up here from the main kitchen. I serve it and include all the other things like drinks, bread and dessert. For the residents on no concentrated sweets, I give them a sugar substitute and diet dessert. For the no added salt diets I don't add any salt on the tray. For [Resident #2 - renal diet] I don't give [him/her] potatoes or tomatoes. Those are all the special diets we have. All that information is printed on the individual meal ticket for each resident." The unit currently serviced 23 residents. One (1) resident received all nutrition through a gastrostomy tube. Twenty-two meal tickets were reviewed and the diets were as follows: 7 regular diets with no restrictions 4 regular mechanical (soft) with no restrictions 2 regular pureed with no restrictions	F 363	3. The kitchen staff will be in serviced on the need to offer, prepare and serve the proper diets as prescribed by the physician to the residents. Included in the in-service will be ensuring that resident likes and dislikes are observed. At the time of meal delivery, the meal tickets and tray will be checked to confirm proper diets are being served and dislikes / likes are being observed. If any discrepancies are identified, the meal tray will be corrected prior to serving to the residents. Discrepancies will be noted and communicated to the Dining Services Coordinator for follow up corrective action. 4. Registered dietician has reviewed all diet orders and reconciled the "Week at a Glance" spreadsheet. Audits completed by registered dietician are shared with Dining Services Coordinator or designee to ensure that diet ordered is diet served to resident. Dining Services Coordinator or designee will perform random cross checks between generated diet sheet and food served. Any discrepancies will be corrected immediately. The registered dietician will report issues related to diet at quarterly Quality Assurance meeting. The Quality Assurance report will drive staff education, changes in practice and/or procedure, if indicated.	Nurse received 6/28/07 6/22/07

PRINTED: 05/31/2007
FORM APPROVED
OMB NO. 0938-0391

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

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F 363	Continued From page 11 A face-to-face interview was conducted with Employee #5 at 9:45 AM on May 23, 2007. He/she stated, "I only prepare a regular diet meal. I don't cook any special diets like renal, low fat or diabetic. I puree foods for those residents needing a pureed diet and I chop the food up for the mechanical diets." A review of the recipe book for "Week 4" (menus for the current week) revealed menus for a regular diet. There were no menus in the recipe book for those residents with special nutritional needs. The nursing facility unit is located on the second floor of the facility. A face-to-face interview with Employee #14, assigned to the second floor kitchen, was conducted on May 21, 2007 at 10:30 AM. He/she stated, "The hot food comes up here from the main kitchen. I serve it and include all the other things like drinks, bread and dessert. For the residents on no concentrated sweets, I give them a sugar substitute and diet dessert. For the no added salt diets I don't add any salt on the tray. For [Resident #2 - renal diet] I don't give [him/her] potatoes or tomatoes. Those are all the special diets we have. All that information is printed on the individual meal ticket for each resident." The unit currently serviced 23 residents. One (1) resident received all nutrition through a gastrostomy tube. Twenty-two meal tickets were reviewed and the diets were as follows: 7 regular diets with no restrictions 4 regular mechanical (soft) with no restrictions 2 regular pureed with no restrictions	F 363	F363 1. Residents #2 and T1 have received diets as prescribed by the physician. Resident # 4 has received the proper textured modified diet as prescribed by the physician. In addition, Resident #T1 has been interviewed to determine her likes / dislikes. 2. An audit will be completed for all residents to confirm diet that is served is the diet that is prescribed. If any discrepancies are identified, proper orders will be obtained and / or proper diets will be served. In addition, residents will be re-interviewed to confirm their likes and dislikes. The resident's likes and dislikes will be noted in resident's health information record and diet card in dietary. 3. The kitchen staff will be in-serviced on the need to offer, prepare and serve the proper diets as prescribed by the physician to the residents. Included in the in-service will be ensuring that resident likes and dislikes are observed. At the time of meal delivery, the meal tickets and tray will be checked to confirm proper diets are being served and dislikes / likes are being observed. If any discrepancies are identified, the meal tray will be corrected prior to serving to the residents. Discrepancies will be noted and communicated to the Dining Services Coordinator for follow up corrective action. 4. Over the next 8 weeks, Dining Service Coordinator or their designee will report discrepancies and corrective action taken at the Quality Assurance monthly meetings.	6/22/07 review requested 6/22/07

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F 363	Continued From page 12 1 regular with no pork and no added salt 1 regular no added salt, no concentrated sweets 1 regular with no added salt 1 no concentrated sweets 1 mechanical, no added salt, no concentrated sweets 1 mechanical, no concentrated sweets, no added salt, lactose intolerant 1 regular no added salt, low fat 1 regular low fat, low cholesterol 1 mechanical, renal no added salt, no concentrated sweets Twenty-two (22) residents were observed during the dinner meal between 5:10 PM and 5:30 PM. Nineteen (19) of 22 residents received the appropriate diets. 1. Facility staff failed to prepare/serve appropriate foods for Resident #2's diet as prescribed by the physician. According to Resident #2's record, a physician's order dated May 18, 2007 directed, "Renal Diet". The resident had a diagnosis of ESRD (End Stage Renal Disease). The resident's meal ticket included, "No concentrated sweets and no added salt." The foods that are to be limited or avoided for Resident #2 (those high in potassium and phosphorous), were not listed on the resident's meal ticket. The dinner meal for Resident #2 was observed being prepared on May 21, 2007 at 5:22 PM. The meal consisted of a cup of chicken gumbo soup (tomato base), chicken [alternate meat], pasta, carrots, a dinner roll, cranberry juice and vanilla	F 363		

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

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F 363	Continued From page 13 ice cream. The "Week at a Glance" spread sheet for week four (4) of May 2007, for a renal diet with no concentrated sweets, was prepared by the dietician (no date indicated). The meal was to consist of chicken rice soup, spaghetti with beef and gravy, California vegetable mix, bread, and applesauce. There was no evidence that the dietician approved the substituted foods actually served. On May 21, 2007 at 5:30 PM a face-to-face interview was conducted with Employee #15. He/She was asked if any other soup was prepared as an alternate choice. Employee #15 stated, " No. Folks seem to like this chicken gumbo soup. I serve what's on the meal ticket. That lists all the dislikes and things the resident can't have or doesn't want." There was no evidence that chicken rice soup, spaghetti with beef and gravy and California vegetable mix were prepared as directed by the dietician. 2. Facility staff failed to follow physician's orders for the texture of Resident #4's meals. Resident #4 was ordered a mechanical soft diet by the physician on May 18, 2007. On May 21, 2007 at 5:10 PM the preparation of the dinner meal was observed. The meal consisted of pureed beef, macaroni and tomato casserole, pureed carrots and mashed potatoes. The meal ticket was printed as "Pureed." On May 21, 2007 at 5:30 PM a face-to-face interview was conducted with Employee #15. He/She was asked about Resident #4's diet.	F 363		

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

PRINTED: 05/31/2007
FORM APPROVED
OMB NO. 0938-0391

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

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F 363	Continued From page 14 He/She stated, "...I serve what's on the meal ticket..." There was no evidence in the record that the physician had changed the consistency of the resident's diet. 3. Facility staff failed to serve Resident T1 low fat and low cholesterol foods as ordered by the physician and offer substitutions for certain foods that the resident disliked. Resident T1 was ordered a low fat, low cholesterol diet on May 18, 2007 by the physician. Foods to be limited or avoided were not listed on the resident's meal ticket. The resident's dinner tray was observed being prepared at 5:30 PM. The meal consisted of a cup of chicken gumbo soup, beef, macaroni and tomato casserole, peas and carrots, a dinner roll, cranberry juice and vanilla ice cream. Included on the resident's meal ticket under "Dislikes" was beef and pasta. Chicken was not offered or served to the resident. The meal ticket did not list the high fat or high cholesterol foods to be limited or avoided.	F 363	F371 1. All pans and skillets have been re-washed and air dried prior to stacking. All pans free of grease and residue. 2. All pans and skillets have been inspected to ensure that they are clean, dry and ready for use. All pans free of grease and residue 3. In-services will be provided to kitchen staff on the need to ensure that pans and skillets are clean, dry and free of grease and residue. Kitchen rounds will be completed on a daily basis by Dining Service Coordinator or their designee. If pans and skillets are observed to be in need of cleaning, the staff will remove them from the storage area and have them cleaned and dried properly. 4. Dining Service Coordinator or their designee will monitor the kitchen daily. Pans will be inspected to ensure that they are free from grease and residue. Any pans or skillets not dry, hung and free from grease or residue will be immediately rewashed to meet the specifications. On a monthly basis, the findings and any necessary corrective action taken from the kitchen rounds will be reported at the Quality Assurance meetings. The Quality Assurance report will drive staff education, changes in practice and/or procedure, if indicated.	[handwritten, partly illegible] 7/1/07 6/22/07
{F 371} SS=E	483.35(i)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by:	{F 371}		

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

PRINTED: 05/31/2007
FORM APPROVED
OMB NO. 0938-0391

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 ______	R 05/21/2007

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

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 371}	Continued From page 15 Based on observations during the tour of the main kitchen, it was determined that dietary services failed to ensure that foods were served and prepared in a safe and sanitary manner as evidenced by soiled hotel pans and skillets. These findings were observed in the presence of Employee #6 on May 21, 2007 at 8:30 AM. The findings include: 1. Hotel pans were observed stored wet and/or with a greasy residue after being washed and ready for reuse in 23 of 26 observations of hotel pans. 2. Skillets were observed stored wet with food debris on the interior surfaces after being washed and ready for reuse in three (3) of six (6) observations of skillets. Employee #6 acknowledged the aforementioned findings at the time of the observations.	{F 371}		
{F 431} SS=D	483.60(b), (d), (e) PHARMACY SERVICES The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	{F 431}		

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{F 371}	Continued From page 15 Based on observations during the tour of the main kitchen, it was determined that dietary services failed to ensure that foods were served and prepared in a safe and sanitary manner as evidenced by soiled hotel pans and skillets. These findings were observed in the presence of Employee #6 on May 21, 2007 at 8:30 AM. The findings include: 1. Hotel pans were observed stored wet and/or with a greasy residue after being washed and ready for reuse in 23 of 26 observations of hotel pans. 2. Skillets were observed stored wet with food debris on the interior surfaces after being washed and ready for reuse in three (3) of six (6) observations of skillets. Employee #6 acknowledged the aforementioned findings at the time of the observations.	{F 371}		6/22/07
{F 431} SS=D	483.60(b), (d), (e) PHARMACY SERVICES The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	{F 431}	F431 1. Controlled medications have been destroyed according to policy and state/federal regulations and paperwork/signatures completed. 2. Controlled medications have been audited and any controlled, discharged/discontinued medications, were destroyed immediately and appropriate paperwork/signatures completed. 3. Nursing staff will be in-serviced on the center's policy for proper destruction and documentation of controlled medications Discontinued or discharged medications will be removed from medication cart and placed in a centralized location for destruction. Licensed nurse will obtain a second signature when placed in secured location. DNS and/or designee will destroy all medications (controlled and non-controlled) monthly during pharmacy consultant visit. Night nurse will review medication carts daily to ensure that all discontinued and discharge medications are removed and stored /destroyed per policy and state/federal regulations. 4. Over the next 8 weeks, Director of Nursing or their designee will report discrepancies and corrective action taken at the Quality Assurance monthly meetings	[handwritten: illegible] 6/22/07

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{F 431}	Continued From page 16 In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on review of the "Destruction of Discontinued Controlled II-V Substances" forms and staff interview, it was determined that facility staff failed to follow facility policy for controlled medication disposal as evidenced by: the lack of two (2) signatures, improper disposal of medication and incomplete forms. The findings include: According to the facility ' s Policy and Procedure, " Controlled Medication Disposal " section II E:1, stipulates, c. " Schedule II-V medication remaining in the facility after a resident has been discharge, or the order discontinued, are disposed of in the facility ..., (1) Drug destruction is carried out by double flushing in the toilet... (3) The form must be signed by the nurse or	{F 431}	F431 1. Controlled medications have been destroyed according to policy and state/federal regulations and paperwork/signatures completed. 2. Controlled medications have been audited and any controlled, discharged/discontinued medications, were destroyed immediately and appropriate paperwork/signatures completed. 3. Nursing staff will be in-serviced on the center's policy for proper destruction and documentation of controlled medications Discontinued or discharged medications will be removed from medication cart and placed in a centralized location for destruction. Licensed nurse will obtain a second signature when placed in secured location. DNS and/or designee will destroy all medications (controlled and non-controlled) monthly during pharmacy consultant visit. Night nurse will review medication carts daily to ensure that all discontinued and discharge medications are removed and stored /destroyed per policy and state/federal regulations. 4. Director of Nursing or their designee will monitor documentation of proper destruction, discontinuation and discharge medication. The findings and any necessary corrective action taken will be reported at the Quality Assurance monthly meetings. Data collected will be used to drive staff development.	Revised received TM 6/28/07 6/22/07

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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{F 431}	Continued From page 17 pharmacist destroying the drugs and a witness. The form must also include the method of destruction and the date the drugs were destroyed... " On May 21, 2007, at approximately 9:30 AM, the "Destruction of Discontinued Controlled II-V Substances" forms were requested for review. The "Destruction of Discontinued Controlled II-V Substances" form dated May 9, 2007 had eight (8) entries. The eight (8) entries included one (1) signature, not the required two (2) signatures and the form documented the method of destruction as discarding the medication into the sharps container for the eight (8) entries. The "Destruction of Discontinued Controlled II-V Substances" form dated May 15, 2007 had two (2) entries. The two (2) entries did not include the method of destruction. A face-to-face interview was conducted with Employee #13 on May 21, 2007 at 3:00 PM. He/she stated that a review of the procedure was needed.	{F 431}		
{F 441} SS=D	483.65(a) INFECTION CONTROL The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections.	{F 441}	F441 1. The cat's medical/vaccination records have been obtained. 2. Both center - owned cats have had their medical/vaccination records obtained. 3. A copy of the cat's medical/vaccination records will be maintained by the Activities department and will be reviewed on a quarterly basis to ensure that they are current and available upon request. 4. On a monthly basis, the Activities Department will bring copies of the medical/vaccination records for the center-owned cats to the Executive Director, if deficient practice is identified, corrective action plans will be developed to address identified areas.	6/22/07 [handwritten, illegible]

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{F 441}	Continued From page 18 This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, facility staff failed to ensure that a cat observed in the dining room had appropriate medical/vaccination records available. The findings include: On May 21, 2007 at approximately 8:25 AM, a black cat was observed walking across the dining room floor. There were six (6) residents eating breakfast in the dining room at the time. A face-to-face interview was conducted with Employee #1 on May 21, 2007 at 9:55 AM. He/she acknowledged that the cat lives in another area of the facility. The cat comes to this side [nursing facility unit] when the door between the two areas is left open [another area of the facility]. The cat walks through the dining room often. A face-to-face interview was conducted with Employee #2 on May 21, 2007 at 5:30 PM. He/she stated, "The cat belongs to the Assisted Living Unit. It [the cat] should not be in the area [of the nursing facility unit]. The cat sneaks over. They [other staff] have to contact the sales person in order to get the papers for the cat." The cat's medical/vaccination records were requested. However, the facility was unable to provide the surveyor with a copy of the cat's medical/vaccination records.	{F 441}	F441 1. The cat's medical/vaccination records have been obtained. All staff have been in serviced regarding not allowing cat in skilled neighborhood. Signs have been posted on both sides of coded door. A spray water bottle is utilized to discourage cat from entered skilled neighborhood. 2. Both center - owned cats have had their medical/vaccination records obtained. 3. A copy of the cat's medical/vaccination records will be maintained by the Activities department and will be reviewed on a quarterly basis to ensure that they are current and available upon request. 4. Activities coordinator will report, at quarterly Quality Assurance meetings, success of preventing cat to enter skilled neighborhood. If measures of preventing cat from entering skilled neighborhood, relocation to another floor in the community will be sought.	Revised 6/22/07 [handwritten] 6/22/07
F 456 SS=D	483.70(c)(2) SPACE AND EQUIPMENT The facility must maintain all essential mechanical, electrical, and patient care	F 456		

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F 456	Continued From page 19 equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined that facility staff failed to ensure that one (1) of three (3) garbage disposals was maintained and serviced timely. The findings include: During a tour of the main kitchen on May 21, 2007 at 8:25 AM with Employee #6, food waste was observed in trash cans with paper and metal waste. Employee #6 stated that the garbage disposal attached to the mechanical dishwasher was broken. Two (2) garbage disposals in the clean food preparation area were tested and were functioning. Employee #6 supplied a copy of the "Maintenance Request Log" dated April 16, 2007, documenting, "Garbage disposal not working (dish machine area)." At 9:38 AM on May 21, 2007, Employee #5 stated, "The garbage disposal has been broken since the middle of April. The motor is burned out. We need a new one. I know that there was a bid received for about $4600 and that corporate thought that was too much money. The dishwasher discards the leftover food on the plates or in the pots and pans into a trash can." An estimate from a company to replace the disposal was dated May 7, 2007 and faxed to the	F 456	F456 1. The garbage disposal has been replaced with a new disposal. 2. The other garbage disposal in the kitchen was inspected and found to be fully operational. 3. The kitchen staff will be in-serviced on maintaining kitchen garbage disposal in proper working order, notifying Maintenance of the need for repairs and proper disposal of food waste. Kitchen rounds will be completed on a daily basis by Dining Service Coordinator or their designee. If garbage disposal are found to be non operational, Maintenance department will be contacted and a work order completed and repairs completed promptly. When repairs are needed, staff will utilize the other operational garbage disposals to deposit food waste. 4. Dining Service Coordinator or designee will monitor the kitchen daily for compliance. Rounds will be completed and deficient practices will be documented and analyzed. Immediate action will be taken, if indicated. On a monthly basis, the findings of the kitchen rounds and corrective actions will be reported at the Quality Assurance meeting. The Quality Assurance report will drive staff education, changes in practice and/or procedure, if indicated.	revision received TF 6/26/07 6/22/07

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F 456	Continued From page 20 facility on the same day. An outside repair company arrived at the facility at approximately 11:15 AM on May 21, 2007. After checking the unit, the serviceman stated that the most cost effective measure was to replace the entire unit. The unit was scheduled to be installed in approximately three (3) to four (4) days.	F 456		
{F 490} SS=E	483.75 ADMINISTRATION A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, it was determined that the administrative staff failed to integrate, coordinate and monitor the facility's practices related to the resident's care and safety. The findings include: 1. Facility staff failed to maintain an environment free of possible accident hazards as evidenced by staff lighting the burners on the gas stove in the main kitchen with paper. Cross Reference CFR 483.25(h)(1), F323 for specific findings regarding the above deficient practice - Identified as Immediate Jeopardy. 2. Facility staff failed to provide maintenance services necessary to maintain a safe environment. Cross Reference CFR 483.15(h)	{F 490}	**F490** 1. A plan of correction has been developed and implemented to address all cited deficiencies. A new Healthcare Administrator has been hired to oversee all operations in the facility. 2. Through monitoring and observation rounds, administrative staff will inspect for compliance with federal and District of Columbia regulations. If areas are identified as needing correction, actions will be taken to achieve compliance. 3. If through the monitoring rounds, discrepancies are identified, staff will be counseled and in-serviced. 4. Results from the monitoring rounds will be discussed on a daily basis to achieve and maintain compliance. Tracking and trends of noncompliance will be discussed at the monthly Quality Assurance meetings, and corrective action plans will be developed to address deficient practice.	6/22/07

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

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{F 490}	Continued From page 21 (2), F253, for specific findings regarding the above deficient practice. 3. Facility staff failed to initiate care plans with appropriate goals, approaches and/or interventions for residents receiving antibiotic and anticoagulant therapy and for management of Hypertension, Atrial Fibrillation, Hyperlipidemia, pain management and constipation. Cross Reference CFR 483. 20(k), F279 for specific findings regarding the above deficient practice. 4. Facility staff failed to ensure that proper infection control procedures were followed during pressure ulcer treatments. Cross Reference CFR 483.25(c)(2), F314 for specific findings regarding the above deficient practice. 5. Facility staff failed to ensure that residents received medication as per facility policy and as ordered by the physician. Cross Reference CFR 483.25(m)(2), F333 for specific findings regarding the above deficient practice. 6. Facility staff failed to prepare diets as ordered by the physician for residents with special nutritional needs. Cross Reference CFR 483.35(c), F363 for specific findings regarding the above deficient practice. 7. Facility staff failed to ensure that foods were served and prepared in a safe and sanitary manner as evidenced by soiled hotel pans and skillets. Cross Reference CFR 483.35(i)(2), F371 for specific findings regarding the above deficient practice. 8. Facility staff failed to follow facility policy for controlled medication disposal as evidenced by:	{F 490}		

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{F 490}	Continued From page 22 the lack of two (2) signatures, improper disposal of medication and incomplete forms. Cross Reference CFR 483.60(b), F431 for specific findings regarding the above deficient practice. 9. Facility staff failed to ensure that a cat observed in the dining room had appropriate medical/vaccination records available. Cross Reference CFR 483.65(a), F441 for specific findings regarding the above deficient practice. 10. Facility staff failed to ensure that the garbage disposal attached to the mechanical dishwasher was maintained and serviced timely. Cross Reference CFR 483.70(c)(2), F456 for specific findings regarding the above deficient practice. 11. Facility staff failed to wear a hair net or other hair covering and/or completely cover their hair while in the main kitchen. Cross Reference CFR 483.75(b), F492 for specific findings regarding the above deficient practice. 12. Facility staff failed to ensure that the facility's quality assurance committee adequately implemented plans of action to correct identified deficient practices facility wide. Cross Reference CFR 483.75(o)(1), F520 for specific practices regarding the above deficient practice.	{F 490}		
{F 492} SS=E	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.	{F 492}		

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{F 492}	Continued From page 23 This REQUIREMENT is not met as evidenced by: Based on observations during a tour of the main kitchen, it was determined that facility staff failed to wear a hair net or other hair covering and/or completely cover their hair while in the main kitchen. The findings include: According to 22 DCMR 3219.6, " Each food service employee shall wear either a hair net or other hair covering. " During observations of the main kitchen on May 21, 2007 the following was observed: At 9:30 AM, Employee #11 was observed entering the kitchen without a hair covering and pouring two (2) cups of coffee. The coffee machine was on the opposite side of the counter from which scrambled eggs, grits and sausage were being served. A face-to-face interview was conducted at the time of the observation with Employee #5. Employee #5 was asked if anyone was allowed in the kitchen without hair covering. Employee #5 stated, "Everyone has to wear a hair net. I ran out of them by the dining room door." Employee #5 immediately replaced hair nets by the dining room door. At 11:30 AM Employee #12 was observed entering the kitchen from the dining room and walk into the main serving area without a hair covering. At 2:00 PM Employee #9 was observed cooking	{F 492}	F492 1. Hairnets were donned by the cited staff members at the time of survey. 2. All kitchen staff will be in-serviced and observed to determine if staff is compliant with hair coverings are requirements. 3. Employees # 9, 10, 11 and 12 have all been counseled on the need to wear hair covering while in the kitchen. All kitchen staff was in-serviced on the importance of wearing a hairnet. The hairnet supply container has been placed next to the kitchen door, to allow staff better access to the hairnets prior to entering the kitchen. Kitchen rounds will be completed on a daily basis by Dining Service Coordinator or their designee. If in-serviced staff are observed not wearing hair nets, staff will be made to wear the hair net and disciplinary action will occur. 4. Dining Service Coordinator or designee will monitor the kitchen daily for compliance. Rounds will be completed and deficient practices will be documented and analyzed. Immediate action will be taken, if indicated. On a monthly basis, the findings of the kitchen rounds and corrective actions will be reported at the Quality Assurance meeting. The Quality Assurance report will drive staff education, changes in practice and/or procedure, if indicated.	[handwritten: revised received TT 6/28/07] 6/22/07

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

PRINTED: 05/31/2007
FORM APPROVED
OMB NO. 0938-0391

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{F 492}	Continued From page 24 at the gas range without his/her hair fully covered. At 2:50 PM, Employee #10 was observed walking through the main kitchen to the main dining room without a hair covering.	{F 492}		
{F 493} SS=F	483.75(d)(1)-(2) GOVERNING BODY The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and the governing body appoints the administrator who is licensed by the State where licensing is required; and responsible for the management of the facility. This REQUIREMENT is not met as evidenced by: Based on staff interview and review of facility documents, it was determined that the governing body failed to appoint an interim licensed nursing home administrator responsible for the management of the facility. The findings include: According to 22 DCMR 3201 (Administrative Management), "An administrator shall be present forty (40) hours per week during regular business hours and shall be responsible for the operation of the facility twenty-four (24) hours per day, seven (7) days per week" and "The administrator shall be: (a) Licensed or otherwise approved as a nursing home administrator in the District of Columbia." During the entrance conference on May 21, 2007	{F 493}	F493 1. A District of Columbia licensed Nursing Home Administrator has been hired as of 5/31/07. ~~An anticipated start date~~ is [handwritten: began 7/16/07 as per CR] 2. All residents have the potential to have been affected by this citation. 3. Community had been recruiting A Licensed Nursing Home Administrator since the resignation of previous administrator. A Healthcare Administrator has been hired and will begin . Ongoing efforts will be made to recruit, retain and /or train additional individuals who may already be licensed, or are eligible to become a licensed Nursing Home Administrator in the District of Columbia, and serve as a secondary Nursing Home Administrator. 4. On a monthly basis, the Human Resources Coordinator or their designee will report to the Quality assurance Meeting the efforts to recruit, retain and / or train potential secondary Licensed Nursing Home Administrators.	6/22/07

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{F 493}	Continued From page 25 at 8:40 AM, a face-to-face interview with Employee #1 revealed that the facility did not have a licensed nursing home administrator employed by the facility. The previous administrator was no longer employed by the facility; the date of separation was May 10, 2007.	{F 493}		
{F 520} SS=E	483.75(o)(1) QUALITY ASSESSMENT AND ASSURANCE A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, it was determined that the facility's quality assurance committee failed to adequately	{F 520}	F520 1. A Quality Assurance Committee that includes the Director of Nursing, the Medical Director and the center's management team has been developed and implemented to address all cited deficiencies. 2. Residents were not affected by citation. 3. Through monitoring and observation rounds, administrative staff will inspect for compliance with federal and District of Columbia regulations. If areas are identified as needing correction, actions will be taken to achieve compliance. 4. On a weekly basis for the next 8 weeks, the Quality Assurance team will meet to discuss the areas cited during the May 21, 2007 revisit survey. On an ongoing basis the center's Quality Assurance team will meet monthly to identify areas of deficient practice and develop corrective action plans to achieve compliance with federal and District of Columbia regulations.	6/22/07

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{F 520}	Continued From page 26 implement plans of action to correct identified deficient practices facility wide. The findings include: On May 21, 2007 at approximately 5:15 PM, a face-to-face interview was conducted with the Executive Director. He/she stated, "The facility has a quality assurance program. We review concerns and issues on a daily basis and addressed the issues identified on the 2567 from the previous survey." There was no evidence that the quality assurance committee developed or implemented appropriate plans of action to correct identified deficiencies, as evidenced by the following: 1. Immediate Jeopardy - Isolated for deficiency F323 2. Potential for more than minimal harm - Widespread for deficiency F493. 3. Potential for more than minimal harm- Pattern for deficiencies F314, F371, F490, and F492. 4. Potential for more than minimal harm - Isolated for deficiencies F253, F279, F333, F363, F431, F441 and F456.	{F 520}		