PRINTED: 05/31/2

	of Correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUIL	ULTIPLE CONSTRUCTION LDING		SURVEY LETED
		095021	B. WIN	G	05/	R <u>/2</u> 1/2007
	PROVIDER OR SUPPLIER E AT THOMAS CIRCLI	E		STREET ADDRESS, CITY, STATE, ZIP 1330 MASSACHUSETTS AVENUI WASHINGTON, DC 20005		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE 1E APPROPRIATE	COMPL DA
F 253 SS=D	A follow-up survey to survey (March 20 the conducted on May 2 Jeopardy (IJ) in the a F323 was identified AM. The facility Exe Corporate Represent and a plan of action resident safety was reffect until approximate deficiencies were based observations and state included six (6) reside annual re-certification supplemental resider 483.15(h)(2) HOUSE The facility must proving anitary, orderly, and This REQUIREMENT by:  Based on observation he tour of the main kinhat the facility staff facility staff facility staff facility staff facility is taff facility in the floor of the janific ceiling.	the annual re-certification rough 22, 2007) was 1, 2007. An Immediate area of CFR 483.25 (h) (1), on May 21, 2007 at 11:19 icutive Director and tative were informed of the IJ to address the issue of received. The IJ remained in ately 1:30 PM. The following sed on record review, iff Interviews. The sample ents based on 60% of the n survey and three (3) its.  IKEEPING/MAINTENANCE ride housekeeping and a necessary to maintain a comfortable interior.  Is not met as evidenced its and staff interview during itchen, it was determined ited to provide maintenance maintain a safe need by the absence of tile torial closet and a hole in	{F 00	Responses to the cited deficient constitute an admission of agree facility of the truth of the facts conclusion set forth in the Statt Deficiencies. The Plan of Comprepared solely as a matter of a point federal and state-law:	ement by the alloged or ement of rection is compliance.  I be replaced in addition, ted in the by June 22, is been fly any other g or scaling. The collection is considered in the learn of the collection in the	all comp tions date as di right Poc and o chud
th		oproximately 2:30 PM, in byee #5, the following was				

Any deficiency statement colding with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other sefeguards 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.

		I AND HUMAN SERVICES  & MEDICAID SERVICES	<del></del>	Le VIDEIU		M APPROV D. 0938-03
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA · IDENTIFICATION NUMBER:	(X2) MULTIF	ELE CONSTRUCTION	(X3) DATE COMP	LEYED
		095021	B. WING		05/	R 21/2007
,,=	PROVIDER OR SUPPLIER E AT THOMAS CIRCL	E	13	EET ADDRESS, CITY, STATE, ZIP CO 30 MASSACHUSETTS AVENUE N ASHINGTON, DC 20005	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETI DATE
F 253 SS=D	A follow-up survey to survey (March 20 the conducted on May 2 Jeopardy (IJ) in the F323 was identified AM. The facility Execution of action resident safety was deficiencies were basely and a plan of action resident safety was deficiencies were basely at the facility must proving the facility staff facility staff facility staff facility staff facility staff facility in the facilit	the annual re-certification rough 22, 2007) was 11, 2007. An Immediate area of CFR 483.25 (h) (1), on May 21, 2007 at 11:19 octive Director and stative were informed of the IJ to address the issue of received. The IJ remained in ately 1:30 PM. The following sed on record review, aff interviews. The sample ents based on 60% of the n survey and three (3) hts.  EKEEPING/MAINTENANCE vide housekeeping and some confortable interior.  Is not met as evidenced as and staff interview during itchen, it was determined alled to provide maintenance.	{F 000}	Responses to the cited deficiencial constitute an admission or agreen facility of the truth of the facts all conclusion set forth in the Statem Deficiencies. The Plan of Correct prepared solely as a matter of committe federal and state law.  P253  1. Janitorial closet will be by June 22, 2007. In a the water pipes located closet will be sealed by 2007 and the hole in the will be repaired by June 2007.  2. Kitchen rounds have be conducted to identify a areas that need tiling or All ceiling areas in the were also inspected to it any open areas. No oth were identified that are tiling, sealing or hole re-	ent by the eged or ent of the control of the contro	all comple tion dates as that a prigne Toc and for the too the

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other saleguards 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.

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		) MULTIPLE CONSTRUCTION (X3) DATE COMPL			'E SURVEY MPLETED	
	51 55111.E511511	1	A. BUII	DING		R		
		095021	B. WIN	G		05/21/20	07	
	PROVIDER OR SUPPLIER E AT THOMAS CIRCL	E			S, CITY, STATE, ZIP CODE HUSETTS AVENUE NW IN, DC 20005			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH	OVIDER'S PLAN OF CORRECTIVE ACTION SHO REFERENCED TO THE APPI DEFICIENCY)	OULD BE CO	(X5) MPLETION DATE	
	main kitchen, had no closure around to closet. Employee #4 been done last year 2. A one (1) foot by tile, was observed a entrance to the kitch don't know why there to fix that."  Employee #5 acknowing findings at the time	set, located at the back of the to tile on the floor. There was the water pipes located in the 5 stated, "That should have two (2) foot hole in the ceiling above an exit door near the nen. Employee #5 stated, "I re is a hole there. They need wledged the aforementioned of the observations.	F2	4.	In-services will be provided kitchen staff on the need to ensure a safe kitchen environment as related to fle and ceiling tiling and sealin water pipes in closets. Kitch rounds will be completely of daily basis by Dining Service Coordinator and/or their designee. If areas are identity to be in need of repair, the Maintenance department with contacted and repairs comply promptly. Dining Service Coordinator designee will monitor the kitchen daily for compliance Rounds will be completed a deficient practices will be	oor g of nen n a ce ified li be leted or		
{F 279} SS=D	483.20(d), 483.20(k CARE PLANS	)(1) COMPREHENSIVE	{F 27	<b>'9</b> }	documented and analyzed.  Immediate action will be talk indicated. On a monthly base		157	
	to develop, review a comprehensive plan				the findings of the kitchen re and corrective actions will be reported at the Quality Assure meeting. The Quality Assure port will drive staff educat changes in practice and/or	ounds re rance ance		
	plan for each reside objectives and timet medical, nursing, an	velop a comprehensive care nt that includes measurable ables to meet a resident's d mental and psychosocial fied in the comprehensive			procedure, if indicated.			
	to be furnished to att highest practicable p psychosocial well-be §483.25; and any se be required under §4 due to the resident's	ing as required under rvices that would otherwise 183.25 but are not provided exercise of rights under e right to refuse treatment		<u>F279</u>	Interim care plans for residents number 6 and were completed by the Director of Health Servi during survey, May 21, to reflect needed service obtain or maintain the resident's highest practiphysical, mental, and ps social well being.	ices 2007 es to		

ECRLICASS/SAMSEN/Enviores/actions structures successive services and the services of the servi

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1` '	ULTIPLE CONS	TRUCTION	(X3) DATE S COMPL	
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		TEMENT OF DEFICIENCIES	ID	1330 MASS WASHING	ESS, CITY, STATE, ZIP CODE ACHUSETTS AVENUE NW TON, DC 20005 PROVIDER'S PLAN OF CORREC		
PRÉFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		ACH CORRECTIVE ACTION SHO SS-REFERENCED TO THE APPR DEFICIENCY)		COMPLETIO DATE
{F 279} 	main kitchen, had no closure around the closet. Employee #5 been done last year 2. A one (1) foot by tile, was observed at entrance to the kitch don't know why there to fix that."  Employee #5 acknow findings at the time of 483.20(d), 483.20(k) CARE PLANS  A facility must use the to develop, review and comprehensive plan. The facility must develop for each resident medical, nursing, and needs that are identificated assessment.  The care plan must detect be furnished to attach ighest practicable phosychosocial well-being 483.25; and any service required under §48 due to the resident's each contract to the resident to the resident to the resident to the resident t	set, located at the back of the or tile on the floor. There was ne water pipes located in the stated, "That should have "  two (2) foot hole in the ceiling bove an exit door near the en. Employee #5 stated, "I is a hole there. They need wledged the aforementioned of the observations.  (1) COMPREHENSIVE  e results of the assessment of revise the resident's of care.  elop a comprehensive care that includes measurable bles to meet a resident's mental and psychosocial ied in the comprehensive  escribe the services that are in or maintain the resident's sysical, mental, and	F 27	F275	1. Interim care plans for residents number 6 and were completed by the Director of Health Serviduring survey, May 21, 2 to address the areas iden All recent admissions care plans will be audited by Director of Health Servic designee to determine if interim care plan has been developed to address resimmediate needs. If an interim care plan is needed one will be developed promptly. Current nursing staff will in-serviced by Director of Health Services or design 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 of designee will review rando admission health informatifiles to ensure that interim care plans are in place. Over the next 8 weeks, the Director of Nursing, or their designee will audit recent admission care plans to determine if an interim care plan has been developed. Tresults of this audit and corrective action taken will	ces 2007 tified re ces or an nident ces	6/22/04
	The Grant Control of the Control of				reported at the Quality Assurance monthly meeting		

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1` ′	MULTIPI ILDING	LE CONSTRUCTIO	ON	(X3) DATE S COMPLE	
		095021	B. WIN				1	R 21/2007
	PROVIDER OR SUPPLIER	.E		133		SETTS AVENUE NW DC 20005		
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	This REQUIREMENt by: Based on record recone (1) of six (6) sa supplemental reside facility staff failed to appropriate goals at assessment and caback pain, receiving history of constipatio (1) resident receiving therapy and a histor Hyperlipidemia and and T1.  The findings include 1. Facility staff failed goals, approaches a pain management, at Urinary Tract Infection Hypertension for Received and 14, 2007. Physician May 14, 2007 include for constipation, Line medications for Hypertension for Hypertension. The recare plans to address constipation and Hypertension and Hypertensi	eview and staff interview for ampled residents and one (1) ent, it was determined that or initiate a care plan with and approaches for the are for: one (1) resident with grantibiotic therapy and a son and Hypertension; and one and anticoagulant and antibiotic ry of Atrial Fibrillation,  Hypertension. Resident #6  deto initiate care plans with and interventions to address antibiotic therapy for an con (UTI), constipation and esident #6.  mitted to the facility on May n's orders signed and dated led OxyContin for pain, Senna ezolid for the UTI and two (2) ertension.  the clinical record, a hospital dated May 14, 2006 was ted that the resident was n, an UTI, constipation and ecord failed to include initial as the resident's pain, UTI,	{F 2	79}	2. 3.	All recent admissions complans will be audited by Director of Health Services to determine it interim care plan has be developed to address not services to obtain or matche resident's highest practicable, physical, mand psycho-social well. If an interim care plan in needed, one will be developed to develop interim care plan that addresses the immediat needs at time of admission the need to develop interim care plan that addresses the immediat needs at time of admission-servicing will be incompleted in the process. Do designee will review rand admission health inform files to ensure that intercare plans are in place. On a continuing basis, to designee will review rand inscion care plans to determine if an interim plan has been develope Immediate action will be taken when indicated results of this audit and corrective action taken, be reported at the Quality Assurance monthly mediate and drive staff development. During quarterly Quality Assurance monthly mediate action will be analyzed and drive staff development. During quarterly Quality Assurance monthly mediate action will be analyzed and drive staff development. During quarterly Quality Assurance monthly mediate action will be analyzed and drive staff development. During quarterly Quality Assurance monthly mediate action will be analyzed and drive staff development. During quarterly Quality Assurance monthly mediate action will be analyzed and drive staff development. During quarterly Quality Assurance monthly mediated.	ices or f an een eeded aintain eental, being is veloped fill be of gnee an ee sion eluded  VS or endom mation rim the r their ent o care d d e The l ity etings.	6/22/07

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		095021	B. WIN	1G	<del></del>		1/2007
ľ	PROVIDER OR SUPPLIER	.E		1:	REET ADDRESS, CITY, STATE, ZIP COD 330 MASSACHUSETTS AVENUE NV NASHINGTON, DC 20005	E	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	ıx	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
{F 279}	11:00 AM who ackr lacked initial care p reviewed on May 2.  2. Facility staff failed goals and approach and antibiotic theral Hyperlipidemia and According to the ad physician on May 18 receiving the followi (anticoagulant) Amid Lopressor and Lasis	nowledged that the resident plans. The record was 1, 2007.  In the case plans with the set to address anticoagulant	{F 27	79}			
	According to the His completed by the ph diagnoses included: Hypertension, Atrial Hyperlipidemia.	story and Physical form hysician on May 18, 2007, : Pulmonary Embolism, I Fibrillation and					
	evidence that care p and approaches for	nt T1's record revealed no plans were initiated with goals anticoagulant and antibiotic ation, Hyperlipidemia and					
{F 314}	Employee #13 on Ma 4:20 PM. He/she ac		{F 31	14}			
. ]1	resident, the facility r who enters the facilit	rehensive assessment of a must ensure that a resident ty without pressure sores essure sores unless the					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	IULTIPL LDING	E CONSTRUCTION	(X3) DATE S COMPL	
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1	PROVIDER OR SUPPLIER	E	•	133	ET ADDRESS, CITY, STATE O MASSACHUSETTS AV ASHINGTON, DC 2000	ZIP CODE	
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{F 314}	individual's clinical of they were unavoidad pressure sores received services to promote prevent new sores of this REQUIREMENT by: Based on observation two (2) of three (3) if it was determined the procedures were not the they were not they were unavoidable to they were unavoidated to they	condition demonstrates that ble, and a resident having eives necessary treatment and healing, prevent infection and	{F 3	14}	in-serviced of protective bath when placing bed table pripressure ulce addition, curbeen in-servit disposal of bid dressing math of over bed to completion of the completion completion confollowed. If of the completion confollowed.	of the treatment.  Ing staff providing  Ins been observed to  Proper clean  Inters and proper  It of practices are  deficient practice is	
	control procedures of treatments for Resident Pressure ulcer treatments and at a pressure ulcer treatment Pressure ulcer ulc	approximately 9:25 AM a ment was observed for approximately 10:50 AM a ment was observed for approximately 10:50 AM a ment was observed for the treatment cart with a to the side of the cart outside om. He/she entered the room applies and a bottle of liquid container of supplies and the placed on the resident's over aning or the use of a			occur and cor be implement  All supplies in have been ind and now inclubags for disponderesting mate disinfectant wo ver bed table in-serviced on techniques to control practic biohazardous licensed team trained on project chniques.  DNS and/or decomplete rand wound care we and then quart proper techniq Immediate acti when indicated these observati action taken we the Quality Assemeeting. Data	n treatment cart lividually bagged, ade biohazard trash ssal of biohazard rials and ripes to wipe down rises. Licensed staff opproper wound care include infection rese and disposal of waste. New members will be per wound care resignee will om observations of reekly for a month erly to ensure	6/2/37

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,	LTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILD		R
		095021	B. WING	·	05/21/2007
	PROVIDER OR SUPPLIER SE AT THOMAS CIRCL	E	s	TREET ADDRESS, CITY, STATE, ZIP CODE 1330 MASSACHUSETTS AVENUE NW WASHINGTON, DC 20005	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE COMPLETION
{F 314	Continued From pa	age 5	{F 314	4}	
	treatment, the soile plastic bag which we resident's room and non-biohazardous place to the treatment call the over bed table a	the completion of the did dressing was discarded in a vas closed, removed from the diplaced in a plastic bag that was attached rt. Employee #3 failed to clean after the treatment. The then rolled to Resident H2's			
	doorway who was s treatment.	scheduled for the next		·	,
	prior to and after the Resident H2. The s hand cleanser bottle	to clean the over bed table e pressure ulcer treatment for ame supply container and e were placed on Resident without a protective barrier.			
	The soiled dressing	was contained in a plastic of in a non-biohazardous bag			
	21, 2007 at approxi Employee #3 who a unaware that the ov prior to and after the	view was conducted on May mately 4:35 PM with icknowledged that he/she was wer bed table required cleaning a pressure ulcer treatment and sings should have been ately.	•		
F 323 SS=J	Employee #1 on Ma He/she stated, "On done, the trash show the trash room and bio-hazardous conta 483.25(h)(1) ACCID	ainer."	F 323	F323  1. The stove with gas burners repaired at the time of the on May 21, 2007. The burners cleaned by kitchen st an outside company inspecting as burners to ensure proprigniting. The open area in service area floor has been repaired.	survey mers aff and ted the

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUIL	ULTIPLE CONSTRUCT  DING	ION	COMPLE COMPLE	TED
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	ROVIDER OR SUPPLIER	E			CITY, STATE, ZIP CODE SETTS AVENUE NW DC 20005		
(X4) ID. PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CO	DER'S PLAN OF CORRECT DRRECTIVE ACTION SHOL FERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 323	Continued From pa	ge 6	F3	23			
	by: Based on observation of a maintenance rethat facility staff failed free of possible accepts facility staff light stove with paper. The Jeopardy (IJ). In acceptance of the main kinds of the			w th ac w th fic id bu 3. In th lig w	Il stoves with gas burners here inspected to determine they properly ignited. In addition, the service area floor is inspected to determine if here are additional holes in the ooring. No issues were lentified with regard to the gurners and service area floor inservices will be provided to the kitchen staff on proper ghting of gas burners. On a reekly basis, the gas burner we inspected and cleaned as eeded. In addition, the naintenance employees will the services will the provided to the services of the gas burner we inspected and cleaned as eeded. In addition, the	ne gas gas gas gas gas gas will	
	The findings include	); ··	· · · -		n-serviced on the need to sec ervice area flooring covers	cure	
	residents and staff f hazard by lighting th the main kitchen wit During a tour of the May 21, 2007, a whi two (2) of the eight (	to ensure the safety of from a possible accident the burners on the gas stove in the paper.  main kitchen at 8:20 AM on the residue was observed on 8) burners on the gas stove. The white residue was,		wbb CCursi ir M	uring repairs. Kitchen rounce ill be completed on a daily asis by Dining Services coordinator or their designee, tilizing the attached rounds heet. If areas are identified to a need of repair, the Maintenance department will ontacted and a work order we submitted to address any dentified areas.	o be	
	Employee #6 stated the staff lights the st leftover paper."	, "The burners don't ignite so ove with paper. That's the		4. D tł k R d	Dining Service Coordinator of their designee will monitor the itchen daily for compliance counds will be completed and efficient practices will be	ne :.	
	(8) burners failed to Employee #7 who prand was beginning twas asked if he/she stove this morning a May 21, 2007. Empuse the burners that	repared the breakfast meal or prepare the soup for dinner had used any burners on the trapproximately 8:30 AM on loyee #7 answered, "I only work. Some of them don't hose." Employee #7 turned		ln it d a ri n n c	locumented and analyzed mmediate action will be take ndicated. On a monthly basi he findings of the kitchen round corrective actions will be eported at the Quality Assurated in the control of the contr	is, April 1 and 1	W 1 (0) (1) (0) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1

	NT OF DEFICIENCIES OF CORRECTION	FICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION RECTION IDENTIFICATION NUMBER:  A BUILDING			(X3) DATE SURVEY COMPLETED		
_		095021	B. WING	·		05/:	R 21/2007
	PROVIDER OR SUPPLIËR E AT THOMAS CIRCL	E		1330 MAS	RESS, CITY, STATE, ZIP CODE SACHUSETTS AVENUE NW GTON, DC 20005		,
(X4) 1D PREFIX TAG	(EACH DEFICIENCY	YEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(15	PROVIDER'S PLAN OF CORRE ACH CORRECTIVE ACTION SI DESCRETERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETIC DATE
F 323	This REQUIREMENty: Based on observation of a maintenance result that facility staff faile free of possible accibly: facility staff lighting stove with paper. The Jeopardy (IJ). In additional pages and the pages of	IT is not met as evidenced ons, staff interview and review quest form, it was determined of to maintain an environment dent hazards as evidenced ng the burners on the gas his resulted in Immediate dition, an unsecured covering a hole near the janitorial ochen.	F 32	1	The stove with gas burners or repaired at the time of the surnon May 21, 2007. The burn were cleaned by kitchen state an outside company inspecting gas burners to ensure proper igniting. The open area in the service area floor has been repaired.  All stoves with gas burners where inspected to determine they properly ignited. In addition, the service area flowas inspected to determine there are additional holes in flooring. No issues were identified with regard to the	ers  eff and  ed the  he  if  oor  if  the	6/2407
t de la company	residents and staff fresidents and staff light the staff lights li	to ensure the safety of om a possible accident burners on the gas stove in paper.  nain kitchen at 8:20 AM on e residue was observed on burners on the gas stove. White residue was, "The burners don't ignite so we with paper. That's the ed and five (5) of the eight			burners and service area flowers and services will be provided the kitchen staff on proper lighting of gas burners. On a weekly basis, the gas burner be inspected and cleaned as needed. In addition, the maintenance employees will in-serviced on the need to see service area flooring covers during repairs. Kitchen rou will be completed on a daily basis by Dining Services Coordinator or their designe utilizing the attached rounds sheet. If areas are identified in need of repair, the Maintenance department with contacted and a work order be submitted to address any identified areas.  4. Over the next 8 weeks, Din Service Coordinator or their designee will monitor the designee will monitor the designee will monitor the designee will monitor the designee will service compliant on a monthly basis, the fine of the kitchen rounds and an necessary corrective action will be reported at the Qual	a r will  I be ecure est to be will to be wi	6/22/37

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION		(X3) DATE S COMPLI	
		095021	B. WIN	IG				R 1/2007
	PROVIDER OR SUPPLIER	E		13	EET ADDRESS, CITY, STATE, ZII 30 MASSACHUSETTS AVENU ASHINGTON, DC 20005			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENCE	TION SHO THE APP	OULD BE	(X5) COMPLETION DATE
F 323	on the two (2) burne meal and both ignite	ers used for the breakfast	F3	323			-	
	Employee #6 on Ma He/She stated that working for more that a copy of a mainten stove dated May 11	the burners had not been an a week. He/she presented ance request to repair the , 2007 at 9:00 AM. The work (6) parts were on order for			. •			
•	queried if he/she wa the stove. Employe	21, 2007, Employee #5 was aware of any problems with e #5 replied, "Some of the			·			
	work order put in ab are waiting for the p are clogged and nee #5 was asked if he/s lighting the burners	when turned on. There was a out a week or so ago. We arts to arrive. The injectors ed to be cleaned." Employee she was aware that staff were with paper. Employee #5. They shouldn't do that. It's						
		d to ensure that a covering ain kitchen was secure.						
	covering over a hole	main kitchen, an unsecured near the janitorial closet was ence of Employee #5 at 1:30				•		
	janitorial closet, curr approximately 2 x 4 pieces of metal supp that was attached to The metal plates we	of flooring across from the ently under repair, feet, covered by two (2) corting a yellow safety cone the walls with electrical wire re not secured to the floor expose the hole in the floor.						

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SI COMPLE	
		095021	B. WIN	ıĢ			R 1/2007
	PROVIDER OR SUPPLIER	E	•	13	EET ADDRESS, CITY, STATE, ZIP CODE 330 MASSACHUSETTS AVENUE NW ASHINGTON, DC 20005		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 3 <b>23</b>	At the time of the ot stated, "Maintenance	oservation, Employee #5 ce was just working there	F	323	F333  1. Residents # JH1 and T1 have their medications properly	ve had	
{F 333} SS=D	no one falls through themselves." 483.25(m)(2) MEDI	CATION ERRORS	{F 3	33}	administered.  2. All residents that are prescriinhalers will have their orde reviewed, ensure medication available, and the nursing st residents will be in-	ers ns are	
	any significant medi	sure that residents are free of cation errors.  IT is not met as evidenced			service/educated for proper administering of inhalers. Licensed nurse will observe residents for return demonstration of proper use inhaler. If after education a training, resident refuses to	e e of	
	interview for two (2) was determined that ensure that one (1) administered an inhoreceived medication Residents JH1 and  The findings include  1. Licensed staff fait JH1 correctly administration Proceed administration of ora	aler and one (1) resident as ordered by the physician. T1.  illed to ensure that Resident istered an inhaler.  inimum Data Set) dated , Section I (Disease I Asthma.  illity's policy "Oral Inhalation edure", Section: III B: 9, se: To allow correct al inhaler to resident, and for			follow established administs protocols, attending MD winotified 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 redemonstration by residents self-administer inhalers, as ordered by their physicians Resident health information record will reflect training a outcome of return demonstratif resident refuses to follow established protocols, attend MD will be called and care plan/health information recommendation will reflect resident's decisifunction of Nursing or their designee will conduct observation rounds to monimaler administration compliance. The findings a any necessary corrective actaken will be reported at the	eturn who and ation. ding ord	(h) 6/22/07
	able to administer th Procedures: Shake	technique for those residents e medication to themselves the inhaler. Attach the cer device, if indicated			Quality Assurance monthly meetings. Data collected w used to drive staff developm and patient education.	ill be nent	6/22/07

FORM CITE 1617 (02:00) Previous Versions Chenete

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

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI	LTIPLE CONSTRUCTION DING	(X3) DATE S COMPL	
	•	095021	B, WING		05/2	R 21/2007
ì	PROVIDER OR SUPPLIER SE AT THOMAS CIRCL	E	5	STREET ADDRESS, CITY, STATE. ZIP COD. 1330 MASSACHUSETTS AVENUE NV WASHINGTON, DC 20005	E	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 323	Continued From pa	ge 8	F 32	23		6/22/07
, {F 333} \$\$=D	stated, "Maintenand yesterday, but they no one falls through themselves." 483.25(m)(2) MEDIC The facility must ensure any significant medical this REQUIREMEN by: Based on observation	CATION ERRORS sure that residents are free of cation errors.  T is not met as evidenced on, record review and staff	{F 333	reviewed, ensure medicat available, and the nursing residents will be in- service/educated for prop administering of inhalers. Residents and licensed nu observe for return demonstrations. If after education and training, re- refuses to follow establish	y cribed ders ions are staff / er	
	was determined that ensure that one (1) radministered an inhareceived medication Residents JH1 and The findings include:  1. Licensed staff fail JH1 correctly administration Proceed According to the facili Administration of oral instruction in proper trable to administer the Procedures: Shake the received an instruction in proceed the procedures: Shake the staff and instruction in proper trable to administer the procedures: Shake the staff and instruction in proper trable to administer the procedures: Shake the staff and instruction in proper trable to administer the procedures: Shake the staff and instruction in proper trable to administer the procedures: Shake the staff and instruction in proper trable to administer the procedures: Shake the staff and instruction in proper trable to administer the procedures: Shake the staff and instruction in proper trable to administer the procedures: Shake the staff and instruction in proper trable to administer the procedure trable to a staff and instruction in proper trable trabl	aler and one (1) resident as ordered by the physician.  1.  ed to ensure that Resident stered an inhaler.  nimum Data Set) dated Section I (Disease Asthma.  ity's policy "Oral Inhalation dure", Section: III B: 9,	an ea seach e tha an	administration protocols, attending MD will notified care plan/health informating record will reflect resident decision.  3. The nursing staff will be inserviced on proper inhaler administration and proper observation of residents we assist in the administration inhaler. Resident health information record will refit training and outcome of redemonstration. If resident refuses to follow establish protocols, attending MD we called and care plan/health information record will refine resident's decision.  4. Over the next 8 weeks, Direct of Nursing or their designed conduct observation round monitor for inhaler administration compliance, findings and any necessary corrective action taken will reported at the Quality Assimonthly meetings	on t's  n  ho tof the flect turn  ed fill be lect rector e will s to  The	16 6 2/67

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M		TIPLE CONSTRUCTION	(X3) DATE S	
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	PROVIDER OR SUPPLIER  E AT THOMAS CIRCL	E		1	REET ADDRESS, CITY, STATE, ZIP CO 1330 MASSACHUSETTS AVENUE N WASHINGTON, DC 20005	DE	·
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
{F 333}	Have the resident ri the rinse water" On May 21, 2007, a	nse his/her mouth and spit out t approximately 10:00 AM,	{F 3	33}			
	500/50 mg and Province Formula From Employee #3. The recorrect procedure for The resident did not space the inhaler prohis/her mouth after the space for the resident for the space for	f his/her inhalers, Adair Air HFC, in the presence of resident did not follow the presence of radministering the inhalers. It is shake the inhaler, did not operly nor did he/she rinse use. Employee #3 did not any time and instruct him/her					
	Employee #3, on Ma	riew was conducted with the ay 21, 2007 at 1:00 PM. resident likes to administer					
:		led to administer two (2) to Resident T1 as ordered				·	
	dated May 19, 2007 discus 250/50 inhala	rsician's order signed and at 10:20 PM "Advair tion bid [twice a day] COPD, [by mouth] Q [every day] - tructive Pulmonary					
	for May 2007 reveale	cation Administration Record ed that Advair and Spiriva ed on May 20, 2007 as cian.				*	
	Resident T1's medic	10:35 AM an observation of ation revealed that a box of as present. The boxes were					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	IULTIPI ILDING	LE CONSTRUCTION	(X3) DATE COMPL	
		095021	B. WII	NG		05/	R <b>21/2007</b>
	PROVIDER OR SUPPLIER  E AT THOMAS CIRCL	E		133	EET ADDRESS, CITY, STATE, ZIP COD 30 MASSACHUSETTS AVENUE NV ASHINGTON, DC 20005		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	unopened.  A face-to-face interestated, "The medic sometime yesterday was here when I go (Monday, May 21, 2 didn't give it at least to give them to [him The resident was of 8:30 AM, 1:00 PM anot observed to be the observations.  The record was revided and the Adequation of Science and be followed.	view was conducted with proximately 10:35 AM. He/she ation must have arrived (Sunday, May 20, 2007). It to work this morning (007). I don't know why they conce yesterday. I am going /her] now."  Deserved on May 21, 2007 at and 3:45 PM. [Resident] was an any distress at the time of the work on May 21, 2007.	{F 3	33}	F363  1. Dietician in serviced staregarding Renal diet. E reviewed and approved ordered within the com Residents #2 and T1 ha received diets as prescrible physician. Residen received the proper text modified diet as prescrible physician. In additing Resident #T1 has been interviewed to determing likes / dislikes.  2. An audit will be compliant residents to confirm is served is the diet tha	pietician all diets munity.  ve ibed by t # 4 has tured bed by ion, he her eted for diet that t is	
	review and review or residents, it was det failed to prepare die for three (3) resident needs and offer sub	f menus for three (3) of 22 ermined that facility staff ts as ordered by the physician ts with special nutritional stitutions for certain foods disliked. Residents #2, 4			prescribed. If any disc are identified, proper of be obtained and proper be served. In addition, will be re-interviewed their likes and dislikes resident's likes and dis be noted in resident's l information record and in dietary.	repancies rders will r diets will residents to confirm The likes will	

	AN OF CORRECTION DENTIFICATION NUMBER:		1, ,			X3) DATE SURVEY COMPLETED	
			A. BUII	EDING		R .	
		095021	B. WIN	NG	I	1/2007	
}	PROVIDER OR SUPPLIER E AT THOMAS CIRCL	E		STREET ADDRESS, CITY, STATE, ZIP CODE 1330 MASSACHUSETTS AVENUE NW WASHINGTON, DC 20005			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		IOULD BE	(X5) COMPLETION DATE	
F 363	A face-to-face intent Employee #5 at 9:4 He/she stated, "I on I don't cook any specification of the mechanical diet."  A review of the recipion the current week regular diet. There book for those residenceds.  The nursing facility of floor of the facility.	view was conducted with 5 AM on May 23, 2007. Ily prepare a regular diet meal. Ecial diets like renal, low fat or ods for those residents liet and I chop the food up for	F3	3- The kitchen staff will be in serviced on the need to offe prepare and serve the prope diets as prescribed by the physician to the residents. Included in the in-service we ensuring that resident likes dislikes are observed. At the time of meal delivery, the residents are served and dislikes / likes a being observed. If any discrepancies are identified meal tray will be corrected to serving to the residents. Discrepancies will be noted communicated to the Dinin Services Coordinator for four promettive action.  4- Registered dietician has reviewed all diet orders and	er,  critical be and ne neal cked being re , the prior		
	kitchen, was conducted AM. He/she stated, from the main kitche the other things like For the residents on give them a sugar surfor the no added sathe tray. For [Reside [him/her] potatoes of special diets we have printed on the individual resident."  The unit currently seresident received all gastrostomy tube. To reviewed and the dietall regular diets with resident with resident surface and the dietall regular diets with resident surface and the dietall regular diets with resident surface and the dietall regular diets with resident surface and the surfa	cted on May 21, 2007 at 10:30 "The hot food comes up here en. I serve it and include all drinks, bread and dessert. no concentrated sweets, I ubstitute and diet dessert. It diets I don't add any salt on ent #2 - renal diet] I don't give r tomatoes. Those are all the e. All that information is dual meal ticket for each erviced 23 residents. One (1) nutrition through a wenty-two meal tickets were ets were as follows: no restrictions I (soft) with no restrictions		reconciled the "Week at a Glance" spreadsheet. Audi completed by registered die are shared with Dining Ser Coordinator or designee to ensure that diet ordered is a served to resident. Dining Services Coordinator or designee to will perform random cross checks between generated a sheet and food served. An discrepancies will be corresimmediately. The register dietician will report issues to diet at quarterly Quality Assurance meeting. The Q Assurance report will drive education, changes in pract and/or procedure, if indicat	ts stician vices liet signee diet y cted ed related vality staff ice	sel selt selt selt	

NAME OF PROVIDER OR SUPPLIER  SUNRISE AT THOMAS CIRCLE  (X4) ID PREFIX PROVIDER OR SUPPLIER  SUNRISE AT THOMAS CIRCLE  (X4) ID PREFIX PROVIDER OR SUPPLIER  (X5) ID PREFIX PROVIDER OR SUPPLIER  (X6) ID PREFIX PROVIDER OF TAX OR SUPPLIER  (X6) ID PREFIX PROVIDER OR SUPPLIER  (X6) ID PREFIX PROVIDER OF TAX OR SUPPLIER  (X6) ID PREFIX PROVIDER  (X6) ID PREFIX PROVIDER OF TAX OR SUPPLIER  (X6) ID PREFIX PROVIDER OF TAX O		IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1.		LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
SUMMISE AT THOMAS CIRGLE   STREET ADDRESS, CITY, STATE, ZIP CODE 1330 MASSACHUSETTS AVENUE NW WASHINGTON, D.C. 20005		•	1	A. BUIL	DINC	·		D
SUNNISE AT THOMAS CIRCLE    CACH   DEPRIES   SUMMARY STATEMENT OF DEFICIENCIES   CACHE   CACHE		<u> </u>	095021	B. WIN	G_		05	•
XASHINGTON_DC 20065   PROVIDERS PLAND OF CORRECTION PROPERTY TAGE   CONTINUED SHAPE PROPERTY AND SUBJECT PROPERTY.    F 363	NAME OF	PROVIDER OR SUPPLIER		7	\$TRI	EET ADDRESS, CITY, STATE, ZIP C	ODE	<u>,                                      </u>
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY BUST BE PRECEDED BY PULL TAG  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, from fact or diabetic. I purse foods for those residents needing a pursed 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 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 no added eath diet 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	SUNRIS	E AT THOMAS CIRCL	E				NW	
F 363 Continued From page 11  A face-to-face interview was conducted with Employee #5 at 9.45 AM on Mey 23, 2007. He/she stated, "I only prepare a regular diet meal. I don't cook any special diets like renal, low fat or the mechanical diets."  A review of the recipe book for "Week 4" (menus for the current week) revealed menus for a regular citet. There were no menus in the recipe book for those residents with Employee #14, assigned to the second floor of the facility. In face-to-face interview with Employee #414, assigned to the second floor of the facility. A face-to-face interview with Employee #14, assigned to the second floor of the facility. I have been an addition, and the confirming that is served in the facility and it is served in the facility and it is a located on 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 despert. For the ne added sait clets I don't add any salt on the tray. For [Resident #2 - renal diel] 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 nuthition through a gastrostorny tube. Twenty-two meal tickets were reviewed and the clets were as follows:  7 regular diets with no restrictions a regular pureed with no restrictions a regular machanical (soff) with no restrictions a regular machanical soff) with no restrictions a regular pureed with no restrictions a regular pureed with no restrictions a regular pureed with no restrictions a regular machanical soff) with	0011111112				W	ASHINGTON, DC 20005		
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A face-to-face interview was conducted with Employee #8 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 no added sait 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 diet swith no restrictions a regular pureed with no restrictions 2 regular pureed with no restrictions	. 1 303	Continued From pa	geri	ГЭ	03	1. Residents #2 and T1 h	ave	6/22/07
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·	the dinner meal between (19) of 22 appropriate diets.  1. Facility staff failed	idents were observed during ween 5:10 PM and 5:30 PM. residents received the  I to prepare/serve appropriate 2's diet as prescribed by the	· ·		·				
	According to Reside order dated May 18,	nt #2's record, a physician's 2007 directed, "Renal Diet". diagnosis of ESRD (End e).					· .		
·	foods that are to be Resident #2 (those h	ticket included, "No s and no added salt." The limited or avoided for high in potassium and not listed on the resident's							
	being prepared on M meal consisted of a (tomato base), chick	Resident #2 was observed lay 21, 2007 at 5:22 PM. The cup of chicken gumbo soup en [alternate meat], pasta, cranberry juice and vanilla							

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL	ULTIPLE CONSTRUCTION  LDING	(X3) DATE S COMPLI	ETED
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F 363	The "Week at a Gla four (4) of May 200 concentrated sweet dietician (no date in consist of chicken ri and gravy, California applesauce. There	ge 13  Ince" spread sheet for week 7, for a renal diet with no s, was prepared by the dicated). The meal was to ice soup, spaghetti with beef a vegetable mix, bread, and was no evidence that the he substituted foods actually	F 3	363		
	interview was condu He/She was asked prepared as an alter	5:30 PM a face-to-face ucted with Employee #15. if any other soup was reate choice. Employee #15 seem to like this chicken				
	gumbo soup. I serve That lists all the disl can't have or doesn' evidence that chicke	e what's on the meal ticket. ikes and things the resident it want." There was no en rice soup, spaghetti with California vegetable mix were				
	for the texture of Re	lered a mechanical soft diet				
·	the dinner meal was consisted of pureed	5:10 PM the preparation of observed. The meal beef, macaroni and tomato arrots and mashed potatoes. printed as "Pureed."				
F	interview was condu	5:30 PM a face-to-face cted with Employee #15. about Resident #4's diet.				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IULTIPLE CONSTRUCTION LDING		(X3) DATE S COMPLE	
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F 363	He/She stated, "I ticket"  There was no evide physician had chan resident's diet.  3. Facility staff failer and low cholesterol physician and offer that the resident dis Resident T1 was or	serve what's on the meal ence in the record that the ged the consistency of the d to serve Resident T1 low fat foods as ordered by the substitutions for certain foods liked.	F3	re-wash stacking and resi 2. All pane inspecte clean, d	s and skillets have ted and air dried p g. All pans free of idue. s and skillets have ed to ensure that th ry and ready for u te of grease and re	rior to f grease been ney are se. All	
{F 371} SS=E	The resident's meal The resident's dinner prepared at 5:30 PN cup of chicken gumitomato casserole, prepared on the resident's was been a offered or served to did not list the high from the limited or avoided 483.35(i)(2) SANITAPREP & SERVICE	or avoided were not listed on ticket.  er tray was observed being M. The meal consisted of a bo soup, beef, macaroni and eas and carrots, a dinner roll, vanilla ice cream.  dent's meal ticket under and pasta. Chicken was not the resident. The meal ticket at or high cholesterol foods to d.  er, prepare, distribute, and	{F 37	3. In-servi kitchen ensure t clean, d residue. complet Dining stheir des skillets a need of remove area and dried properties of their des kitchen inspecte free from Any pan hung and residue rewashes specificate basis, the necessar from the reported meetings	ces will be provid staff on the need of hat pans and skillery and free of great Kitchen rounds we do na daily basis. Service Coordinates signee. If pans and are observed to be cleaning, the staff them from the stool have them cleane operly. Service Coordinates ignee will monito daily. Pans will be do ensure that then grease and resid as or skillets not did free from grease will be immediated to meet the attons. On a monte of findings and any y corrective action kitchen rounds wat the Quality Ass. The Quality	ed to to to tets are ase and will be s by or or d in will rage ed and or or or the e ey are ue. ry, or ly hly n taken will be ssurance	100 2/07
	This REQUIREMEN by:	T is not met as evidenced		education	ce report will drive n, changes in prac rocedure, if indica	tice	6/22/07

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER:  A BUILDING				(X3) DATE SURVEY COMPLETED	
		095021	B. WING	· · · · · · · · · · · · · · · · · · ·	R 05/21/2007	
l .	F PROVIDER OR SUPPLIER ISE AT THOMAS CIRCL	E	s	TREET ADDRESS, CITY. STATE, ZIP CODE 1330 MASSACHUSETTS AVENUE NW WASHINGTON, DC 20005		
(X4) IC PREFO TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE COMPLETE	
F 36	He/She stated, "I ticket"  There was no evide physician had change resident's diet.  3. Facility staff failed and low cholesterol	nce in the record that the ged the consistency of the I to serve Resident T1 low fat foods as ordered by the substitutions for certain foods iked.	F 36	3		
	cholesterol diet on M Foods to be limited of	lay 18, 2007 by the physician. or avoided were not listed on cket		F371	4/22/07	
SS=E	The resident's dinner prepared at 5:30 PM cup of chicken gumb tomato casserole, per cranberry juice and volumed on the reside "Dislikes" was beef a offered or served to the did not list the high fabe limited or avoided 483.35(i)(2) SANITAPREP & SERVICE  The facility must store serve food under san	r tray was observed being The meal consisted of a console	{F 371}	I. All pans and skillets have to re-washed and air dried print stacking.  2. All pans and skillets have to inspected to ensure that the clean, dry and ready for use inspected to ensure that the clean, dry and ready for use insure that pans and skillets clean, dry and sanitary. Kite rounds will be completed on daily basis by Dining Service Coordinator or their designe pans and skillets are observed be in need of cleaning, the still remove them from the storage area and have them cleaned and dried properly.  4. Over the next 8 weeks, Dining Service Coordinator or their designee will monitor the dail kitchen rounds for compliants On a monthly basis, the finding and any necessary corrective action taken of the kitchen rounds will be reported at the Quality Assurance meetings	een y are to are hen a e e. If d to aff	

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M		PLE CONSTRUCTION	(X3) DATE S	
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	<u>.</u>	095021	B. WIN	<u> </u>		05/2	1/2007
ł	PROVIDER OR SUPPLIER  E AT THOMAS CIRCL	<b>E</b>		13	EET ADDRESS, CITY, STATE, ZIP CODE 330 MASSACHUSETTS AVENUE NW VASHINGTON, DC 20005		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
{F 371}	Continued From pa	ge 15	{F 3	71}	·		
	Based on observati kitchen, it was deter failed to ensure that prepared in a safe a evidenced by soiled These findings were	ons during the tour of the main rmined that dietary services t foods were served and and sanitary manner as hotel pans and skillets. e observed in the presence of by 21, 2007 at 8:30 AM.					
	with a greasy residu	bbserved stored wet and/or se after being washed and 3 of 26 observations of hotel					
	debris on the interio	erved stored wet with food r surfaces after being washed in three (3) of six (6) ets.					
{F 431} SS=D	findings at the time of 483.60(b), (d), (e) Plant The facility must em a licensed pharmaci of records of receipt controlled drugs in saccurate reconciliation records are in order controlled drugs is maccurated.  Drugs and biological	PHARMACY SERVICES  ploy or obtain the services of st who establishes a system and disposition of all ufficient detail to enable an on; and determines that drug and that an account of all naintained and periodically sused in the facility must be	{F 43	31}			
	professional principle appropriate accesso						

	IENT OF DEFICIENCIES AN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI	JLTIPLE CONS	TRUCTION	(X3) DATE SI COMPLE	
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1	OF PROVIDER OR SUPPLIER LISE AT THOMAS CIRCL	E		1330 MASS	ESS. CITY, STATE, ZIP CODE ACHUSETTS AVENUE NW TON, DC 20005		
(X4) I PREF YAG	X (EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EA	PROVIDER'S PLAN OF CORRECT CH CORRECTIVE ACTION SHOU SS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X6) COMPLETION DATE
{F 431} \$S=D	Based on observativitichen, it was determined to ensure that prepared in a safe a evidenced by soiled. These findings were Employee #6 on Ma. The findings include 1. Hotel pans were with a greasy residuready for reuse in 23 pans.  2. Skillets were observations of skillets were observed by the skillets wer	ons during the tour of the main mined that dietary services a foods were served and and sanitary manner as hotel pans and skillets. The observed in the presence of y 21, 2007 at 8:30 AM.  The observed stored wet and/or e after being washed and of 26 observations of hotel en/ed_stored_wet_with food is surfaces after being washed in three (3) of six (6) ets.  The observations. HARMACY SERVICES  Tology or obtain the services of the observations of all efficient detail to enable an in; and determines that drug and that an account of all eintained and periodically asset in the facility must be the with currently accepted and include the y and cautionary	{F 43*	F431 1. 2.	been destroyed according to policy and state/federal regulations and paperwork/signatures completes	i.	6/22/07

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DA CO	MPLE	
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	PROVIDER OR SUPPLIER	E	·	1:	REET ADDRESS, CITY, STATE, ZIP CODE 330 MASSACHUSETTS AVENUE NW VASHINGTON, DC 20005		_	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	E	(X5) COMPLETION DATE
{F 431}	facility must store a locked compartment controls, and permit have access to the The facility must propermanently affixed controlled drugs list. Comprehensive Drucontrol Act of 1976 abuse, except when package drug distrik quantity stored is mister be readily detected.  This REQUIREMENT by:  Based on review of Discontinued Control and staff interview, i staff failed to follow	State and Federal laws, the II drugs and biologicals in its under proper temperature only authorized personnel to keys.  Divide separately locked, compartments for storage of ed in Schedule II of the ing Abuse Prevention and and other drugs subject to in the facility uses single unit bution systems in which the inimal and a missing dose can of the "Destruction of olled II-V Substances" forms the was determined that facility facility policy for controlled	{F 4	31}	I. Controlled medications have destroyed according policy and state/federal regulations and paperwork/signatures come 2. Controlled medications have audited and any controlled medications, were destrowed immediately and appropripaperwork/signatures comediately and appropripaperwork/signatures comediately and appropripaperwork/signatures comediately and document controlled medications. Discontinued or discharge medications will be removed from medication cart and in a centralized location from the destruction. Licensed nur obtain a second signature placed in secured location and/or designee will destruction medications (controlled are controlled) monthly during pharmacy consultant visit nurse will review medication carts daily to ensure that a	npleted.  ave rrolled,  yed ate npleted.  rviced proper ation of  ded  or se will when . DNS oy all nd non- g . Night ion !!		
	two (2) signatures, in medication and inco. The findings include According to the fact. "Controlled Medicat stipulates, c. " Sche remaining in the fact discharge, or the ord disposed of in the fact (1) Drug destruction flushing in the toilet	mplete forms.  E:  Ility 's Policy and Procedure, ion Disposal "section II E:1, dule II-V medication lity after a resident has been ler discontinued, are cility, is carried out by double			discontinued and discharg medications are removed a stored /destroyed per polici state/federal regulations.  4. Director of Nursing or the designee will monitor documentation of proper destruction, discontinuation discharge medication. The findings and any necessary corrective action taken will reported at the Quality Assimonthly meetings. Data collected will be used to distaff development.	eir on and nee y und nee y li be surance	مارود معم	6/22/07

	INT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIÉR/CLIA IDENTIFICATION NUMBER:	A. BUI	ULTIPLE CONSTRUCTION  LDING	(X3) DATE SL COMPLE	
Í		095021	B. WIN	IG		1/2007
	PROVIDER OR SUPPLIER SE AT THOMAS CIRCL	E	STREET ADDRESS, CITY, STATE, ZIP CODE 1330 MASSACHUSETTS AVENUE NW WASHINGTON, DC 20005			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI.		SHOULD BE	(X5) COMPLETIC DATE
{F 431)	The form must also destruction and the destroyed"  On May 21, 2007, a "Destruction of Disc Substances" forms The "Destruction of Substances" form of (8) entries. The eight signature, not the rethe form documente	ing the drugs and a witness. include the method of date the drugs were  It approximately 9:30 AM, the ontinued Controlled II-V were requested for review. Discontinued Controlled II-V lated May 9, 2007 had eight ht (8) entries included one (1) quired two (2) signatures and of the method of destruction edication into the sharps	{F 43	31)		
(F 441) SS=D	Substances" form da (2) entries. The two method of destruction A face-to-face intervi Employee #13 on Ma He/she stated that a needed. 483.65(a) INFECTIO The facility must esta infection control prog safe, sanitary, and co to prevent the develor disease and infection an infection control pr investigates, controls, the facility; decides w isolation should be ap	iew was conducted with ay 21, 2007 at 3:00 PM review of the procedure was N CONTROL  ablish and maintain an ram designed to provide a semiortable environment and pment and transmission of the facility must establish rogram under which it and prevents infections in that procedures, such as a polied to an individual as a record of incidents and	{F 44	1. The cat's medical/vaccin records have been obtain 2. Both center - owned cats had their medical/vaccin records obtained. 3. A copy of the cat's medical/vaccination reco be maintained by the Act department and will be re on a quarterly basis to en they are current and avail upon request. 4. On a monthly basis, the Activities Department wi copies of the medical/vac records for the center-ow to the Executive Director deficient practice is ident corrective action plans with developed to address ident areas.	ed. have ation  rds will ivities reiewed sure that lable  Il bring cination ned cats , if ified, ill be	6/22/07

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SI COMPLE		
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{F 431}	pharmacist destroyi The form must also	ige 17 ing the drugs and a witness. include the method of date the drugs were	{F 4	31}				
	"Destruction of Disc Substances" forms The "Destruction of Substances" form of (8) entries. The eig signature, not the re the form documente	at approximately 9:30 AM, the continued Controlled II-V were requested for review.  Discontinued Controlled II-V dated May 9, 2007 had eight tht (8) entries included one (1) equired two (2) signatures and the method of destruction redication into the sharps tht (8) entries.						
SS=D	The "Destruction of Substances" form d (2) entries. The two method of destruction A face-to-face interved Employee #13 on M He/she stated that a needed. 483.65(a) INFECTION The facility must estimate infection control programmer and infection an infection control programmer in	Discontinued Controlled II-V ated May 15, 2007 had two (2) entries did not include the on.  View was conducted with lay 21, 2007 at 3:00 PM. a review of the procedure was DN CONTROL.  Ablish and maintain an gram designed to provide a comfortable environment and opment and transmission of n. The facility must establish program under which it s, and prevents infections in what procedures, such as applied to an individual ains a record of incidents and	{F 44	41}				

T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	`		STRUCTION	(X:		
				·	_	1	R .
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(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFI TAG		ACH CORRECTIVE AC SS-REFERENCED TO	TION SHOULD THE APPROP	BE .	(X5) COMPLETION DATE
This REQUIREMENt by: Based on observati facility staff failed to the dining room had medical/vaccination. The findings include On May 21, 2007 at black cat was observoom floor. There we breakfast in the dining A face-to-face intervent of the facility. Increase a face the facility unit two areas is left open the cat walks through A face-to-face intervent of the face of the nursing facility unit. It [the cat walks through the stated, "The Living Unit. It [the cat walks through the face of the nursing facility of the nursing facility of the nursing facility of the stated. However, and the surveyor medical/vaccination was 70(c)(2) SPACE.	ons and staff interviews, ensure that a cat observed in appropriate records available.  approximately 8:25 AM, a ved walking across the dining vere six (6) residents eating a room at the time.  A weak was conducted with y 21, 2007 at 9:55 AM, ed that the cat lives in another he cat comes to this side when the door between the n [another area of the facility], gh the dining room often.  A weak was conducted with y 21, 2007 at 5:30 PM, cat belongs to the Assisted at should not be in the area y unit]. The cat sneaks over, we to contact the sales at the papers for the cat."  A ccination records were the facility was unable to with a copy of the cat's records.  AND EQUIPMENT		F443	1. The cat's medical records have been staff have been in regarding not allow skilled neighborthe have been posted coded door. A spris utilized to discontered skilled neighborthe have been posted to discontered skilled neighborthe have been posted to discontered skilled neighborthe have been posted to discontered skilled neighborthood, relowed to a skilled neighborthood, relowed to the posted to the maintained by the partment and without the partment and without the partment and upon request.  4. Activities coordinated at quarterly Quality meetings, success cat to enter skilled if measures of previous properties and the properties of the previous properties.	obtained. All serviced wing cat in tood. Signs on both sides of ay water bottle urage cat from ghborhood. Ed cats have vaccination of the Activities of the Activities of the available of the available of the available of preventing neighborhood. The available of the available of the available of preventing neighborhood. The available of the ava	reil	6/20/27
mechanical, electrica	ai, and patient care						
	PROVIDER OR SUPPLIER  E AT THOMAS CIRCLE  SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE  Continued From pa  This REQUIREMENT by: Based on observation facility staff failed to the dining room had medical/vaccination  The findings include  On May 21, 2007 at black cat was obser room floor. There we breakfast in the dini  A face-to-face interve Employee #1 on Ma He/she acknowledg area of the facility. I [nursing facility unit] two areas is left ope The cat walks throug  A face-to-face interve Employee #2 on Ma He/she stated, "The Living Unit. It [the ca [of the nursing facilit They [other staff] ha person in order to ge The cat's medical/vac requested. However provide the surveyor medical/vaccination 483.70(c)(2) SPACE  The facility must mai	OF CORRECTION IDENTIFICATION NUMBER:  095021  PROVIDER OR SUPPLIER  E AT THOMAS CIRCLE  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 18  This REQUIREMENT is not met as evidenced	PROVIDER OR SUPPLIER  E AT THOMAS CIRCLE  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  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.  483.70(c)(2) SPACE AND EQUIPMENT  The facility must maintain all essential	DENOVIDER OR SUPPLIER  E AT THOMAS CIRCLE  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  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. 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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 comes to this side [nursing facility unit] when the door between the two areas is left open [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 sheaks 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.  483.70(c)(2) SPACE AND EQUIPMENT  The facility must maintain all essential	PROVIDER OR SUPPLIER  E AT THOMAS CIRCLE  SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD REGULATORY OR LSC IDENTIFYING INFORMATION)  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 astated, "The cat comes to this side [nursing facility unit]. The cat sonducted 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 facility. The cat walks through the dining room often.  The cat's medical/vaccination records will be maintained by the discourage cat from enteries skilled neighborhood. 2. Both center - owned cats have been posted on both sides ocade door. A spay water bottle is utilized to discourage cat from enteries skilled neighborhood. 2. Both center - owned cats have been posted on both sides ocade door. A spay water bottle is utilized to discourage cat from enteries skilled neighborhood. 2. Both center - owned cats have been posted on both sides ocade door. A spay water bottle is utilized to discourage cat from enteries skilled neighborhood. Place the staff have been posted on the skilled neighborhood and the pattern of 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 for the facility. 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 we	DEFORMED OR SUPPLIER  BATHOMAS CIRCLE  SUMMARY STATEMENT OF DEFICIENCIES (CAND DEFICIENCE) SUMMASSACHUSETTS AVENUE NW WASHINGTON, DC 20005  SUMMARY STATEMENT OF DEFICIENCIES (CAND DEFICIENCE) SUMMASSACHUSETTS AVENUE NW WASHINGTON, DC 20005  SUMMARY STATEMENT OF DEFICIENCIES (CAND DEFICIENCE) SUMMASSACHUSETTS AVENUE NW WASHINGTON, DC 20005  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.  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SUNRISI	E AT THOMAS CIRCL	E			80 MASSACHUSETTS AVENUE NW ASHINGTON, DC 20005		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
	This REQUIREMENT by: Based on observation determined that factions (1) of three (3) maintained and service of the findings included the finding included the finding included the finding included	on and staff interview, it was lity staff failed to ensure that garbage disposals was viced timely.  main kitchen on May 21, h Employee #6, food waste sh cans with paper and metal stated that the garbage the mechanical dishwasher  posals in the clean food re tested and were  ed a copy of the lest Log" dated April 16, 2007, age disposal not working.  21, 2007, Employee #5 edisposal has been broken April. The motor is burned one. I know that there was out \$4600 and that corporate much money. The the leftover food on the and pans into a trash can."	F	456	1. The garbage disposal has bee replaced with a new disposal.  2. The other garbage disposal in kitchen was inspected and for to be fully operational.  3. The kitchen staff will be in-serviced on maintaining kitchen garbage disposal in proper working order, notifyin 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 garbage disposal are found to non operational, Maintenance department will be contacted a work order completed and repairs completed promptly. When repairs are needed, staf will utilize the other operation garbage disposals to deposit if waste.  4. Dining Service Coordinator of designee will monitor the kitchen daily for compliance Rounds will be completed and deficient practices will be documented and analyzed. Immediate action will be take indicated. On a monthly basis the findings of the kitchen round corrective actions will be reported at the Quality Assuranceting. The Quality Assuranceting. The Quality Assuranceting in practice and/or procedure, if indicated.	the und  If be and  If nal food  or A  d  en, if s, unds  ance once	Charlos
		May 7, 2007 and faxed to the					

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

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (DENTIFICATION NUMBER:			Ι' ΄	ULTIPI.	(X	(X3) DATE SURVEY COMPLETED		
		095021	1	LDING IG		1		R
NAME OF	PROVIDER OR SUPPLIER	033021		CTDE	ET ADDRESS, CITY, STATE, ZIP CO	DE	05/2	1/2007
ł	E AT THOMAS CIRCL	E	:	133	O MASSACHUSETTS AVENUE N ASHINGTON, DC 20005			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
	This REQUIREMENT by: Based on observation determined that factions (1) of three (3) of maintained and servations are supported by: The findings include During a tour of the 2007 at 8:25 AM with was observed in trass waste. Employee #6 disposal attached to was broken.  Two (2) garbage dispreparation area well functioning.  Employee #6 supplies "Maintenance Requestion and the supplies "Maintenance Requestion area well as the supplies "Maintenan	perating condition.  IT is not met as evidenced on and staff interview, it was lity staff failed to ensure that garbage disposals was viced timely.  It is not met as evidenced on and staff interview, it was lity staff failed to ensure that garbage disposals was viced timely.  It is not met as evidenced was lity staff failed to ensure that garbage and metal is stated that the garbage the mechanical dishwasher posals in the clean food re tested and were led a copy of the lest Log" dated April 16, 2007, lage disposal not working	F 4	156	F456  1. The garbage disposal I replaced with a new di 2. The other garbage disposal to be fully operational. 3. The kitchen staff will be in-serviced on maintain kitchen garbage dispose proper working order, Maintenance of the near repairs and proper disposal programmer working order, Maintenance of the near repairs and proper disposal waste. Kitchen will be completed on a basis by Dining Service. Coordinator or their degarbage disposal are for non operational, Mainten department will be completed prom when repairs are needed will utilize the other op garbage disposals to dewaste. 4. Over the next 8 weeks, Service Coordinator or designee will monitor to kitchen rounds for component of the next be and corrective action ta	sposal. sposal in the and found for the sposal in the sposal in the sposal in the sposal of the spos	d Alanka	6/22/07
	At 9:38 AM on May 2 stated, "The garbage since the middle of A out. We need a new a bid received for abothought that was too dishwasher discards plates or in the pots a An estimate from a care	1, 2007, Employee #5 disposal has been broken pril. The motor is burned one. I know that there was out \$4600 and that corporate			kitchen rounds will be r the Quality Assurance r		t	
	700 00 Day 1 10 - 1				ID THOMAS HOUSE			

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIÉR/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY TED			
			A. BUILDII	NG	} ,	₹			
_		095021	B. WING			1/2007			
	PROVIDER OR SUPPLIER E AT THOMAS CIRCL	E		STREET ADDRESS, CITY, STATE, ZIP CODE  1330 MASSACHUSETTS AVENUE NW  WASHINGTON, DC 20005					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE			
	An outside repair coapproximately 11:15 checking the unit, the most cost effective entire unit. The unit installed in approximately 483.75 ADMINISTR  A facility must be acceptable it to use its efficiently to attain opracticable physical well-being of each resident's care and some administrative staff fand monitor the facility staff failed free of possible acciptaff lighting the burn main kitchen with pa 483.25(h)(1), F323 for each resident's care with pa 483.25(h)(1), F323 for each resident re	ompany arrived at the facility at 5 AM on May 21, 2007. After the serviceman stated that the measure was to replace the was scheduled to be nately three (3) to four (4)  ATION  Iministered in a manner that resources effectively and remaintain the highest, mental, and psychosocial esident.  IT is not met as evidenced ons, record review and staff termined that the ailed to integrate, coordinate lity's practices related to the safety.  It to maintain an environment dent hazards as evidenced by hers on the gas stove in the per. Cross Reference CFR or specific findings regarding practice - Identified as	F 456		nted to noies. A strator e all inspect eral and ulations. needing he taken ourseled ing on a diacking mice will ally nece will nly ness, and ill be	6/20/07			
j	Facility staff failed services necessary t	I to provide maintenance		,	-				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		IPLE CONSTRUCTION  IG	(X3) DATE SU COMPLE	
		095021	B. Wil	1G _	· · ·		R 1 <b>/2007</b>
	PROVIDER OR SUPPLIER  E AT THOMAS CIRCL	E		1	REET ADDRESS, CITY, STATE, ZIP CODE 330 MASSACHUSETTS AVENUE NW VASHINGTON, DC 20005		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
{F 490}	(2), F253, for specif above deficient prac	ic findings regarding the tice.	{F 4	90}			
	appropriate goals, a interventions for res anticoagulant theraphypertension, Atrial pain management a Reference CFR 483	d to initiate care plans with pproaches and/or idents receiving antibiotic and by and for management of Fibrillation, Hyperlipidemia, and constipation. Cross . 20(k), F279 for specific the above deficient practice.					
	infection control propressure ulcer treatr	d to ensure that proper cedures were followed during ments. Cross Reference CFR or specific findings regarding.				<u></u>	
	received medication ordered by the physi	to ensure that residents as per facility policy and as cian. Cross Reference CFR for specific findings regarding					
	by the physician for inutritional needs. Cr	specific findings regarding the				· . ·	
	served and prepared manner as evidence skillets. Cross Refer	I to ensure that foods were l in a safe and sanitary d by soiled hotel pans and ence CFR 483.35(i)(2), F371 egarding the above deficient					
		to follow facility policy for disposal as evidenced by:					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	ULTIPLE LDING	E CONSTRUCTION	(X3) DATE S COMPLE	
		095021	B. WIN	iG			R <b>1/2007</b>
	PROVIDER OR SUPPLIER  E AT THOMAS CIRCL	E		1330	T ADDRESS, CITY, STATE, ZIP COD D MASSACHUSETTS AVENUE NV SHINGTON, DC 20005		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
{F 490}	the lack of two (2) sof medication and in Reference CFR 483 findings regarding to 9. Facility staff faile observed in the dinimedical/vaccination Reference CFR 483 findings regarding to 10. Facility staff faile disposal attached to was maintained and Reference CFR 483	ignatures, improper disposal accomplete forms. Cross 3.60(b), F431 for specific the above deficient practice.  Indicate that a cat any room had appropriate records available. Cross 3.65(a), F441 for specific the above deficient practice.  Indicate that the garbage of the mechanical dishwasher a serviced timely. Cross 3.70(c)(2), F456 for specific	{F 4	90}			
{F 492} SS=E	11. Facility staff fail hair covering and/or while in the main kit 483.75(b), F492 for above deficient practices factor pract	ed to ensure that the facility's ormmittee adequately of action to correct identified acility wide. Cross Reference 520 for specific practices deficient practice.	{F 49	92}			

1	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	IULTIPLE CONSTR	RUCTION	(X3) DATE SI COMPLE	E SURVEY IPLETED	
		5		LDING			R	
	<u>.                                      </u>	095021	B. WII	NG	_ <del></del>	05/2	1/2007	
	PROVIDER OR SUPPLIER E AT THOMAS CIRCL	<b>E</b>		1330 MASSA	SS, CITY, STATE, ZIP CODE CHUSETTS AVENUE NW ON, DC 20005		_	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG	IX (EAC	ROVIDER'S PLAN OF CORRECTH CORRECTIVE ACTION SHO S-REFERENCED TO THE APPR DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
	This REQUIREMENt by: Based on observation kitchen, it was deter to wear a hair net of completely cover the kitchen.  The findings include According to 22 DC service employee slother hair covering.  During observations 21, 2007 the following the kitchen pouring two (2) cups machine was on the from which scramble were being served.  A face-to-face intervitime of the observation being served.  A face-to-face intervitime of the observation without his stated, "Everyone hout of them by the diffusion door.  At 11:30 AM Employentering the kitchen walk into the main secovering.	NT is not met as evidenced ons during a tour of the main rmined that facility staff failed r other hair covering and/or eir hair while in the main e:  MR 3219.6, " Each food hall wear either a hair net or	{F 4	92} F492 1. 2. 3.	cited staff members at the tin survey.  All kitchen staff will be inserviced and observed to determine if staff is complia with hair coverings are requirements.  Employees # 9, 10, 11 and 1 have all been counseled on the need to wear hair covering win the kitchen. All kitchen swas inserviced on the importance of wearing a hair. The hairnet supply container been placed next to the kitch door, to allow staff better action the hairnets prior to enterithe kitchen. Kitchen rounds be completed on a daily basi. Dining Service Coordinator their designee. If inservices staff are observed not wearin hair nets, staff will be made wear the hair net and disciplinaction will occur.	me of  2 he while taff met. has been cess mg will is by or d ng to inary  en, if is, bunds e rance ance	10 10 10 10 10 10 10 10 10 10 10 10 10 1	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A BUILDING		(X3) DATE SURVEY COMPLETED					
		095021	B. WING			1	R 21/2007
	PROVIDER OR SUPPLIER E AT THOMAS CIRCL	E .		1330 MASSA	SS, CITY, STATE, ZIP CODE CHUSETTS AVENUE NW ON, DC 20005	1 0012	.112001_
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PF (EAC	ROVIDER'S PLAN OF CORRECTIVE ACTION SHO REFERENCED TO THE APPROPRIES.	ULD BE	(X5) COMPLETION DATE
	This REQUIREMENT by: Based on observation kitchen, it was deter to wear a hair net or completely cover the kitchen.  The findings include According to 22 DCI service employee strother hair covering.  During observations 21, 2007 the following At 9:30 AM, Employee entering the kitchen pouring two (2) cups machine was on the from which scramble were being served.  A face-to-face intervation time of the observation Employee #5 was as the kitchen without h stated, "Everyone ha out of them by the di #5 immediately repla room door.  At 11:30 AM Employee entering the kitchen if walk into the main se covering.	ons during a tour of the main mined that facility staff failed other hair covering and/or eir hair while in the main.  AR 3219.6, "Each food hall wear either a hair net or of the main kitchen on May	{F 49	F492 1. 2. 3.	cited staff members at the ti survey.  All kitchen staff will be inserviced and observed to determine if staff is complia with hair coverings are requirements.  Employees # 9, 10, 11 and I have all been counseled on the need to wear hair covering in the kitchen. All kitchen is was in-serviced on the importance of wearing a hair the hairnet supply contained been placed next to the kitch door, to allow staff better act to the hairnets prior to enter the kitchen. Kitchen rounds be completed on a daily basi Dining Service Coordinator their designee. If in-service staff are observed not wearin hair nets, staff will be made wear the hair net and discipl action will occur.	me of  12 the while staff rnet. r has nen cess ing is by or do inary  ng illy ce. ings of the ted at	6/22/07.

	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		CONSTRUCTION	COMPLE	
		095021	B. WIN	G		1	R 1/2007
NAME OF F	PROVIDER OR SUPPLIER	<del></del>		STREE	T ADDRESS, CITY, STATE, ZIP CODE		1/2001
SUNRIS	E AT THOMAS CIRCL	E .			MASSACHUSETTS AVENUE NW SHINGTON, DC 20005		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
{F 492}	Continued From pa	ge 24	{F 4	92}			
	at the gas range wit	thout his/her hair fully covered.					
ניד אַסְאַי	through the main kill without a hair cover		(F. 4)	221			
{F 493} SS=F	483.75(d)(1)-(2) GC	VERNING BODY	{F 49	93}	F493		
55-r	designated persons body, that is legally and implementing p management and or governing body app licensed by the Stat and responsible for	ve a governing body, or functioning as a governing responsible for establishing olicies regarding the peration of the facility; and the oints the administrator who is e where licensing is required; the management of the			<ol> <li>A District of Columbia lice         Nursing Home Administrate         been hired as of 5/31/07. A         anticipated start date is</li> <li>All residents have the poten         have been affected by this         citation.</li> <li>Community had been recruit         A Licensed Nursing Home         Administrator since the         resignation of previous</li> </ol>	or has  tial to	or as
	This REQUIREMENty: Based on staff intendocuments, it was disposed body failed to appoin home administrator management of the The findings include According to 22 DCI Management), "An aforty (40) hours per violate facility twenty-seven (7) days per violate to 10 the facility twenty-seven (7) days per violate to 20 License nursing home admin Columbia."	IT is not met as evidenced view and review of facility etermined that the governing int an interim licensed nursing responsible for the facility.			administrator. A Healthcare Administrator has been hired will begin Ongoin efforts will be made to recru retain and/or train additional individuals who may already licensed, or are eligible to become a licensed Nursing It Administrator in the District Columbia, and serve as a secondary Nursing Home Administrator.  4. On a monthly basis, the Hum Resources Coordinator or the designee will report to the Quality assurance Meeting the efforts to recruit, retain and / train potential secondary Licensed Nursing Home Administrators.	d and ng it, l v be dome of	Chados

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M		TIPLE CONSTRUCTION	(X3) DATE S COMPLE	
'		·					R
		095021	B. WIN	NG_			1/2007
	PROVIDER OR SUPPLIER E AT THOMAS CIRCL	Ε		1	REET ADDRESS, CITY, STATE, ZIP COD 1330 MASSACHUSETTS AVENUE N WASHINGTON, DC 20005	DE	·
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 493}	Continued From pa	ge 25	{F 4	—- 93}			
{F 520}	at 8:40 AM, a face-t Employee #1 revea have a licensed nur employed by the fac administrator was n facility; the date of s 483.75(o)(1) QUALI	o-face interview with led that the facility did not sing home administrator	{F 5:			· .	
SS=E	assurance committee nursing services; a	ain a quality assessment and se consisting of the director of physician designated by the 3 other members of the			A Quality Assura     Committee that ir     Director of Nursi     Medical Director     center's managen     has been develop     implemented to a     cited deficiencies	ncludes the ng, the and the nent team ed and ddress all	
į	issues with respect and assurance active develops and impler action to correct idea. A State or the Secret disclosure of the recept insofar as succept insofar as suc	least quarterly to identify to which quality assessment ities are necessary; and ments appropriate plans of ntified quality deficiencies.  etary may not require ords of such committee ch disclosure is related to the committee with the section.  by the committee to identify eficiencies will not be used as			by citation.  Through monitor observation roun administrative strinspect for comp federal and Distr Columbia regula areas are identifineding corrective will be taken to a compliance.  On a weekly bas next 8 weeks, the Assurance team to discuss the are during the May a revisit survey. Congoing basis the Quality Assurant will meet month identify areas of practice and device compliance compliance.	ing and ds, aff will liance with ict of tions. If ed as on, actions achieve  is for the e Quality will meet cas cited 21, 2007 on an e center's ce team ly to deficient elop n plans to nnce with rict of	6/22/07

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  095021		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A BUILDING			R		
		095021	B. WING			05/21/2007		
NAME OF PROVIDER OR SUPPLIER  SUNRISE AT THOMAS CIRCLE				STREET ADDRESS, CITY, STATE, ZIP CODE  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 PREF TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
{F 520}	• '	action to correct identified acility wide.	{F 5	20}				
	On May 21, 2007 at face-to-face intervie Executive Director. has a quality assura concerns and issue addressed the issue the previous survey. There was no evide committee develope	approximately 5:15 PM, a w was conducted with the He/she stated, "The facility nce program. We review s on a daily basis and is identified on the 2567 from						
	as evidenced by the  1. Immediate Jeopar F323  2. Potential for more Widespread for deficiencies F314  4. Potential for more	following: rdy - Isolated for deficiency e than minimal harm -						