STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095021	A. BUILDING _____ B. WING _____	03/22/2007

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

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L 000	Initial Comments An annual licensure survey was conducted March 20 through March 22, 2007. The following deficiencies were based on record review, observations, and interviews with the facility staff and residents. The sample included 10 residents and two (2) supplemental residents, based on a census of 23 residents on the first day of survey.	L 000		
L 001	3200.1 Nursing Facilities Each nursing facility shall comply with the Act, these rules and the requirements of 42 CFR Part 483, Subpart B, Sections 483.1 to 483.75; Subpart D, Sections 483.150 to 483.158; and Subpart E, section 483.200 to 483.206, all of which shall constitute licensing standards for nursing facilities in the District of Columbia. This Statute is not met as evidenced by: Based on record review and staff interview for one (1) of 10 sampled residents, it was determined that the physician failed to comply with CFR 483.40 by failure to assess one (1) resident's right lower leg while it was in an immobilizer [the resident subsequently developed a Stage III pressure ulcer], write an order for the immobilizer and ensure that a splint was placed on the resident's right wrist as ordered. Resident #1. The findings include: 1. The physician failed to assess the right lower leg of Resident #1 while it was in an immobilizer [the resident subsequently developed a Stage III pressure ulcer] and write an order for the immobilizer to the right leg on the resident's return from the hospital A. The resident was readmitted to the facility on	L 001	Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusion set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with federal and state law.	

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L 001	Continued From page 1 December 28, 2006. A nurse's note dated December 29, 2006 included, "...placed immobilizer with right leg..." The readmission orders signed and dated by the physician on December 29, 2007 failed to include an order for an immobilizer. The "Medical Data Base" dated and signed by the physician on December 29, 2006 and a physician's note signed and dated January 8, 2007 did not include an assessment of the resident's right lower leg nor did the assessments make reference to the immobilizer. A telephone order dated January 11, 2007 at 2:00 PM included, "...TDWB (R) LE (total dependent weight bearing right lower extremity) in brace..." This was the first physician's reference to the immobilizer to the resident's right lower leg. A physician's progress note dated January 14, 2007 included, "Patient recently had a fall and ORIF (R) hip due to fracture. [Resident] says he/she has pain in that leg but says he/she is able to manage with pain meds... Ext. (extremity) (R) lower leg - immobilizer..." There was no assessment of the resident's right lower leg. "Weekly Ulcer Assessment" was initiated for the right lateral leg on January 18, 2007. The wound was described as an acquired (developed in the facility) Stage III, 10 cm x 9cm, with blackish necrotic area, small amount of drainage and no odor. There was no evidence of skin assessments or evidence of the pressure ulcer to the right lower leg prior to the identification of the Stage III pressure ulcer on January 18, 2007.	L 001	1. A. Physician has inspected this resident's legs, written orders, & documented in progress notes. B. Physician has documented in order & progress notes regarding (R) wrist splint. OT plan of care now includes (R) wrist splint. Resident is wearing splint. 2. All other residents reviewed to ensure doctor's order includes ortho devices & devices are in place on resident. 3. Physician & Rehab Therapist will review all residents to ensure orders written & devices on residents. 4. Physician & Rehab will report to QA Committee.	3/29/07 3/29/07 4/13/07 5/6/07 & on going 5/6/07 & on going

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L 001	Continued From page 2 On March 20, 2007 at approximately 2:25 PM a dressing change was observed to the right leg of Resident #1. During the observation, the treatment nurse [Employee #6] explained that the pressure ulcer was the result of pressure from an immobilizer. On March 21, 2007 at approximately 3:00 PM, a face-to-face interview was conducted with Employee #6 who indicated, " The resident returned from the hospital with the immobilizer in place. Skin assessments are done on admission by the treatment nurse. There is not a daily assessment form for the CNAs to document residents skin condition. If a CNA sees something, they follow up with it by telling a nurse. When we observed the wound, it was late. When she went out, they said it was infected." The physician failed to assess the resident's right lower leg while in an immobilizer which subsequently resulted in the development of a pressure ulcer, initially observed and identified as a Stage III pressure ulcer. The record was reviewed on March 20, 2007. B. The physician failed to ensure that a splint was placed to the resident's right wrist as ordered. The readmission orders dated December 28, 2006 included, "Right wrist splint per OT (occupational therapy). The "Medical Data Base" dated and signed by the physician on December 29, 2006 included: "... [Resident] has had a slight hand deformity before he/she went to the hospital and the hand being swollen after the fall, he/she got X-rays that	L 001	1. A. Wrist splint applied to resident #1. B. Order stating location of (L) splint rewritten for (L) arm. 2. All residents checked by nursing and Rehab for use of splints/pads/ guards. All other patients had ortho devices present. 3. DON or designee and rehab staff will monitor use of splints/pads/guards. 4. DON or designee will report to QA Committee re: outcomes of audits on splints pads/guards. Note: Rehab to schedule inservices for ortho devices. Schedule to be added to Cardex. Note: See copies of In-service	03/23/07 3/29/07 04/12/07 05/06/07 on going 05/06/07 on going 05/06/07

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L 001	Continued From page 3 showed no signs of acute fracture..." The physician's progress notes dated January 8 and 14, 2007 did not include reference to the right hand or right wrist splint. The OT clarification order dated December 30, 2006 failed to include reference to the right wrist splint. The "Occupational Therapy Plan of Care for Rehabilitation" form dated January 29, 2007 for services rendered from December 30, 2006 through January 28, 2007 included, right hand deformity from previous CVA with edema of right hand. There was no reference to the right wrist splint. The January 2007 TAR (Treatment Administration Record) included, "12/28/06, R (right) wrist splint per OT, FYI (for your information)". There were no initials entered for the month of January to indicate that the splint was placed on the resident. The resident was observed on March 20, 2007 at approximately 2:25 PM. The resident was not wearing a right wrist splint. The record was reviewed on March 20, 2007.	L 001		
L 043	3208.5 Nursing Facilities The Director of Nursing shall provide for, at a minimum, the following: (a)Delivery of nursing care services in accordance with these rules; (b)Developing and maintaining nursing service objectives, standards of practice, policy and	L 043		

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L 043	Continued From page 4 procedure manuals, and written job descriptions for each level of nursing personnel; (c)Planning for and recommendation to the Administrator the number and levels of nursing personnel to be employed; (d)Coordinating nursing personnel, which include the following: (1)Recruitment; (2)Selection; (3)Position assignment; (4)Orientation; (5)In-service education; (6)Supervision; and (7)Termination (e)Developing a staffing plan that considers residents' needs for various types of nursing care; (f)Working with the medical staff and the interdisciplinary team in developing and implementing policies for resident care; (g)Working with other employees to ensure that the interdisciplinary care plan (ICP) is coordinated and maintained; and (h)Working with the Administrator and the Medical staff or Medical Director in the allocation of funds for facility programs.	L 043		

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L 043	Continued From page 5 This Statute is not met as evidenced by: Based on a review of four (4) of four (4) newly hired employee records and staff interview, it was determined that the Director of Nursing failed to provide orientation inclusive of abuse prohibition practices for newly hired employees. The findings include: A review of newly hired employee records revealed the following: Date of Hire Employee #1 February 26, 2007 Employee #2 March 15, 2007 Employee #5 March 17, 2007 Employee #9 February 20, 2007 Employee #1 replaced Employee #15; Employee #15's last day at the facility was February 28, 2007. A review of the schedule for February and March 2007 revealed that the above employees worked two (2) or more shifts since their date of hire. There was no evidence that the above employees participated in orientation inclusive of abuse prohibition practices. A face-to-face interview was conducted on March 21, 2007 at 10:30 AM with the Administrator. He/she acknowledged that the aforementioned employees did not receive orientation.	L 043	(1) The four new staff have been trained on abuse prohibition practices.(Social worker's staff training is 2 times / year). Human Resources' orientations also include abuse training prohibition. (2) All employee files will be reviewed to ensure training has occurred. (3) Human Resource Coordinator will ensure new hire files reflect employee signatures for abuse prohibition training before beginning work. HRC will audit monthly. (4) Human Resource Coordinator will report to QA Committee to ensure training is documented prior to staff's start date. (See in-service sign in sheets. see new hire declaration sheets.) resident rights and abuse policy added to new package (along with background check and drug screen). acknowledgement receipts must be signed and in file prior to an employee working.	3/27/07 5/06/07 on going 5/06/07 on going 05/06/07 on going
L 051	3210.4 Nursing Facilities A charge nurse shall be responsible for the following:	L 051		

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L 051	Continued From page 6 (a)Making daily resident visits to assess physical and emotional status and implementing any required nursing intervention; (b)Reviewing medication records for completeness, accuracy in the transcription of physician orders, and adherences to stop-order policies; (c)Reviewing residents' plans of care for appropriate goals and approaches, and revising them as needed; (d)Delegating responsibility to the nursing staff for direct resident nursing care of specific residents; (e)Supervising and evaluating each nursing employee on the unit; and (f)Keeping the Director of Nursing Services or his or her designee informed about the status of residents. This Statute is not met as evidenced by: Based on staff interview and record review for five (5) of ten sampled residents, it was determined that the charge nurse failed to assess the lower extremity of one (1) resident whose right leg was in an immobilizer and who subsequently developed a Stage III pressure ulcer, ensure that a right wrist splint was placed on the resident as ordered by the physician, develop a care plan for the assessment and care of the resident's right lower leg while wearing an immobilizer and revise the care plan with new interventions and approaches after multiple falls; adequately and consistently assess one (1) resident for pain and discontinue a medication as per physician's orders; clarify an order for a left splint for one (1) resident; and develop care plans	L 051		

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L 051	Continued From page 7 for two (2) residents for the potential adverse drug interactions of nine (9) or more medications. Residents #1, 7, 3, 4 and 5. The findings include: 1. The charge nurse failed to assess the right lower extremity of Resident #1 whose right leg was in an immobilizer and who subsequently developed a Stage III pressure ulcer, ensure that a right wrist splint was placed on the resident as ordered by the physician, develop a care plan for the assessment and care of the resident's right lower leg while wearing an immobilizer and revise the care plan with new interventions and approaches after multiple falls. A. On March 20, 2007 at approximately 2:25 PM a dressing change was observed on the right leg of Resident #1. During the observation, the treatment nurse explained that the pressure ulcer was the result of pressure from an immobilizer. The review of the nurses' notes dated for December 29 to January 18, 2007 revealed that an immobilizer was placed on the resident's right lower leg. The "Medical Data Base" dated and signed by the physician on December 29, 2006 and a physician's note signed and dated January 8, 2007 did not include an assessment of the resident's right lower leg nor did the assessments make reference to the immobilizer. According to a nurse's note dated January 11, 2007 at 5:02 PM, " Resident left unit for ortho appointment. Returned to unit and new orders were given. Orders were transcribed and faxed	L 051	1 A Staff now assessing resident's leg and documenting in medical record. Doctor's orders have been clarified. 2 No other residents have immobilizers. 3 DON or designee will audit nursing assessments of residents with immobilizers. 4 DON or designee will report to QA Committee on immobilizer and treatment ~~cart~~ audit outcomes.	03/2907 03/29/07 05/06/07 on-going 05/06/07 on-going

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L 051	Continued From page 8 to pharmacy. (1) Follow up in six weeks, (2) TDWB R LE in brace, (3) ROM active and assisted right knee, OOB. (3) Pain control as tolerated. On return Pt. report of consultation stated that his/her staples were removed by Dr. [name]. On assessment this nurse noticed that pt has 15 staples on right lateral thigh. Call was placed to Dr.'s office for clarification. Secretary at Dr.'s office said that Dr. [name] will call us back at the facility. Phone number was given. This nurse had not received a call from Dr.'s office yet. " According to a nurse's note dated January 18, 2007 at 6:00 AM, "...Remain right leg immobilizer intact. Same condition." "Weekly Ulcer Assessment " was initiated for the right lateral leg on January 18, 2007. The wound was described as an acquired (developed in the facility) Stage III, 10 cm x 9cm, with blackish necrotic area, small amount of drainage and no odor. There was no evidence of skin assessments or evidence of the pressure ulcer to the right lower leg prior to the identification of the Stage III pressure ulcer on January 18, 2007. On March 21, 2007 at approximately 3:00 PM, a face-to-face interview was conducted with Employee #6 who indicated, " The resident returned from the hospital with the immobilizer in place. Skin assessments are done on admission by the treatment nurse. There is not a daily assessment form for the CNAs to document residents skin condition. If a CNA sees something, they follow up with it by telling a nurse. When we observed the wound, it was late. When she went out, they said it was infected."	L 051		

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L 051	Continued From page 9 The facility staff failed to assess the resident's skin under the immobilizer which subsequently resulted in the development of a pressure ulcer which was initially observed and identified as a Stage III pressure ulcer. The record was reviewed on March 20, 2007. B. The charge nurse failed to ensure that a right wrist splint was placed on the resident as ordered by the physician. The readmission orders dated December 28, 2006 included, "Right wrist splint per OT (occupational therapy). The OT clarification order dated December 30, 2006 at 2:15 PM included: Skilled OT 5x/wk x4 wks to provide self-care training, functional mobility for ADL, w/c mobility training, WBAT right lower extremity, safety awareness, therapeutic activities/exercises, neuromuscular re-ed (re-education), in group or 1:1 sessions, patient/caregiver training. There was no reference to the right wrist splint. The "Occupational Therapy Plan of Care for Rehabilitation" form dated January 29, 2007 for services rendered from December 30, 2006 through January 28, 2007 included right hand deformity from previous CVA with edema of right hand. There was no reference to the right wrist splint. The significant change MDS dated January 9, 2007, Section P3 (Nursing Rehabilitation/Restorative Care) failed to code the resident for splint or brace assistance. The January 2007 TAR (Treatment Administration Record) included, "12/28/06, R	L 051	1. B Wrist splint applied to resident #1. 2. All residents checked by nursing and Rehab for use of splints/pads/ guards. All other patients had ortho devices present. 3. DON or designee and rehab staff will monitor use of splints/pads/guards. 4. DON or designee will report to QA Committee re: outcomes of audits on splints pads/guards. Note: Rehab to schedule inservices for ortho devices. Schedule to be added to Cardex.	03/23/07 04/12/07 05/06/07 on going 05/06/07 on going 05/06/07

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L 051	Continued From page 10 (right) wrist splint per OT, FYI (for your information)". There were no initials entered for the month of January to indicate that the splint was placed on the resident. The resident was observed on March 20, 2007 at approximately 2:25 PM. The resident was not wearing a right wrist splint. C. The charge nurse failed to develop a care plan for the assessment and care of the resident's right lower leg while wearing an immobilizer. Resident #1 returned to the facility on December 28, 2006 after surgery for a fracture to the right femur. Through an interview conducted on March 21, 2007 at 3:00 PM with Employee #6, it was determined that an immobilizer was applied to the lower right extremity. A review of the care plan dated December 29, 2006 listed a problem, "Alteration in ADL's (Activities of Daily Living) and function ability related to Right femur fracture S/P ORIF (Status Post Open Reduction Internal Fixation). Use of the leg immobilizer was listed as one (1) of the approaches . However, the care plan failed to include goals and approaches for the assessment and care of the resident's right lower leg while wearing the immobilizer. On March 21, 2007 at approximately 2:30 PM a face-to-face interview was conducted with the Director of Nursing. He/she acknowledged that the record lacked a care plan for the assessment and care of the resident's right lower leg while wearing the immobilizer. The record was reviewed on March 20, 2007.	L 051	(1) C Care plan reviewed to reflect assessment & care of affected leg 2. Care plans of all residents with immobilizers reviewed to identify any other residents with potential to be affected. 3. Director of Nursing or Designee will revise all care plans at Care Plan Meetings to ensure compliance for residents with immobilizers ~~& /or~~ 9 4. Director of Nursing or Designee will report to QA Committee regarding care plan compliance for patients with immobilizers & other resident needs. Director of Nursing or Designee will review Physician's Initial Plan of Care for all admissions & will initiate cardex. Assessment by nursing, dietary, activities & social services will be reviewed at weekly care plan meeting.	3/29/07 4/20/07 5/6/07& on going 5/6/07 & on-going 5/6/07 on-going

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L 051	Continued From page 11 D. The charge nurse failed to revise the care plan with new interventions and approaches after multiple falls. A review of Resident #1's record revealed that the resident had fallen as follows for 2006: January 30, February 3, June 28, 2006 and October 16, 2006. There were no injuries associated with these falls. The care plan for falls was initiated August 14, 2004 and last reviewed by facility staff on October 16, 2006. There was no evidence that the care plan was revised to include additional goals and approaches to prevent falls after the aforementioned falls. A nurse's note dated December 19, 2006 at 11:45 PM indicated, "At 11:02 PM nurse heard a loud cry coming from room [number] as medications were being prepared. Nurse went to room and noted resident lying on bath room floor. Resident was crunched in the bathroom corner crying and saying that [he/she] was in a lot of pain. Resident was assessed from head to toe. No LOC (Loss of Consciousness). Unable to perform ROM (Range of Motion) due to pain... Dr. [name] was made aware and stated that resident should go to the emergency room (ER) to rule out fracture or concussion. Resident left unit at 11:26 PM..." A physician's note dated December 29, 2006 indicated, " 85 year old...resident at the Long Term Care [name] who had sustained a fall and fractured right lower femur. Pt. (patient) is S/P (status post) ORIF (Open reduction and internal fixation). [Resident] is transferred back here for rehab. (Rehabilitation)..."	L 051	(1) Care plan for resident #1 revised with new approaches to prevents falls. (2)Care plans for all the residents with history of falls were reviewed to determine if new approaches were required. (3)Director of Nursing will review plans at care plan meeting to ensure any resident with history of falls has been reviewed. (4)Director of Nursing or designee will report to QA Committee on care plan status re: falls.	3/28/07 3/30/07 5/06/07 on going 5/06/07 on going

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L 051	Continued From page 12 A face-to-face interview was conducted with the Administrator on March 22, 2007 at approximately 4:15 PM. He/She acknowledged that the care plan was not updated with new goals and approaches for fall prevention. The record was reviewed on March 20, 2007. 2. The charge nurse failed to adequately and consistently assess Resident #7 for pain and discontinue the administration of Simvastatin (Zocor) as ordered by the physician. Resident #7 was receiving Hospice care. A. The charge nurse failed to adequately and consistently assess and medicate Resident #7 for pain. The resident was readmitted to the facility on January 4, 2007. The admission MDS (Minimum Data Set) dated January 14, 2007 revealed: moderately impaired cognitive skills for daily decision-making, periods of restlessness and cognitive status deteriorated in Section B; sometimes understands others and is rarely never understood in Section C; sad, pained, worried facial expressions and resists care in Section E; diagnoses of Osteoporosis and Dementia other than Alzheimer's Disease in Section I; and joint pain, soft tissue pain and hip fracture in last 180 days in Section J. Initial physician's orders dated and signed January 4, 2007 and renewed February 8, 2007 directed the following: "Acetaminophen 500 mg II (two) caps (1000 mg) po (orally) TID (three times daily) for pain. Roxanol 5 mg po every 4 hours PRN (as needed) for pain." The January and February 2007 Medication Administration Records (MARs) were requested	L 051	2 A. This resident #7 will be assessed & given pain med 1 hour before wound care. Nurse will complete & document a pain assessment prior to, & during wound care. If resident exhibits pain, nurse will stop treatment, notify physician, obtain pain med order & medicate resident prior to resuming wound care. Nurse(Treatment Nurse) responsible for wound care will administer pain med. B. Nursing staff will consistently & adequately assess & medicate& document for resident #7 See above.	3/23/07 5/6/07.& on-going

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	095021	A. BUILDING _____ B. WING _____	03/22/2007

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L 051	Continued From page 13 and could not be located at the time of this review. According to the March 2007 MAR, there was no evidence that Resident #7 received the aforementioned pain medication from March 1 through 21, 2007. A review of the "Controlled Medication Utilization Record" revealed that Roxanol was not administered to the resident for January 2007. The February and March 2007 "Controlled Medication Utilization Record" was requested and could not be located at the time of this review. The care plan problem entitled, "Pain Care Plan" initiated January 5, 2007 and evaluated January 9, 2007, included the approach, "Provide analgesia as ordered, evaluate effectiveness and consult with MD accordingly for needed adjustments; Evaluate current pain experience. Use appropriate pain scale: 0-10." A review of the Hospice nurses ' notes revealed the following: March 6, 2007 at 1110: " Hospice RN: Pt. agitated when touched. No distress noted ... " March 9, 2007 at 1210: " Hospice RN: Pt. remains agitated and more combative when touched ... " March 20, 2007 at 1:00 PM: " Hospice RN: ...Pt. did say " Ouch " when I assessed him/her for edema ... " According to the facility nurses' notes, the resident was described as voicing no complaints of pain or discomfort and/or no facial expression of pain on February 2 and 12, 2007. On March 18, 2007 the resident was described as being unable to answer questions of pain. There was	L 051	2. All residents receiving pain meds prior to treatments, have been reviewed to ensure proper care & /or documentation..	5/6/07
			3. Director of Nursing will audit care to ensure & / or documentation.	5/6/07 & on-going
			4.Director or Nursing or Designee will report to QA Committee on outcomes of audits of pain meds, discontinued meds,	5/6/07 & on-going

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L 051	Continued From page 14 no evidence in the record that facility staff adequately and consistently assessed the resident for pain. B. The charge nurse failed to discontinue the administration of Simvastatin (Zocor) as ordered by the physician for Resident #7. A Physician' s Order dated and signed by the physician on January 5, 2007 revealed, " D/C [discontinue] Simvastatin " . Additionally, the above order was audited by a facility Registered Nurse on January 6, 2007 at 3:00 AM. The January and February 2007 Medication Administration Records (MARs) were requested but were not available at the time of this review. According to the March 2007 MAR, Simvastatin 20mg tab [tablet] PO [by mouth] daily was administered on March 1 through 21, 2007 [21 doses] as evidenced by facility staff ' s initials in designated boxes, indicating that the medication was given. A review of the medication cart, in the presence of facility staff on March 21, 2007 at approximately 12:00 PM, revealed Simvastatin 20mg was in Resident # 7 ' s medication drawer. A face-to-face interview was conducted with the Director of Nursing on March 21, 2007 at 1:20 PM. He/she acknowledged that facility staff failed to follow up with the physician ' s order to discontinue the administration of Simvastatin. This record was reviewed March 21, 2007. 3. The charge nurse failed to clarify an order for a left splint for Resident #3.	L 051	2. B. Zocor discontinued for resident #7. 2. All residents with discontinued meds have been reviewed to ensure proper care 7/or documentation. 3. Director of Nursing will audit care to ensure & / or documentation. 4. DON or designee will report to QA Committee on outcomes of audits of discontinued meds and any other issues DON determines are relevant to quality care.	3/23/07 5/6/07 5/6/07 & on-going 5/6/07 & on-going

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L 051	Continued From page 15 Physician's orders dated and signed February 7, 2007, directed, " Left splint for swelling - Splint on at all times except during self care, Remove if swelling, skin changes develop. " There was no clarification of the above order to indicate what area of the body the left splint should be applied. The resident was observed on March 20, 2007 at 1:00 PM and 3:00 PM. There was no splint applied to the left upper or lower extremity. The resident was observed wearing a left arm splint on March 21, 2007. The record was reviewed March 21, 2007. 4. The charge nurse failed to develop a care plan with goals and approaches for the potential adverse drug interactions of nine (9) or more medications. Resident #4. The review of the clinical record for Resident #4 revealed a physician's order dated and signed February 27, 2007 that included the following medications: Amiodarone, Aspirin, Atenolol, Plavix, Hydrochlorothiazide, Synthroid, Potassium, Senna, Sorbitol, Timolol, and Trazodone. A review of the care plan that was last updated on January 5, 2007 revealed there was no problem identified with appropriate goals and approaches for potential adverse drug interactions involving nine (9) or more medications. On March 21, 2007 at approximately 2:30 PM a face-to-face interview was conducted with the Director of Nursing. He/she acknowledged that the record lacked a care plan for nine (9) or more	L 051	3. Order stating location of (L) splint rewritten for (L) arm. 2. All residents with orders for splints have been reviewed to ensure proper care &/or documentation. 3. Director of Nursing will audit care to ensure & / or documentation. 4. DON or designee will report to QA Committee on outcomes of splin audit and any other issues DON determines are relevant to quality care. 4. Care plan revised to reflect potential adverse drug interactions involving 9 or more meds for residents #4.	5/6/07 5/6/07 & on-going 5/6/07 & on-going 3/29/07

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L 051	Continued From page 16 medications and the care plan should have been updated. The record was reviewed on March 21, 2007. 5. The charge nurse failed to develop a care plan with goals and approaches for the potential adverse drug interactions of nine (9) or more medications. Resident #5. The review of the clinical record for Resident #5 revealed a physician's order dated and signed February 27, 2007 that included the following medications: Aspirin, Tenormin, Hydrochlorothiazide, Feosol, Folic Acid, Lisinopril, Multivitamin, Prilosec, Seroquel and Oxycodone. A review of the care plan that last updated on January 10, 2007 revealed there was no no problem identified with appropriate goals and approaches for potential adverse drug interactions involving nine (9) or more medications. On March 21, 2007 at approximately 2:30 PM a face-to-face interview was conducted with the Director of Nursing. He/she stated that the record lacked a care plan for nine (9) or more medications and the care plan should have been updated. The record was reviewed on March 21, 2007.	L 051	5. Care plan revised to reflect potential adverse drug interactions involving 9 or more meds for resident #5. 2. Care plans of all residents on nine or more meds reviewed to identify any other residents with potential to be affected. 3. Director of Nursing or Designee will revise all care plans at Care Plan Meetings to ensure compliance for residents with immobilizers & /or 9 or more meds & all other residents. 4. Director of Nursing or Designee will report to QA Committee regarding care plan compliance for patients with immobilizers & /or 9 or more meds & other resident needs.	3/29/07 4/20/07 5/6/07& on going 5/6/07 & on-going
L 052	3211.1 Nursing Facilities Sufficient nursing time shall be given to each resident to ensure that the resident receives the following: (a)Treatment, medications, diet and nutritional supplements and fluids as prescribed, and rehabilitative nursing care as needed;	L 052	Director of Nursing or Designee will review Physician's Initial Plan of Care for all admissions & will initiate cardex. Assessment by nursing, dietary, activities & social services will be reviewed at weekly care plan meeting.	5/6/07 on-going

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L 052	Continued From page 17 (b)Proper care to minimize pressure ulcers and contractures and to promote the healing of ulcers; (c)Assistants in daily personal grooming so that the resident is comfortable, clean, and neat as evidenced by freedom from body odor, cleaned and trimmed nails, and clean, neat and well-groomed hair; (d) Protection from accident, injury, and infection; (e)Encouragement, assistance, and training in self-care and group activities; (f)Encouragement and assistance to: (1)Get out of the bed and dress or be dressed in his or her own clothing; and shoes or slippers, which shall be clean and in good repair; (2)Use the dining room if he or she is able; and (3)Participate in meaningful social and recreational activities; with eating; (g)Prompt, unhurried assistance if he or she requires or request help with eating; (h)Prescribed adaptive self-help devices to assist him or her in eating independently; (i)Assistance, if needed, with daily hygiene, including oral acre; and j)Prompt response to an activated call bell or call for help. This Statute is not met as evidenced by:	L 052		

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L 052	Continued From page 18 Based on observation, staff interview and record review for seven (7) of 10 sampled residents, it was determined that facility staff failed to provide sufficient nursing time as evidenced by failure to: assess the right lower extremity of one (1) resident whose right leg was in an immobilizer and who subsequently developed a Stage III pressure ulcer, assess the resident for pain and administer pain medication during a wound treatment and adequately supervise the resident who had a fall and sustained a fracture to the right femur; assess and administer pain medication prior to a wound treatment and discontinue a medication as per physician's orders for one (1) resident; reweigh one (1) resident as per physician's orders; administer a tube feeding for one (1) resident per physician's orders; use a cleansing agent for three (3) residents during wound treatments as ordered by the physician; and administer medications to two (2) residents as ordered by the physician. Residents #1, 7, 2, 3, 9, JH1 and JH2. The findings include: 1. Facility staff failed to assess the right lower extremity of Resident #1 whose right leg was in an immobilizer and who subsequently developed a Stage III pressure ulcer; assess and medicate the resident for pain during a wound treatment and adequately supervise the resident who had a fall and sustained a fracture to the right femur. A. Facility staff failed to assess the right lower extremity of Resident #1 whose right leg was in an immobilizer and who subsequently developed a Stage III pressure ulcer. On March 20, 2007 at approximately 2:25 PM a dressing change was observed on the right leg of	L 052	1 A Staff now assessing resident's leg and documenting in medical record. Doctor's orders have been clarified. 2 No other residents have immobilizers. ~~No other bottles have been relabeled.~~ 3 DON or designee will audit nursing assessments of residents with immobilizers. DON or designee will inspect treatment cart to ensure no relabeling. 4 DON or designee will report to QA Committee on immobilizer and treatment cart audit outcomes.	03/2907 03/29/07 05/06/07 on-going ~~05/06/07~~ on-going

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L 052	Continued From page 19	L 052		

Resident #1. During the observation, the treatment nurse [Employee #6] explained that the pressure ulcer was the result of pressure from an immobilizer.

The review of the nurses' notes dated for December 29 to January 18, 2007 revealed that an immobilizer was placed on the resident's right lower leg.

The "Medical Data Base" dated and signed by the physician on December 29, 2006 and a physician's note signed and dated January 8, 2007 did not include an assessment of the resident's skin under the immobilizer, right lower leg, nor did the assessments make reference to the immobilizer.

According to a nurse's note dated January 11, 2007 at 5:02 PM, " Resident left unit for ortho appointment. Returned to unit and new orders were given. Orders were transcribed and faxed to pharmacy. (1) Follow up in six weeks, (2) TDWB R LE in brace, (3) ROM active and assisted right knee, OOB. (3) Pain control as tolerated. On return Pt. report of consultation stated that his/her staples were removed by Dr. [name]. On assessment this nurse noticed that pt has 15 staples on right lateral thigh. Call was placed to Dr.'s office for clarification. Secretary at Dr.'s office said that Dr. [name] will call us back at the facility. Phone number was given. This nurse had not received a call from Dr.'s office yet. "

According to a nurse's note dated January 18, 2007 at 6:00 AM, "...Remain right leg immobilizer intact. Same condition."

" Weekly Ulcer Assessment " was initiated for the right lateral leg on January 18, 2007.

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L 052	Continued From page 20 The wound was described as an acquired (developed in the facility) Stage III, 10 cm x 9cm, with blackish necrotic area, small amount of drainage and no odor. There was no evidence of skin assessments or evidence of the pressure ulcer to the right lower leg prior to the identification of the Stage III pressure ulcer on January 18, 2007. On March 21, 2007 at approximately 3:00 PM, a face-to-face interview was conducted with Employee #6 who indicated, " The resident returned from the hospital with the immobilizer in place. Skin assessments are done on admission by the treatment nurse. There is not a daily assessment form for the CNAs to document residents skin condition. If a CNA sees something, they follow up with it by telling a nurse. When we observed the wound, it was late. When she went out, they said it was infected." The facility staff failed to assess the resident's skin under the immobilizer which subsequently resulted in the development of a pressure ulcer which was initially observed and identified as a Stage III pressure ulcer. The record was reviewed on March 20, 2007. B. A Stage IV (post debridement) wound treatment to the right lower leg was observed on March 20, 2007 at 2:15 PM. The resident moaned and jerked throughout the treatment when the right leg was touched. The treatment nurse [Employee #6] failed to stop the treatment and assess the resident for pain. A physician's order dated February 16, 2007 directed, "Oxycodone 10 mg orally every 4 hours as needed for pain."	L 052		

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L 052	Continued From page 21 A physician's order dated March 9, 2007 directed, "OxyContin 40mg every 12 hours for pain." A face-to-face interview was conducted with Employee #6 at the time of the wound treatment. He/she stated, "[Resident] had received something for pain about 45 minutes ago." According to the March 2007 Medication Administration Record (MAR), the resident received OxyContin 40mg at 9:00 AM on March 20, 2007. There was no evidence that additional pain medication was administered prior to the wound treatment. The care plan was reviewed and failed to include approaches and goals related to pain related to the Stage IV pressure ulcer to the right lower leg..	L 052	**1.B** This resident will be assessed and given pain meds one hour before wound care. Nurse will complete & document a pain assessment prior to, and during wound care. If resident exhibits pain,	3/23/07
	There was no evidence that the resident's pain was assessed prior to and during the wound treatment. There was no evidence that additional pain medication was administered prior to or during the wound treatment in response to the resident's discomfort. The record was reviewed March 20, 2007. C. Facility staff failed to adequately supervise the resident who had a history of multiple falls and subsequently fell and sustained a fracture to the right femur. A nurse's note dated December 19, 2006 at 11:45 PM indicated, "At 11:02 PM nurse heard a loud cry coming from room [number] as medications were being prepared. Nurse went to room and noted resident lying on bath room floor. Resident was crunched in the bathroom corner crying and saying that [he/she] was in a lot of		**2.** All residents receiving pain meds prior to treatments have been reviewed to ensure proper care &/or documentation. **3. Director of Nursing will audit care to ensure &/ or documentation.** **4.** DON or designee will report to QA Committee on outcomes of audits of pain meds and any other issues DON determines are relevant to quality care.	5/6/07 5/6/07 & on-going 5/6/07 & on-going

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L 052	Continued From page 22 pain. Resident was assessed from head to toe. No LOC (Loss of Consciousness). Unable to perform ROM (Range of Motion) due to pain. Vitals were Temperature (T) 98.3, Pulse (P) 77, Respirations (R) 28, and (Blood Pressure) B/P 211/96. Pulse ox (oximetry) 97% R/A (Room Air). FS (Finger Stick) 157mg/dl. Resident had already received her 10:00 PM Oxycontin 20mg. Three (3) nurses assisted resident into w/c (wheelchair) as [he/she] was unable to stand. Dr. [name] was made aware and stated that resident should go to the emergency room (ER) to rule out fracture or concussion. Resident left unit at 11:26 PM. Sister [name] responsible party made aware. " According to the annual Minimum Data Set (MDS) signed and dated October 6, 2006, at Section G, "Physical Functioning and Structural Problems", walk in room/ corridor was coded "1" for supervision and Toilet use was coded for "3" extensive assistance. Section J, "Accidents", was coded for "Fell past 31-180 days". A physician's note dated December 29, 2006 indicated, " 85 year old...resident at the Long Term Care [name] who had sustained a fall and fractured right lower femur. Pt. (patient) is S/P (status post) ORIF (Open reduction and internal fixation). [Resident] is transferred back here for rehab. (Rehabilitation)... Pt. was ambulatory before with walker [he/she] says [he/she] had pain but the current regimen is helping. [Resident] denies dyspnea. [Resident] says [he/she] knows [he/she] is better. Patient has functional decline and back for rehab. " On March 20, 2007 at approximately 2:30 PM, a face-to-face interview was conducted with the resident who indicated that [he/she] remembered	L 052	(1) Care plan for resident #1 revised with new approaches to prevents falls. (2)Care plans for all the residents with history of falls were reviewed to determine if new approaches were required. (3)Director of Nursing will review plans at care plan meeting to ensure any resident with history of falls has been reviewed. (4)Director of Nursing or designee will report to QA Committee on care plan status re: falls.	3/28/07 3/30/07 5/06/07 on going 5/06/07 on going

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L 052	Continued From page 23	L 052		

going to the bathroom, was standing at the sink washing his/her face in preparation for bed, stumbled back, fell and was unable to get up without help.

On March 22, 2007 at approximately 4:50 PM at a face-to-face interview was conducted with Employee #9, who indicated, " I was here the day of the incident. The resident was in the bathroom. A CNA (Certified Nurse Aide) summoned me to the room. CNA reported that the resident was on the floor. I went to the bathroom and noted the resident on the bathroom floor. I assessed her by dong ROM to [his/her] extremities. [She/he] did not tolerate ROM to the right leg because it hurt. MD on call was notified. [Resident] was medicated for pain. The doctor gave an order to send the resident to the ER via 911 to rule out a fracture. The resident was sent to ER [emergency room]. POA (power of attorney) was notified. [He/she] left via stretcher alert an oriented x3."

A review of Resident #1's record revealed that the resident had fallen as follows for 2006: January 30, February 3, June 28 and October 16, 2006. There were no injuries associated with these falls.

The care plan entitled "Falls" was initiated August 14, 2004 and last reviewed by facility staff on October 16, 2006. There was no evidence that the care plan was revised to include additional goals and approaches to prevent falls after the aforementioned falls.

Facility staff failed to provide adequate supervision for Resident #1 with a history of falls who subsequently fell and sustained a fracture to the right femur. The record was reviewed on

Health Regulation Administration

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	095021	A. BUILDING _____ B. WING _____	03/22/2007

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

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L 052	Continued From page 24 March 20, 2007. 2. Facility staff failed to assess and administer pain medication to Resident #7 prior to a Stage IV wound treatment. During the positioning of the resident prior to the wound treatment, the resident was moaning, groaning, and saying "ouch." Employee #6 failed to assess the resident for pain prior to initiating the wound treatment. The wound treatment for a Stage IV sacral pressure ulcer was observed on March 21, 2007 at 1:30 PM. During the treatment, the resident continued to moan, groan and say "ouch" and clenched his/her hand tightly to the arm of the staff member assisting with the wound treatment. The treatment nurse failed to stop the treatment and assess the resident ' s pain. A face-to-face interview was conducted with the treatment nurse on March 21, 2007 at approximately 1:35 PM. He/she stated, " The resident was administered pain medication prior to the dressing change. " However, the responsibility for administering medications both scheduled and as needed medication was assigned to another nurse [medication nurse]. Initial physician's orders dated and signed January 4, 2007 and renewed February 8, 2007 directed the following: "Acetaminophen 500 mg II (two) caps (1000 mg) po (orally) TID (three times daily) for pain. Roxanol 5 mg po every 4 hours PRN (as needed) for pain." The March 2007 MAR lacked evidence that pain	L 052	2 A. This resident #7 will be assessed & given pain med 1 hour before wound care. Nurse will complete & document a pain assessment prior to, & during wound care. If resident exhibits pain, nurse will stop treatment, notify physician, obtain pain med order & medicate resident prior to resuming wound care. Nurse(Treatment Nurse) responsible for wound care will administer pain med.	3/23/07
			B. Nursing staff will consistently & adequately assess & medicate& document for resident #7 See above.	5/6/07.& on-going
			2. All residents receiving pain meds prior to treatments, all residents with discontinued meds, all residents with orders for splints, & one resident on G-Tube feeding have been reviewed to ensure proper care & /or documentation..	5/6/07
			3. Director of Nursing will audit care to ensure & / or documentation.	5/6/07 & on-going
			4.Director or Nursing or Designee will report to QA Committee on outcomes of audits of pain meds, discontinued meds, splints, G Tube feedings, & any other issues Director of Nursing determines are relevant to quality care.	5/6/07 & on-going

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L 052	Continued From page 25 medication was administered from March 1 through the 21, 2007. A face-to-face interview was conducted with the Director of Nursing on March 21, 2007 at approximately 2:20 PM. He/she acknowledged that the March 2007 MAR lacked evidence that the resident was administered pain medication prior to the dressing change. This record was reviewed March 21, 2007. 3. Facility staff failed to reweigh Resident #2 as ordered by the physician. A review of Resident #2 ' s interim order form dated March 13, 2007 at 7:00 AM revealed the following order, " Weigh resident to verify weight status. (He/she has had significant weight gain 7.8% [one] month). " A review of the resident's weight record, nurses' notes, and nutritional progress notes lacked evidence that the resident was reweighed as ordered. A face to face interview was conducted with the Director of Nursing on March 21, 2007 at 1:20 PM. He/she acknowledged that there was no evidence that the resident was reweighed as ordered. This record was reviewed March 20, 2007. 4. Facility staff failed to follow physician's orders regarding Resident #3's G-tube (gastrostomy tube) feedings. A. Facility staff failed to follow physician's orders regarding Resident #3's G-tube (gastrostomy tube) feedings	L 052	3. 1. Record lacked evidence resident was ever reweighed after previously reported weight gain. No edema. No negative outcome. Patient discharged to home on 4/1/07 in much improved condition. 2.All residents' weights have been reviewed to ensure no similar situation exists and to ensure proper proper care &/or documentation. 3.DON or designee will audit care to ensure proper care &/or documentation. 4.DON or designee will report to QA Committee on outcomes of weight audits and any other issues DON determines are relevant to quality care.	5/6/07 5/6/07 5/6/07 & on-going 5/6/07 & on-going

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L 052	Continued From page 26 The resident was observed lying in bed with his/her G-tube connected to a feeding pump on March 21, 2007 at 10:00 AM, 11:00 AM and 12:00 PM. The feeding pump was tumed off and there was no enteral feeding in the attached bag. A physician's order dated February 7, 2007, " Resource Diabetic via g-tube at 50 mls/ hr x 20 hrs or until total volume has been delivered. " According to the March 2007 Treatment Administration Record (TAR), the facility had designated that the tube feeding would be " down " (stopped) at 12:00 AM and " up " (started) at 4:00 AM. The night nurse's initials were present on the March 2007 TAR indicating that the tube feeding was stopped at 12:00 AM and started at 4:00 AM. According to the MDS completed January 8, 2007, in Section K, " Oral/Nutritional Status, " the resident received 100% of his/her nutrition via tube feedings. A face-to-face interview with the medication nurse [Employee #3] was conducted on March 21, 2007 at 2:00 PM. He/she stated, " I hung the tube feeding at 12:30 PM. The new bag should have been hung at 4 AM. " There was no evidence in the record that the resident experienced any untoward effects. Although it was documented on the Treatment Administration Record that the tube feeding was administered at 4:00 AM, through interview and observation, it was determined that the tube feeding was administered at 12:30 PM. 5. During wound treatment observations for	L 052	4.1 On 3/21/07 G Tube feeding was not given at times on TAR. No negative outcome. Proper times will be followed. 2. No other residents on G-Tube feedings. All residents on G-Tube feedings in the Future will be reviewed to ensure proper care &/or documentation. 3. Director of Nursing will audit care to ensure & / or documentation. 4. DON or designee will report to QA Committee on outcomes of G-Tube audits & any other issues DON determines are relevant to quality care.	3/29/07 5/6/07 5/6/07 & on-going 5/6/07 & on-going

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L 052	Continued From page 27 Residents #1, 7 and 9, the treatment nurse [Employee #6] failed to use a cleansing agent as per the physician's order. A wound treatment for Resident #1 was observed on March 20, 2007 at 2:15 PM. A physician's order dated February 16, 2007 directed, Right leg wound Stage 4: cleanse with normal saline solution and apply Hydrogel and cover with gauze daily. A wound treatment for Resident #7 was observed on March 21, 2007 at 1:30 PM. A physician's order dated March 5, 2007 directed, Cleanse sacral ulcer Stage IV with normal saline solution and apply Hydrogel. Cover with 4 x 4 gauze. A wound treatment for Resident #9 was observed on March 21, 2007 at 2:30 PM. According to a physician's order dated February 1, 2007, Clean sacral ulcer with normal saline solution. The treatment nurse used a cleansing solution contained in a bottle with white tape across the product name. The product name, "Carra Klenz", was evident through the white tape. There was no writing on the white tape. A face-to-face interview was conducted with the treatment nurse at the time of the wound observation. He/she was asked if Carra Klenz was the same as normal saline solution. The nurse replied, "No, they are different. I poured normal saline into this bottle, so that I could use the spray. That's why I put the tape over the Carra Klenz." There was no evidence that the contents of the spray bottle was normal saline solution. 6. Facility staff licensed nurses failed to	L 052	1 Bottle containing normal saline (with old label covered) was discarded. 2 No other bottles have been relabeled. 3 DON or designee will audit nursing assessments of residents with immobilizers. DON or designee will inspect treatment cart to ensure no relabeling. 4 DON or designee will report to QA Committee on immobilizer and treatment cart audit outcomes.	03/21/07 03/29/07 05/06/07 on-going 05/06/07 on-going

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L 052	Continued From page 28 administer medication to two (2) residents as ordered by the physician. A. On Tuesday, March 20, 2007, the medication nurse [Employee #5] was observed administering medications to Resident JH1 at approximately 9:00 AM. After the medication pass, the physician's orders were checked. It was discovered that the medication nurse administered three (3) of six (6) ordered medications to resident JH1 for 9:00 AM. The resident received one tablet of Lisinopril 2.5 mg and Prandin 0.5 mg and two tablets of Flomax 0.4mg. According to the physician's orders, Resident JH1 was ordered Aggrenox one tablet, Toprol XL 50 mg and Lovenox 40 mg. The Medication Administration Record (MAR) indicated that the medications were to be administered at 9:00 AM. However, the medication nurse was not observed administering the aforementioned medications during the medication pass. A face-to-face interview was conducted with the DON on March 20, 2007 at approximately 11:30 AM. He/she explained that the nurse started less than a week ago. B. On Wednesday, March 21, 2007 at approximately 9:15 AM the medication nurse [Employee #3] was observed administering medications to Resident JH2. Spiriva inhaler was not administered to Resident JH2. The physician ' s order read, " Spiriva 18mcg w/handihaler one puff qd for COPD " . According to the MAR, Spiriva was to be administered at 9:00 AM. A face-to-face interview was conducted with the medication nurse on March 21, 2007 at	L 052	1. A. Patient now receiving correct meds. New Nurse #5 trained in med pass. B. Patient now receiving inhaler medications as ordered. Nurse #3 trained in med pass. 2. All MARS reviewed to ensure all patients receiving proper meds. Competency test will be given to all med nurses. 3. Director of Nursing or Designee monitor med pass compliance. Pharmacy will schedule med pass observations/training. 4. Director of Nursing or Designee will report to QA Committee on Med Pass Compliance.	3/23/07 3/23/07 4/19/07 & on-going 5/6/07 & on-going 5/6/07 & on-going

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L 052	Continued From page 29 approximately 11:00 AM. The medication nurse stated that he/she did not know that the inhaler was to be given.	L 052	1. Employee counseled regarding the importance of washing/sanitizing hands between med passes.	3/23/07
L 091	3217.6 Nursing Facilities The Infection Control Committee shall ensure that infection control policies and procedures are implemented and shall ensure that environmental services, including housekeeping, pest control, laundry, and linen supply are in accordance with the requirements of this chapter. This Statute is not met as evidenced by: Based on observations during wound treatments and the environmental tour, it was determined that proper procedures were not followed to control the spread of communicable diseases as evidenced by: failure of the medication nurse to wash his/her hands after contact with two residents and closed boxes and opened packages were stored on the clean linen room floor. This observation was made in the presence of the Administrator and the Director of Environmental Services. The findings include: 1. The medication nurse [Employee #5] failed to wash his/her hands after contact with two (2) residents during medication pass. On March 20, 2007 at approximately 9:30 AM, while observing the medication pass, the medication nurse [Employee #] did not wash or sanitize his/her hands before or after administering medication to Residents JH1 and #4. 2. Closed boxes and opened packages of pads, diapers and washcloths were stored on the floor	L 091	2. All licensed staff in-serviced on importance of washing/sanitizing between med passes. Director of Nursing observed staff to ensure improper technique was isolated. Sanitizing product will be kept on med cart. 3. Director of Nursing will monitor staff to ensure med passes are proper. Pharmacy called to observe/train staff for proper med pass technique. 4. Director of Nursing or Designee will report to QA Committee on med observation outcome. 1.Boxes were picked up off carpet & placed on shelf. 2.All supply areas were inspected to ensure no other boxes were on the floor. 3.Director of Housekeeping will inspect supply areas to ensure all boxes are off the floor & will record in unit log box. 4.Director of Housekeeping will report to QA Committee on outcome of audits.	3/30/07 3/30/07 & on going 3/30/07 & on going 3/22/07 3/22/07 5/6/07 & on going 5/6/07 & on going

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L 091	Continued From page 30 in the clean linen room on the second floor in six (6) of six (6) boxes/packages observed at 2:30 PM on March 20, 2007. The above observation was acknowledged by the Director of Environmental Services and the Administrator.	L 091		
L 099	3219.1 Nursing Facilities Food and drink shall be clean, wholesome, free from spoilage, safe for human consumption, and served in accordance with the requirements set forth in Title 23, Subtitle B, D. C. Municipal Regulations (DCMR), Chapter 24 through 40. This Statute is not met as evidenced by: Based on observations during the survey period, it was determined that dietary services were not adequate to ensure that foods were prepared and served in a safe and sanitary manner as evidenced by: soiled can openers, dishwasher slats, hotel pans, sheet pans, chinaware, dead insects (roaches) on a shelf, unlabeled food in the refrigerator, cleaning equipment stored on the floor, marred and damaged walls and exit doors, and temperatures in the main kitchen and second floor serving area were 86 degrees Fahrenheit (F). These observations were made on March 20, 2007 between 8:45 AM and 3:30 PM and observed by the Food Service Director. The findings include: 1. Can openers in the salad and cook ' s preparation areas were soiled on the cutting edges with food debris and metal shavings in two (2) of two (2) can openers observed. 2. Slats on the clean and soiled side of the dishwasher were observed soiled with food debris	L 099	1 1. Can openers cleaned & sanitized. 2. Dishwasher slats cleaned & sanitized. 3. Hotel pans cleaned, sanitized & air dried. 4. Sheet pans cleaned, sanitized & air dried. 5. Chinaware cleaned, sanitized & air dried. 6. Two dead roaches removed. All food removed & all shelf surfaces in cabinet cleaned. 7. All food items discarded.	3/22/07 3/22/07 3/22/07 3/22/07 3/22/07 3/22/07 3/22/07

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L 099	Continued From page 31 and mineral deposits. 3. 14 of 16 hotel pans size 14 " x 24 " x 2 " and seven (7) of 11 hotel pans size 14 " x 6 " x 10 " (deep) were observed soiled with grease, food debris and stored wet and ready for reuse. 4. 17 of 19 sheet pans were observed soiled with grease and stored wet and ready for reuse. 5. Chinaware was observed soiled with food debris after being washed as follows: five (5) of five (5) salad preparation bowls, 16 of 26 soup bowls, and six (6) of 11 plates. 6. Two (2) dead insects (roaches) were observed on the shelf surfaces in the stainless steel cabinet in the cook ' s preparation area. 7. Unlabeled sliced fruit, bread, and salads were stored in the refrigerator in three (3) of six (6) food items observed. 8. Cleaning equipment such as mops, brooms and dustpans were stored on the floor of the janitorial closet in the main kitchen. The concrete floor was soiled and uneven in one (1) of one (1) janitorial closet observed. 9. Walls in the pot and pan wash area and the area near the juice dispenser were marred and damaged with missing baseboard tiles in two (2) of two (2) walls observed. 10. Exit doors in the rear of the kitchen were marred and damaged in three (3) of three (3) exit doors observed. 11. Temperatures in the main kitchen and the second floor serving area were recorded at 86	L 099	8. All mop, brooms & dust pans properly hung. Janitor's closet floor cleaned. 9. Baseboard tiles on 2 walls replaced. 10.Exit doors in rear of kitchen repaired & painted. 11.Director of Maintenance seeking proposals for air supply vents. When airconditioning is on, the temperature should be correct. 2. All other food service areas inspected to ensure some conditions do not exist elsewhere. 3. Food Service Director or Designee will inspect all food service Areas monthly to ensure compliance & prevent recurrence of above conditions. 4. Food Service Director or Designee will report to QA Committee on inspections outcomes.	3/22/07 5/6/07 5/6/07 5/6/07 4/13/07 5/6/07 on going 5/6/07 on going

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L 099	Continued From page 32 degrees F [temperature range should be 71 - 81 degrees F]. Both areas lacked air supply vents. The aforementioned observations were acknowledged by the Food Service Director at the time of the tour.	L 099		
L 163	3227.14 Nursing Facilities Destruction of controlled substances shall be witnessed by two (2) licensed nurses and a signed and dated notation shall be made in the resident's medical record. This Statute is not met as evidenced by: Based on staff interview and review of documents, it was determined that facility staff failed to complete the "Destruction of Discontinued Controlled II-V Substances" form as per facility policy. The findings include: Facility staff failed to complete the "Destruction of Discontinued Controlled II-V Substances" form as per facility policy. 22 DCMR 3227.14 stipulates, " Destruction of controlled substances shall be witnessed by two (2) licensed nurses..." The facility ' s policy and procedure, " Controlled Medication Disposal " section IIE:1 d. stipulates, " The controlled dangerous substance disposition form required by the Division of Drug Control is completed each time controlled drugs are destroyed. " (3) The form must be signed by the nurse or pharmacist destroying the drugs and a witness. The form must also include the method of destruction and the date the drugs were destroyed " (5) A copy must be sent to the	L 163	1. "Destruction of Discontinued Controlled II-V Substances" form is now being completed per facility policy. 2. DON has audited medication destruction system to ensure no similar issues exist. 3. DON or designee will audit drug destruction system to ensure to ensure no similar issue recurs in the future. 4. DON or designee will report to QA Committee on results of drug destruction audit.	5/06/07 5/06/07 5/06/07 on going 5/06/07 on going

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L 163	Continued From page 33 Division of Drug Control " On March 22, 2007, at approximately 10: 00 AM, the " Destruction of Discontinued Controlled II-V Substances " form was requested. The form did not document the Method of Destruction nor did it contain two (2) signatures for the destruction of Morphine Sulfate 15 mg tablet for 42 tablets and Morphine Sulfate 20mg / ml for 30 ml. The policy and forms were reviewed on March 20, 2007.	L 163		
L 168	3227.19 Nursing Facilities The facility shall label drugs, and biologicals in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and their expiration date. This Statute is not met as evidenced by: Based on observation of four (4) of six (6) multi-dose vials and review of facility policy, it was determined that facility staff failed to date and initial opened multi-dose medication vials. The findings include: The facility ' s policy and procedure, " Vials and Ampules of Injectable Medications " section IIIA:3, stipulates, " The date opened and the initials of the first person to use the vial are recorded on multidose vials either on the vial label or on an accessory label affixed for the purpose. " On March 20, 2007, at approximately 10:45 AM, during the inspection of the medication storage area, four (4) of six (6) opened multi-dose vials were observed in the medication refrigerator without a date or initials of the person who	L 168	1.Opened vials discarded. Opened vials labeled (dated & initialed). 2. All multidose vials have been checked to assure opened vials are dated & initialed. 3. Director of Nursing or Designee will inspect vials monthly to ensure open vials are labeled (dated & initialed).. 4. Director of Nursing will report to QA Committee regarding vial inspections outcome	3/23/07 3/23/07 5/6/07 & on going 5/6/07 & on going.

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L 168	Continued From page 34 opened the vials. The medication included: 1. Novolin-R Insulin R4662612 2. Lantus Insulin R4692293 3. Novolin-R Insulin R4677044 4. Novolin-R Insulin- R16922300	L 168		
L 999	DC CODE This Statute is not met as evidenced by: Based on staff interview and review of personnel records, it was determined that facility staff failed to obtain a criminal background check for two (2) employees before the date of hire. The findings include: Facility staff failed to obtain a criminal background check for two (2) employees before the date of hire. According to the 22 District of Columbia Municipal Regulations (DCMR), 4701.2 "Each facility shall obtain a criminal background check, and shall either obtain or conduct a background check before employing or using the contract services on an unlicensed person." A. The personnel record of the Director of Nursing (DON) [employee #1] revealed a hire date of February 26, 2007. A criminal background check was completed on March 23, 2007. The criminal background check did not reveal any criminal convictions. B. The personnel record of the licensed Registered Nurse (RN) [employee #2] revealed a hire date of March 15, 2007. A criminal	L 999	1. Criminal back-ground check results are now being obtained prior staff begin work. 3/27/ 2. Staff records have been reviewed to ensure no other staff began working without criminal background checks. DON or Designee is monitoring "Destruction of Discontinued Controlled II-V Substances" form per facility policy. 5/06/07 on going 3. New QA tool developed and department heads will be held accountable for reporting issues to the QA Committee. 5/06/07 on going 4. QA Committee will be responsible for monitoring compliance 5/06/07 on going	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095021	A. BUILDING _____ B. WING _____	03/22/2007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 999	Continued From page 35 background check was completed on March 22, 2007. The criminal background check did not reveal any criminal convictions. A face-to-face interview was conducted on March 20, 2007 at 3:15 PM with the Human Resources Representative. He/she stated, " The background checks were not done for these employees prior to hire." The records were reviewed on March 20, 2007.	L 999		