	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPP IDENTIFICATION N		A BUILDI	TIPLE CONSTRUCTION	(X3) DATE S COMPL	
		095021		B. WING	· · · · · · · · · · · · · · · · · · ·	03/2	2/2007
AME OF F	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY	STATE, ZIP CODE		
UNRISI	E AT THOMAS CIRCLI	E		SSACHUSE	TTS AVENUE NW 20005	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENC MUST BE PRECEDED E SC IDENTIFYING INFOR	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLET DATE
L 000	Initial Comments			L 000			
	An annual licensure 20 through March 22 deficiencies were ba observations, and in and residents. The and two (2) supplem census of 23 resider	2, 2007. The follow ased on record revi terviews with the find sample included 1 itental residents, ba	wing iew, acility staff 0 residents ased on a				
L 001	3200.1 Nursing Faci	lities		L 001			
	Each nursing facility these rules and the r 483, Subpart B, Sect Subpart D, Sections Subpart E, section 4 which shall constitute nursing facilities in th This Statute is not m Based on record revi	requirements of 42 tions 483.1 to 483. 483.150 to 483.15 83.200 to 483.206, e licensing standar ne District of Colum- net as evidenced b iew and staff interv	CFR Part 75; 8; and , all of ds for hbia. y: iew for		Responses to the cited defi do not constitute an admi agreement by the facility truth of the facts alle conclusion set forth Statement of Deficiencies Plan of Correction is p solely as a matter of con- with federal and state law.	ssion or of the ged or in the The prepared	
	one (1) of 10 sample determined that the p with CFR 483.40 by 1 resident's right lower immobilizer [the resid developed a Stage III order for the immobili was placed on the resid	ohysician failed to o failure to assess or leg while it was in lent subsequently pressure ulcer], w izer and ensure tha sident's right wrist	comply ne (1) an vrite an at a splint				
	ordered. Resident #1 The findings include:						
 	1. The physician faile eg of Resident #1 wh the resident subseque pressure ulcer] and w mmobilizer to the righ	tile it was in an imr iently developed a rite an order for th it leg on the reside	nobilizer Stage III: e				
1997 . F	eturn from the hospit	al ====================================		" a a a a a a a a a a a a a a a a a a a			رم ت ية. المصلح

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THE R. LEWIS CO., LANSING MICH.

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM		(X2) MULT A. BUILDI B. WING		(X3) DATE COMP	SURVEY LETED
		095021	_,]:			03/	22/2007
AME OF I	PROVIDER OR SUPPLIER		STREET ADDRE	SS, CITY,	STATE, ZIP CODE		
UNRIS	E AT THOMAS CIRCL	E	1330 MASSA WASHINGTO		TTS AVENUE NW 20005		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY F SC IDENTIFYING INFORMAT		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
L 001	Continued From pa	ge 1		001	· · · · · · · · · · · · · · · · · · ·		
· .		A nurse's note date included, "placed ht leg"	d	· .	· · · · · · · · · · · · · · · · · · ·	· · ·	
		ders signed and dated nber 29, 2007 failed to obilizer.			1. A. Physician has inspected resident's legs, written orders,	. &	
(physician on Decem physician's note sign 2007 did not include	ned and dated Januar an assessment of the r leg nor did the asses	y 8, e		documented in progress notes B. Physician has documented order & progress notes regard (R) wrist splint. OT plan of c now includes (R) wrist splint. Resident is wearing splint.	in ing are	3/29/07
· · · ·	PM included, "TD\ weight bearing right This was the first ph	ated January 11, 2007 WB (R) LE (total depe lower extremity) in bra ysician's reference to sident's right lower leg	ndent ace" the		2. All other residents reviewe to ensure doctor's order includ ortho devices & devices are in place on resident.		4/13/07
	2007 included, "Patie ORIF (R) hip due to he/she has pain in th able to manage with (R) lower leg - immo	ss note dated January ent recently had a fall fracture. [Resident] s nat leg but says he/she pain meds Ext. (ex bilizer" There was r esident's right lower le	and ays e is tremity) 10	n	 Physician & Rehab Therapy will review all residents to ensu- orders written & devices on res Physician & Rehab will rep QA Committee. 	ire idents.	5/6/07 & on going 5/6/07 & on going
	right lateral leg on Ja The wound was desc (developed in the fac with blackish necrotic drainage and no odo	sment " was initiated nuary 18, 2007. cribed as an acquired ility) Stage III, 10 cm c area, small amount o r. There was no evide evidence of the press	x 9cm, of nce of			· · · · · · · · · · · · · · · · · · ·	
i	January 18, 2007.	er leg prior to the tage III pressure ulcer	ron				
Regulat	ion Administration						

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM		A. BUILDIN	······································	(X3) DATE S COMPL	SURVEY ETED
•		095021	• •	B. WING	· · · · · · · · · · · · · · · · · · ·	03/2	2/2007
	PROVIDER OR SUPPLIER			· .	STATE, ZIP CODE		<u></u>
SUNRIS	E AT THOMAS CIRCL	-E		SACHUSET TON, DC 20	TS AVENUE NW 0005		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY F SC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLET DATE
L 001	Continued From pa	age 2	· · ·	L 001			· · · · ·
	dressing change w Resident #1. Durin treatment nurse [En pressure ulcer was	at approximately 2:25 as observed to the right the observation, the nployee #6] explained the result of pressure	that the	·		· · · · · · · · · · · · · · · · · · ·	
· · · · · · · · · · · · · · · · · · ·	face-to-face intervie	at approximately 3:00 w was conducted with ndicated, " The reside			1. A. Wrist splint application re	sident #1.	<u>03/23/07</u>
	returned from the h place. Skin assess by the treatment nu assessment form for	ospital with the immob ments are done on ad rse. There is not a da or the CNAs to docume ition. If a CNA sees	ilizer in mission ily		B. Order stating location of (I rewritten for (L) arm.	.) splint	3/29/07
	something, they follonurse. When we ob	ow up with it by telling oserved the wound, it w nt out, they said it was	vas	· · · · ·	2. All residents checked by nurs and Rehab for use of splints/pad guards. All other patients had ortho devices present.	s/	<u>04/12/07</u>
	lower leg while in an subsequently resulte pressure ulcer, initia	ed in the development Ily observed and identi ulcer. The record was	of a ified as		 3. DON or designee and rehab s monitor use of splints/pads/guar 	taff will	05/06/07 on going
1		iled to ensure that a sp sident's right wrist as	plint		4. DON or designee will report QA Committee re: outcomes of audits on splints pads/guards.		<u>05/06/07</u>
2		lers dated December 2 It wrist splint per OT y).	28,				on going
r	ohysician on Deceml Resident] has had a	ase" dated and signed ber 29, 2006 includ <u>ed:</u> slight hand deformity	before	·	Note: Rehab to schedule inservic for ortho devices. Schedule to be added to Cardex.		<u>05/06/07</u>
s	wollen after the fall,	ospital and the hand be he/she got X-rays that		No	ote: See copies of In-service]	٠
n Regulati E FORM	on Administration	· · · · · · · · · · · · · · · · · · ·	6899	BO4	9011	If continuation	sheet 3 of 3

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU 095021			ILDIN	IPLE CON		-ion 			(X3) DATE COMPI	ETED
		035021	STREET AD			STATE 7					03/	22/2007
	PROVIDER OR SUPPLIER	E	1330 MA WASHING	SSACHL	JSEI	TS AVI				,		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREF TAG		•	EACH CO	RRECTI	AN OF CO VE ACTIC ED TO TH ICIENCY	N SHOU	LD BE	(X5) GOMPLET DATE
L 001	Continued From page	ge 3		L 001		•						
. [.]	showed no signs of	acute fracture"		} . 								
	and 14, 2007 did no	gress notes dated Ja t include reference to			• . •	·	,		•			
	hand or right wrist s	plint.						· ·				
	The OT clarification 2006 failed to includ splint.	order dated Decemb e reference to the rig										
	The "Occupational T Rehabilitation" form services rendered fr through January 28, deformity from previo hand. There was no splint.	dated January 29, 20 om December 30, 20 2007 included, right ous CVA with edema	007 for 006 hand of right				. ·			•	• • • • •	
	The January 2007 Ta Administration Record (right) wrist splint per information)". There the month of January was placed on the re	rd) included, "12/28/0 r OT, FYI (for your were no initials ente y to indicate that the	red for	· · ·		• .		•				
	The resident was ob- approximately 2:25 P wearing a right wrist The record was revie	M. The resident was splint.	s not	•				-	· · ·	•		· · · · ·
L 043	3208.5 Nursing Facil	ties	. {	Ŀ 043		·			н 1911 г. т	:		
	The Director of Nursi minimum, the followir		ata						· .			·
	(a)Delivery of nursing accordance with thes					 				• •		
	(b)Developing and ma objectives, standards								•		-	· · ·

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TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY L 043 Continued From page 4 L 043 procedure manuals, and written job descriptions for each level of nursing personnel; L 043 (c)Planning for and recommendation to the Administrator the number and levels of nursing personnel to be employed; L 043 (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 the allocation*	ATEMENI D PLAN C	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUL		A. BUILD	DING				(X3) DATE COMF	SURVEY	,
3330 MASSACHUSETTS AVENUE NW WASHINGTON, DC 2005 D PREFIX Con ID PREFIX Isummary statement of opericiencies (reach opericency must be preceded by Full, TAG D PREFIX PROVIDERS PLAN OF CORRECTION (reach corrective action should be cross-reference) to the appropriate periciency) c L 043 Continued From page 4 procedure manuals, and written job descriptions for each level of nursing personnel; L 043 L 043 (c)Planning for and recommendation to the Administrator the number and levels of nursing personnel to be employed; L 043 Image: Construction operation (d)Coordinating nursing personnel, which include the following: Image: Construction operation (d)Coordinating nursing personnel, which include the following: Image: Construction operation (d)Coordination (f)Prefix Image: Construction (f)Coordination (f)Dreation; (g)Developing a staffing plan that considers residents' needs for various types of nursing care; (f)Working with the medical staff and the interdisciplinary care plan (ICP) is coordinated and maintained; and Image: Construction (f)Working with other employees to ensure that the interdisciplinary care plan (ICP) is coordinated and maintained; and Image: Construction (f)Working with the Administrator and the Medical staff or Medical Director in the allocation		· · · · · · · · · · · · · · · · · · ·	095021	· · ·	B. WING	;		·		03	/22/200	7
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSCIDENTIFYING INFORMATION) PREFIX TAG CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) c L 043 Continued From page 4 L 043 procedure manuals, and written job descriptions for each level of nursing personnel; L 043 (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; (?)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 (I)Working with the Administrator and the Wedical staff or Medical Director in the allocation*		• •	E	1330 MA	SSACHUSI	ETTS	AVENUE N			· ·		
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 (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 		(3)Position assignm	ent;									
 (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] ((4)Orientation;										• •*
 (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 	((5)In-service educat	ion;	:					•			
 (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 	(6)Supervision; and						· · ·	1		1 .	
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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						. ~	×			•		-
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	i i	nterdisciplinary tean	n in developing and	·	· · · · · · · · · · · · · · · · · · ·			• • •				
Medical staff or Medical Director in the allocation	t	he interdisciplinary of	r employees to ensu are plan (ICP) is coo	re that rdinated					· · · ·		• • • • • • • • •	
of funds for facility programs.	Ň	Aedical staff or Medi	cal Director in the all									

earth Regulation Administration

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If continuation sheet 5 of 36

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU 095021		(X2) MUI A. BUILD B. WING			(X3) DATE : COMPL	
AME OF F	ROVIDER OR SUPPLIER	· · · · ·	STREET ADD	DRESS, CITY	, STATE, ZIP CC	DDE		
	E AT THOMAS CIRCL	. E `	1330 MAS WASHING		ETTS AVENU 20005	ENW		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	(EACH	DVIDER'S PLAN OF CORR I CORRECTIVE ACTION SE REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLE DATE
L 043	Continued From pa	age 5	· · ·	L 043				
	Based on a review hired employee rec determined that the	met as evidenced by of four (4) of four (4) ords and staff intervie Director of Nursing f inclusive of abuse pro hired employees.	newly ew, it was failed to			(1) The four new sta trained on abuse pro- practices.(Social wo training is 2 times / y Human Resources' of also include abuse tr prohibition.	hibition rker's staff year). prientations	3/27/07
	The findings include A review of newly h revealed the followi	ired employee récord	ls	. ·		(2) All employee fil reviewed to ensure occurred.	es will be training has	<u>5/06/07</u> on goin
	Employee #1 Employee #2 Employee #5 Employee #9 Employee #1 replac	e of Hire February 26, 20 March 15, 2007 March 17, 2007 February 20, 2007 ed Employee #15; Er facility was February	nployee			(3) Human Resource will ensure new hird employee signatures prohibition training beginning work. HR monthly.	files reflect for abuse before C will audit	<u>5/06/07</u> on going
t T	2007 revealed that t wo (2) or more shift There was no evider	dule for February and he above employees s since their date of h nce that the above en	worked hire. hployees		(Sec in-service	(4) Human Resource will report to QA Co to ensure training is prior to staff's start of the sign in sheets. declaration sheets.)	mmittee documented	
F A 2 F	orohibition practices A face-to-face interv 1, 2007 at 10:30 AM	iew was conducted o I with the Administra d that the aforement	n March tor.	· . ·	added to new background c acknowledge	s and abuse policy package (along with heck and drug screen) ment receipts must be file prior to an emplo		
· ·	210.4 Nursing Facil			. 051	· · · · · · · · · · · ·			
fc	A charge nurse shall bllowing: on Administration	be responsible for th	e					• .

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PRINTED: 04/04/2007
FORM APPROVED

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MUL A. BUILDI B. WING		(X3) DATE S COMPLI	
		095021		· ·		03/2	2/2007
NAME OF P	ROVIDER OR SUPPLIER		STREET AD	DRESS, CITY	, STATE, ZIP CODE		
SUNRISE	E AT THOMAS CIRCL	E		SSACHUSE GTON, DC	TTS AVENUE NW	· · · · ·	×
(X4) ID PREFIX TAG	(EACH DEFICIENC	TEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
L 051	Continued From pa	nge 6		L 051		· · · · ·	, "
• • • • • • • • • •		ident visits to assess us and implementing revention;				· · · ·	
		cation records for uracy in the transcript nd adherences to sto		· · · · ·			
}		ents' plans of care for nd approaches, and r					
	(d)Delegating respo direct resident nursi	nsibility to the nursing ng care of specific re	g staff for sidents;				•
	(e)Supervising and employee on the un	evaluating each nursi it; and	ng				· · ·
	(f)Keeping the Direc or her designee info residents.	tor of Nursing Service rmed about the statu	es or his s of				
1	This Statute is not r Based on staff inter	net as evidenced by: /iew and record revie ed residents, it was	w for	· · ·			
c t	determined that the he lower extremity of	charge nurse failed to of one (1) resident wh nmobilizer and who					
l l	subsequently develo	ped a Stage III press right wrist splint was p dered by the physicia	placed				· · · ·
i c	levelop a care plan of the resident's righ	for the assessment a t lower leg while wear	nd care			· · ·	•
j	nterventions and ap idequately and cons	se the care plan with proaches after multip istently assess one (discontinue a medic	le falls; 1)				• • •
-p	er physician's order	s; clarify an order for dent; and develop ca	a left				• •

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM			- (X3) DATE S COMPL - 03/2	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CI	TY, STATE, ZIP CODE		
• •	E AT THOMAS CIRCI	-		SETTS AVENUE NW		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY F LSC IDENTIFYING INFORMAT		PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
	drug interactions of Residents #1, 7, 3, 4 and 5. The findings includ 1. The charge nurs lower extremity of F was in an immobiliz developed a Stage a right wrist splint w ordered by the phys the assessment and lower leg while wea the care plan with n approaches after m A. On March 20, 20 a dressing change w of Resident #1. Dur treatment nurse exp was the result of pre The review of the nu December 29 to Jar an immobilizer was lower leg. The "Medical Data E physician on Decem physician's note sigr 2007 did not include resident's right lower make reference to th	s for the potential adve f nine (9) or more medi e: se failed to assess the i Resident #1 whose righ er and who subsequer III pressure ulcer, ensu- vas placed on the resid- sician, develop a care p d care of the resident's ring an immobilizer and ew interventions and ultiple falls. 007 at approximately 2: was observed on the rig- ring the observation, the plained that the pressure sure from an immobil urses' notes dated for nuary 18, 2007 revealed placed on the resident's Base" dated and signed ber 29, 2006 and a ned and dated January an assessment of the rieg nor did the assess the immobilizer.	right it leg htly ure that ent as blan for right d revise 25 PM ght leg e e ulcer lizer. d that s right I by the 8, sments	 A Staff now assessing r and documenting in med Doctor's orders have been No other residents have Mo other residents have DON or designee will assessments of resider immobilizers. DON or designee will r Committee on immobil out audit outcomes. 	lical record. en clarified. re immobilizers. audit nursing ats with report to QA	03/29/07 03/29/07 05/06/07 on-going 05/06/97 on-going
2	2007 at 5:02 PM, " I appointment. Return	's note dated January Resident left unit for orl ed to unit and new ord were transcribed and fa	tho ers	in the second s		

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SUNRISE AT THOMAS CIRCLE 1330 MASSACHUSETTS AVENUE NW WASHINGTON, DC 20005 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X4) ID SUMMARY STATEMENT OF DEFICIENCIES		IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI 095021		(X2) MUI A. BUILD B. WING		· · · · · · · · · · · · · · · · · · ·	(X3) DATE S COMPL	
SUMRISE AT THOMAS CIRCLE 1330 MASSACHUSETTS AVENUE NW WASHINGTON, DC 20035 (x) (b) PREFIX TAG SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSG IDENTIFYING INFORMATION) ID PREFIX TAG PROVDER'S PLAN OF CORRECTION (EACH CORRECTION ACTION SHOULD BE DEFICIENCY) (x) (y) (EACH CORRECTION FEEL ATTION SHOULD BE DEFICIENCY) (y) (EACH CORRECTION FEEL ATTION SHOULD BE DEFICIENCY) (y) (EACH CORRECTION FEEL ATTION SHOULD BE DEFICIENCY) (y) (EACH CORRECTION FEEL ATTION TAG (y) (Y) (Y) (Y) (Y) (Y) (Y) (Y) (Y) (Y) (Y				STREET AD	DRESS. CITY	. STATE. ZIP CODE		0314	.2/2007
PREFix TAG (EACH DEFICIENCY MURT BE PRECEDED BY FULL REGULATORY OR US: IDENTRYING INFORMATION) PREFix TAG (EACH DEFICIENCY MURT BE PRECEDED BY FULL TAG (EACH DEFICIENCY MURT BE PRECED BY BUT BY BUT BAG (EACH DEFICIENCY (EACH DEFICIENCY) (EACH DEFICIENCY (EACH DEFICIENCY <td< th=""><th></th><th>·. ·</th><th>.E</th><th>1330 MAS</th><th>SACHUS</th><th>ETTS AVENUE NW</th><th>-</th><th></th><th></th></td<>		·. ·	.E	1330 MAS	SACHUS	ETTS AVENUE NW	-		
 to pharmacy. (1) Follow up in six weeks, (2) TDWB R LE in brace, (3) ROM active and assisted right Nee, COB (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 ski ewen out, they said it was 	PREFIX	(EACH DEFICIENC)	MUST BE PRECEDED BY	FULL	PREFIX	(EACH CORRE CROSS-REFERE	CTIVE ACTION SHO NCED TO THE APP	OULD BE	COMPLETE
pt has 15 staples on right lateral thigh. Call was placed to Dr.'s office for clarification. Sceretary 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	L 051	to pharmacy. (1) F TDWB R LE in brac assisted right knee, tolerated. On return stated that his/her s	ollow up in six weeks ce, (3) ROM active an OOB. (3) Pain contro n Pt. report of consult taples were removed	id ol as ation I by Dr.	L 051				
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 she went out, they said it was		pt has 15 staples or placed to Dr.'s office Dr.'s office said that the facility. Phone r had not received a c	n right lateral thigh. C e for clarification. See t Dr. [name] will call u number was given. T call from Dr.'s office y	call was cretary at s back at his nurse et. "	· · ·			 	
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		2007 at 6:00 AM, " intact. Same condit "Weekly Ulcer Asse	.Remain right leg imn ion." ssment " was initiate	nobilizer	· .				
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		The wound was des (developed in the fa- with blackish necroti drainage and no odd skin assessments of ulcer to the right low identification of the S	cribed as an acquired cility) Stage III, 10 cm c area, small amount or. There was no evid r evidence of the pres er leg prior to the	x 9cm, of ence of sure					
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	, , , , , , , , , , , , , , , , , , ,	On March 21, 2007 a					. .		
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	i i i i i i i i i i i i i i i i i i i	Employee #6 who in eturned from the ho place. Skin assessn	dicated, " The reside spital with the immob nents are done on ad	nt ilizer in mission				· · · ·	. ·
	r r	assessment form for residents skin condit something, they follo nurse. When we obs	the CNAs to docume ion. If a CNA sees w up with it by telling served the wound, it v	ent a				· .	
			t out, they said it was			· · · ·			· · ·

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI		(X2) MULTIP A. BUILDING B. WING		(X3) DATE S COMPL	SURVEY ETED 22/2007
	PROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, S	TATE, ZIP CODE	001x	
	E AT THOMAS CIRCL	E	1330 MAS		S AVENUE NW		
(4) ID REFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLE DATE
L 051	Continued From pa	ge 9	·	L 051		· · · · · · · · · · · · · · · · · · ·	
х	The facility staff faile skin under the imme resulted in the deve which was initially o	ed to assess the residual obilizer which subseq lopment of a pressur bserved and identifie lcer. The record was	uently e ulcer d as a				
· · ·		e failed to ensure tha ed on the resident as			1. B Wrist splint applied	to resident #1.	<u>03/23/0</u>
	The readmission or 2006 included, "Righ (occupational therap		r 28,			.*	
· · ·	2006 at 2:15 PM inc wks to provide self-c mobility for ADL, w/c lower extremity, safe	ning. There was no	wk x4 al 3AT right peutic		 All residents checked by and Rehab for use of splints guards. All other patients has ortho devices present. DON or designee and re monitor use of splints/pads 	s/pads/ ad hab staff will	04/12/0 05/06/0 on goin
	The "Occupational T Rehabilitation" form services rendered fro through January 28, deformity from previo hand. There was no splint.	dated January 29, 20 om December 30, 20 2007 included right h ous CVA with edema	07 for 06 and of right		4. DON or designee will r QA Committee re: outcome audits on splints pads/guard	es of	<u>05/06/0</u> on goin
	The significant chang 2007, Section P3 (Nu Rehabilitation/Restor resident for splint or l	ursing ative Care) failed to o brace assistance.			Note: Rehab to schedule in for ortho devices. Schedule added to Cardex.		<u>05/06/01</u>
	The January 2007 TA Administration Recor		6, R				۰ ·
-	tion Administration		<u> </u>	<u>.</u>		<u> </u>	
FORM	,	· · · · · · · · · · · · · · · · · · ·	6899	BO4	Q11	If continuation	sheet 10 o

Health I	Regulation Administr	ation					: 04/04/20 APPROVE
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUME		(X2) MULI A. BUILDII B. WING		(X3) DATE S COMPLI	
· _		095021		B. WING	· · · · · · · · · · · · · · · · · · ·	03/2	2/2007
NAME OF I	PROVIDER OR SUPPLIER		STREET ADDR	ESS, CITY,	STATE, ZIP CODE		
SUNRIS	E AT THOMAS CIRCL		1330 MASS		TTS AVENUE NW 20005		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF CON (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
L 051	Continued From pa	ge 10		051	······································	· ·	
	(right) wrist splint p information)". Ther	er OT, FYI (for your e were no initials enter ry to indicate that the s					
	The resident was of approximately 2:25 wearing a right wris C. The charge nurs	bserved on March 20, 2 PM. The resident was	not		(1) C Care plan reviewed to assessment & care of affec		
	resident's right lowe immobilizer. Resident #1 returne	d to the facility on Dec			leg 2. Care plans of all residen bilizers	ts with immo	3/29/0
	femur. Through an March 21, 2007 at 3	interview conducted or :00 PM with Employee t an immobilizer was a	n #6, it		reviewed to identify any ot residents with potential to I 3. Director of Nursing or D	be affected.	4/20/0
	2006 listed a problet (Activities of Daily Li related to Right femi Post Open Reductio the leg immobilizer v approaches. Howe include goals and ap	plan dated December m, "Alteration in ADL's ving) and function abili ur fracture S/P ORIF (S n Internal Fixation). Us vas listed as one (1) of ver, the care plan failed proaches for the	ty Status se of the d to		 will revise all care plans at Meetings to ensure compli- residents with immediater Director of Nursing or D report to QA Committee re plan compliance for patient 	Care Flan ance for s & /or-9 Designee will garding care	5/6/07 on go
	assessment and car leg while wearing the	e of the resident's right immobilizer.	· · ·		immobilizers other resident needs.	æ	5/6/07 on-gōi
	face-to-face interview Director of Nursing. the record lacked a c and care of the resid wearing the immobili		he that sment		Director of Nursing or Desi review Physician's Initial P for all admissions & will in cardex. Assessment by nur	lan of Care itiate sing, dietary,	
	reviewed on March 2				activities & social services reviewed at weekly care pla		5/6/07 on-goi

TATE FORM

8899

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If continuation sheet 11 of 36

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	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/		TIPLE CONSTRUCTION	(X3) DATE		
	OF CORRECTION	IDENTIFICATION NUMB	ER:	A. BUILDING B. WING			
		095021	B. WING				
	PROVIDER OR SUPPLIER		TREET ADDRESS, CITY,		03/	03/22/2007	
	FROVIDER OR SUFFLIER	· ·	330 MASSACHUSE			•	
SUNRIS	E AT THOMAS CIRC		VASHINGTON, DC				
(X4) ID	SUMMARY ST		ID	PROVIDER'S PLAN OF CORR	ECTION	(X5)	
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FU LSC IDENTIFYING INFORMATIC	LL PREFIX	(EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	COMPLET	
L 051	Continued From p	age 11	L 051		- · .		
• .	D The charge put	rse failed to revise the ca	oro in the second se				
		ventions and approache		(1)D Care plan for resident	#1	· · .	
	multiple falls.	termone and approache		Fevised with new approach	hes		
				to prevents falls.		3/28/07	
	A review of Reside	nt #1's record revealed i	hat			2/20/0/	
		llen as follows for 2006:	·····				
	January 30, Febru	ary 3, June 28, 2006 and	d i l	(2)Care plans for all the re	cidente		
	October 16, 2006.	There were no injuries	· [SICILIS		
	associated with the	ese falls.		with history of falls were			
	· ·			reviewed to determine if n	ew		
·		alls was initiated August		approaches were required.		3/30/07	
1		wed by facility staff on C				1	
		as no evidence that the c					
		include additional goals	and	(3)Director of Nursing		1	
	approaches to prev			will review plans at care p	lan		
	aforementioned fall	ls.		meeting to ensure any resid			
		·		history of falls has been re-		5/06/07	
		d December 19, 2006 at				on going	
		, "At 11:02 PM nurse he	arda				
		m room [number] as					
		eing prepared. Nurse w		(4)Director of Nursing or			
		ident lying on bath room		designee will report to QA			
		hed in the bathroom cor		Committee on care p	lan		
		hat [he/she] was in a lot o assessed from head to		status re: falls.		<u>5/06/07</u>	
		onsciousness). Unable l				on going	
		ge of Motion) due to pair			Real and the second second		
		te aware and stated that					
		o the emergency room (•.		
		or concussion. Resident					
	unit at 11:26 PM"					ŀ .	
		dated December 29, 200					
ļi	indicated, "85 year	oldresident at the Lon	g				
: -	Term Care [name] v	vho had sustained a fall	and				
		femur. Pt. (patient) is §		· · ·		1	
		Open reduction and inte		· · · · · · · · · · · · · · · · · · ·		· ·	
		is transferred back here	for	·	- 1 - 1		
r	rehab. (Rehabilitatio	n)"					
·	· · · ·	•	1 1		14 g.		

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM	/CLIA BER:	A. BUILDI		(X3) DATE COMF	SURVEY
		095021		B. WING		03	/22/2007
AME OF I	PROVIDER OR SUPPLIER	<u> </u>	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
SUNRIS	E AT THOMAS CIRCL	E		SSACHUSE	TTS AVENUE NW 20005		· .
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY F SC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLE DATE
L 051	Continued From pa	ge 12		L 051			
		view was conducted w	rith the	• •	· · · · ·	(
	Administrator on Ma						
		PM. He/She acknowl as not updated with ne					
		es for fall prevention.					
		d on March 20, 2007.					· .
(Geografi			1
		failed to adequately a			2 A This resident #7 will be a	ssessed &	
ł		Resident #7 for pain a inistration of Simvasta			given pain med 1 hour before	wound	
					care. Nurse will complete & c	locument	
	(Zocor) as ordered by the physician. Resident #7 was receiving Hospice care.				a pain assessment prior to, &	during	· [·
1	was receiving recipion care.				wound care. If resident exhibit		
· .		e failed to adequately a			nurse will stop treatment, noti	•	1
		and medicate Resider	nt #7 for		physician, obtain pain med ord		
·	pain.		ł	· ·	medicate resident prior to res	· · · ·	
•	The resident was rea	admitted to the facility	on		wound care. Nurse(Treatment		
		e admission MDS (Mi			responsible for wound care wi administer pain med.	D .	2/22/07
		uary 14, 2007 revealed			administer pair med.		3/23/07
		cognitive skills for dai		- '	B. Nursing staff will consistent	lv	;
200	decision-making, per	riods of restlessness a riorated in Section B;	ind	、	adequately assess & medicat		
		nds others and is rare	lv		ocument for resident #7		5/6/07.&
		Section C; sad, pained			See above.	· .	on-going
•••	worried facial expres	sions and resists care		· •	e Na series de la construcción de l		88
		of Osteoporosis and). •				
		Alzheimer's Disease i ain, soft tissue pain an		į.			
	fracture in last 180 d			·			1.
			. (· [
		ers dated and signed				•	
(•	January 4, 2007 and	renewed February 8, 2	2007				
		: "Acetaminophen 500					{
) po (orally) TID (three nol 5 mg po every 4 ho					
	PRN (as needed) for						{
	· · · · ·						
		ruary 2007 Medication					1.
	Administration Record	ds (MARs) were requé	ested		-		1

÷ · · · · · · · · · · · · · · · · · · ·	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMB		(X2) MULT A. BUILDII	TIPLE CONSTRUCTION	(X3) DATE S COMPLE	
		095021		B. WING		03/2	2/2007
NAME OF F	PROVIDER OR SUPPLIER	s	TREET ADD	RESS, CITY,	STATE, ZIP CODE		
SUNRISI	E AT THOMAS CIRCL			SACHUSE TON, DC 2	TTS AÝENUE NW 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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
L 051	Continued From pa	ge 13		L 051		_	
(and could not be lo review.	cated at the time of this	;				
	According to the March 2007 MAR, there was no evidence that Resident #7 received the				·	· · · , · · · · ·	
			vas no		ר. 	· · · · · · · · · · · · · · · · · · ·	
		n medication from Marc	ch 1	•	2. All residents receiving pain	meds prior to	the second
· · · · ·	through 21, 2007.			• .	treatments, have been reviewed to ensure prop		
[A review of the "Controlled Medication Utilization		zation		documentation	er care & /or	5/6/07
· [at Roxanol was not			documentation		
(resident for January 20	007. (• •.	3. Director of Nursing will au	dit care to	5/6/07
Í	The February and March 2007 "Controlled Medication Utilization Record" was requested and could not be located at the time of this review.		ted and		ensure & / or documentation.		on-goin
{				,		· ·	
ł			_		4.Director or Nursing or Desi	gnee will	
	initiated January 5, 2	em entitled, "Pain Care 2007 and evaluated Jar		-	report to QA Committee on o audits of pain meds, discontin	ntcomes of ned meds,	5/6/07 a
	analgesia as ordere	e approach, "Provide d, evaluate effectivenes	ss and				
		ordingly for needed ate current pain experie					
	Use appropriate pail						
· [· · · · ·				!	· .
	A review of the Hosp the following:	pice nurses ' notes reve	ealed				
		10: "Hospice RN: Pt.	· · · · [1
		ed. No distress noted	"	1 1			
		10: "Hospice RN: Pt. I more combative wher	n ··			· ./	
	touched "			.*			· .
		00 PM: "Hospice RN:		. :			
	did say " Ouch " wh edema "	en I assessed him/her				· . ·	-
			l l		· · · · · · · · · · · · · · · · · · ·	· · · ·	
		lity nurses' notes, the			· · · · · · · · · · · · · · · · · · ·	· · · ·	• •
		ed as voicing no compl and/or no facial expres			भाषतम् मा विकासम्बद्धाः १		
		2 and 12, 2007. On Ma		. {		· <u></u> 	·.
•	18, 2007 the residen	t was described as beir	ng	[
. 1	unable to answer que	estions of pain. There v	was	•	· · ·		

. ·					. · · · ·	PRINTE	D: 04/04/20
						FORM	APPROVI
<u>lealth i</u>	Regulation Administr			-)		·	
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPL IDENTIFICATION N	IER/CÌA IUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE : COMPL	
	·	095021	•	B. WING _		03/	22/2007
	PROVIDER OR SUPPLIER	033021		DRESS CITY	STATE, ZIP CODE	037	
	E AT THOMAS CIRCL	.E	1330 MA		TTS AVENUE NW		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENC Y MUST BE PRECEDED B SC IDENTIFYING INFORM	YFULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
L 051	Continued From pa	ige 14		L 051			
	no evidence in the adequately and cor resident for pain.			· · · · · ·			
	B. The charge nurs administration of Si				2. B.		
	by the physician for			 	Zocor discontinued for resi	dent #7.	3/23/07
	A Physician' s Orde physician on Janua [discontinue] Simva above order was au Nurse on January 6	ry 5, 2007 revealed, statin " . Additional idited by a facility Re	" D/C ly, the egistered		ζ.	• • • • •	
	The January and Fe Administration Reco	ebruary 2007 Medic ords (MARs) were re	ation equested	· · · · · · · · · · · · · · · · · · ·	2. All residents with discontine meds have been reviewed to proper care 7/or documentation	ensure on.	5/6/07
	According to the Ma 20mg tab [tablet] P(administered on Ma doses] as evidenced designated boxes, in was given. A review of the med of facility staff on Ma	rch 2007 MAR, Sim D [by mouth] daily w rch 1 through 21, 20 d by facility staff 's i ndicating that the m ication cart, in the p	nvastatin vas 007 [21 nitials in edication		 Director of Nursing will au ensure & / or documentation. DON or designee will re QA Committee on outcomes audits of discontinued meds any other issues DON determ are relevant to quality care. 	port to of and	5/6/07 on-goi 5/6/07 on-goin
	approximately 12:00 20mg was in Reside A face-to-face interv Director of Nursing o	nt # 7 ' s medication iew was conducted on March 21, 2007 a	n drawer. with the at 1:20				
	PM. He/she acknow to follow up with the discontinue the adm This record was revi	physician 's order l inistration of Simva	to statin.			• • •	
	3. The charge nurse a left splint for Resid		order for				
Regulat FORM	tion Administration	· ·		³⁹⁹ B(D4Q11	If continuatio	n sheet 15 o
•		10 . 10 . 21 .					•. •

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Health Regulation Administration

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIEI IDENTIFICATION NUM 095021	18ER:	A. BUILDIN B. WING _		(X3) DATE COMPL 03/2	
NAME OF I	PROVIDER OR SUPPLIER		STREET ADD	RESS, CITY,	STATE, ZIP CODE	· · ·	
SUNRIS	E AT THOMAS CIRC	LE	1330 MAS WASHING	SACHUSET TON, DC 2	TTS AVENUE NW 0005	· :	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY F LSC IDENTIFYING INFORMA	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	SHOULD BE	(X5) COMPLET DATE
	Physician's orders 2007, directed, " Lo at all times except swelling, skin chan There was no clarif indicate what area should be applied. The resident was o 1:00 PM and 3:00 F applied to the left u resident was obser on March 21, 2007. The record was rev 4. The charge nurs with goals and appr	dated and signed Feb eft splint for swelling - during self care, Remo ges develop. " fication of the above or of the body the left spl bserved on March 20, PM. There was no spli pper or lower extremity ved wearing a left arm riewed March 21, 2007 se failed to develop a c oaches for the potentia ctions of nine (9) or mo	Splint on ove if der to int 2007 at nt y. The splint are plan al	L 051	 3. Order stating location of splint rewritten for (L) arm. 2. All residents with order splints have been reviewed ensure proper care &/or documentation. 3. Director of Nursing wittensure & / or documentation. 	rs for ed to 11 audit care to	5/6/07 5/6/07 a on-goin
	The review of the cl revealed a physicial February 27, 2007 t medications: Amiod Plavix, Hydrochlorof Potassium, Senna, Trazodone. A review of the care on January 5, 2007 problem identified w approaches for pote interactions involving medications. On March 21, 2007 face-to-face interview Director of Nursing.	inical record for Residen's order dated and signat included the follow larone, Aspirin, Atenolo thiazide, Synthroid, Sorbitol, Timolol, and plan that was last upd revealed there was no ith appropriate goals a intial adverse drug	ned ing ol, lated ind PM a the I that		 4. DON or designee will to QA Committee on outcaudit and any other issues determines are relevant to 4. Care plan revised potential adverse drug involving 9 or more meresidents #4. 	omes of splin DON quality care. to reflect interactions	5/6/07 & on-going 3/29/07

Health	Regulation Administr	ation		j		<u>г</u> .,	
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		A BUILD		(X3) DATE S COMPLE	
	· · ·	095021		B. WING	· · · · · · · · · · · · · · · · · · ·	03/2	2/2007
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY	, STATE, ZIP CODE		
SUNRIS	SE AT THOMAS CIRCL	.E		SSACHUSE GTON, DC	TTS AVENUE NW 20005		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL ·	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
L 051	Continued From pa	age 16	· ·	L 051			
		e care plan should ha rd was reviewed on M				· . · · · · ·	
	with goals and appr adverse drug intera medications. Resid The review of the con- revealed a physicia February 27, 2007 for medications: Aspirit Hydrochlorothiazide Multivitamin, Prilose A review of the care January 10, 2007 re problem identified w approaches for pote	linical record for Resid n's order dated and si that included the follow n, Tenormin, e, Feosol, Folic Acid, L ec, Seroquel and Oxyc e plan that last update vealed there was no vith appropriate goals ential adverse drug	ial hore gned wing isinopril, codone. d on ho		 Care plan revised to reflect potential adverse drug interact involving 9 or more meds for resident 5. care plans of all residents on ormore meds reviewed to ident other residents with potential to affected. Director of Nursing or Designility will revise all care plans at Care 	ions nine ify any be gnee	3/29/07 4/20/07
	face-to-face intervie Director of Nursing. record lacked a care medications and the	g nine (9) or more at approximately 2:30 w was conducted with He/she stated that th plan for nine (9) or n care plan should hav d was reviewed on Ma	i the e nore e been		Meetings to ensure compliance residents with immobilizers & or more meds & all other resid 4. Director of Nursing or Desig report to QA Committee regard plan compliance for patients w immobilizers & /or 9 or more r	e fốr /or 9 lents. gnee will ling care ith	5/6/07& on going 5/6/07 &
L 052	3211.1 Nursing Faci	lities	.	L 052	other resident needs.		on-going
	resident to ensure th receives the followin	g:		·	Director of Nursing or Designe review Physician's Initial Plan for all admissions & will initiat cardex. Assessment by nursing	of Care e dietary,	· ·
	supplements and flu rehabilitative nursing	ations, diet and nutriti ids as prescribed, and care as needed;			activities & social services will reviewed at weekly care plan m	Ibe	5/6/07 on-going
aith Regula	tion Administration						

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If continuation sheet 17 of 36

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIEF IDENTIFICATION NUM	VCLIA IBER:	(X2) MULT A. BUILDIN B. WING	IPLE CONSTRUCTION	(X3) DATE S COMPL	
	· /	095021				03/2	22/2007
NAME OF I	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
SUNRIS	E AT THOMAS CIRC	LE	1330 MASS		ITS AVENUE NW 0005		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY F LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
L 052	Continued From p	age 17	L	. 052		· · · · · · · · · · · · · · · · · · ·	
		, , , , , , , , , , , , , , , , , , , ,				. <u></u>	
· .		minimize pressure ulce o promote the healing o					
	the resident is con evidenced by freed	ily personal grooming s nfortable, clean, and ne dom from body odor, cl and clean, neat and	at as		·····		
· ·	(d) Protection from	accident, injury, and ir	nfection;			•.	
	(e)Encouragement self-care and group	, assistance, and training activities;	ng in			 	
	(f)Encouragement	and assistance to:					
	his or her own cloth	ed and dress or be dres hing; and shoes or slipp n and in good repair;					
	(2)Use the dining re	oom if he or she is able	and				·
	(3)Participate in me recreational activitie						· _
	(g)Prompt, unhurrie requires or request	ed assistance if he or sh help with eating;	ne	· .		32.4. · · · ·	
	(h)Prescribed adap him or her in eating independently;	tive self-help devices to	o assist				· · ·
	(i)Assistance, if nee including oral acre;	eded, with daily hygiene and	,				
	j)Prompt response f for help.	to an activated call bell	or call			्रम् स्टब्स् राज्यात्र प्राप्त राज्यात्र राज्यात्र	
· .	This Statute is not	met as evidenced by:				· · · · · · · · · · · · · · · · · · ·	

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MULT	IPLE CONSTRUCTION	(X3) DATE COMPL			
		095021		B. WING	· · · · · · · · · · · · · · · · · · ·	03/2	22/2007		
NAME OF I	PROVIDER OR SUPPLIER		STREET ADD	REET ADDRESS, CITY, STATE, ZIP CODE					
SUNRIS	E AT THOMAS CIRCI	-E		SACHUSE [®] TON, DC 2	TTS AVENUE NW 0005				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	ON SHOULD BE E APPROPRIATE	(X5) COMPLE DATE		
L 052	Continued From pa	age 18	· ·	L 052					
	review for seven (7 was determined the	ion, staff interview an) of 10 sampled resid at facility staff failed to	ents, it provide	 					
	assess the right lov resident whose right and who subseque	me as evidenced by f ver extremity of one (nt leg was in an immo ntly developed a Stag	1) @ bilizer _ e III			· "· · · · · · · · · · · · · · · · · ·	· 		
: · · ·	administer pain me treatment and adec who had a fall and s	ess the resident for p dication during a wou juately supervise the i sustained a fracture to	nd resident (/ o the				 		
	medication prior to discontinue a medic	and administer pain a wound treatment ar cation as per physicia esident; reweigh one (nd n's		1. 1. 1.				
	resident as per physitube feeding for one orders; use a cleans residents during wo	sician's orders; admin e (1) resident per phys sing agent for three (3 und treatments as ord idminister medication	iister a sician's 3) -0 dered by	-	A Staff now assessing resident and documenting in med record. Doctor's orders here a clarified.	lical	<u>03/2907</u>		
		ered by the physician. 3, 9, JH1 and JH2.		· · ·	2 No other residents have in No other bottles have bee	mmobilizers.	<u>03/29/07</u>		
• •	1. Facility staff faile extremity of Resider	d to as <u>sess</u> the right l nt #1 whose right leg v who subsequently dev	was in		3 DON or designee will au assessments of residents v immobilizers.	with			
·. · ·	a Stage III pressure the resident for pain and adequately supe	ulcer; assess and me during a wound treat ervise the resident wh fracture to the right fe	edicate ment o had a		DON or designee will ins treatment cart to ensure n	o relabeling.	05/06/07 on-goin		
	A. Facility staff faile extremity of Residen	d to assess the right k it #1 whose right leg v	ower vas_in		4 DON or designee will rep Committee on immobilize cart audit outcomes.	er and treatment	<u>05/06/07</u> on-going		
	an immobilizer and v a Stage III pressure	vho subsequently dev ulcer.							
	On March 20, 2007 a dressing change was	at approximately 2:25	PM a				· .		

	 PRINTED: 04/04/2007 FORM APPROVED

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU 095021		(X2) MUL A. BUILD B. WING	-	RUCTION		ATE SURVEY OMPLETED 03/22/2007	
			STREET A	DDRESS, CITY	, STATE, ZIP C	ODE		OULLILOUT	<u> </u>
· · · ·	E AT THOMAS CIRCL	E	1330 MA	ASSACHUSETTS AVENUE NW NGTON, DC 20005					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIE: Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	(EAC	OVIDER'S PLAN OF C H CORRECTIVE ACTIK -REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPL DATI	ETE
L 052	Continued From pa	ige 19	A mode	L 052					
	treatment nurse [Er pressure ulcer was	g the observation, the nployee #6] explained the result of pressure	that the				· · · · · ·		
···· ·	immobilizer.	··· ··· · · · ·	·			· · · ·	· ··		
1 	December 29 to Ja	urses' notes dated fo nuary 18, 2007 revea placed on the reside	led that						
	physician on Decem physician's note sign	Base" dated and sign ber 29, 2006 and a ned and dated Janua an assessment of th	ry 8,	· .					
,	resident's skin unde	r the immobilizer, rigl essments make refere	nt lower		:				
	2007 at 5:02 PM, "	e's note dated Januar Resident left unit for d	ortho		·		· . ·		
	were given. Orders to pharmacy. (1) Fo	ed to unit and new of were transcribed and llow up in six weeks, e, (3) ROM active and	faxed (2)	· ·			• • •		
	assisted right knee, tolerated. On return stated that his/her st	OOB. (3) Pain contro Pt. report of consulta aples were removed nent this nurse notice	l as ition by Dr.						
	pt has 15 staples on placed to Dr.'s office Dr.'s office said that	right lateral thigh. Ca for clarification. Sec Dr. [name] will call us	all was retary at back at (
	had not received a c	umber was given. Th all from Dr.'s office ye	et. "						:
		's note dated Januaŋ Remain right leg imm ɔn."		- 					
	Weekly Ulcer Assen he right lateral leg of ion Administration	ssment " was initiate n January 18, 2007.	d for			· ·		· · · · · · · · · · · · · · · · · · ·	.:

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM 095021		(X2) MUL A. BUILDI B. WING	TIPLE CONSTRUCTION NG	(X3) DATE S COMPLE		
÷	PROVIDER OR SUPPLIER		1330 MAS	ADDRESS, CITY, STATE, ZIP CODE MASSACHUSETTS AVENUE NW INGTON, DC 20005				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY F .SC IDENTIFYING INFORMAT		ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE	
L 052	Continued From pa	age 20		L 052				
· · · · · · · · · · · · · · · · · · ·	(developed in the fa with blackish necro drainage and no oc skin assessments of ulcer to the right low	scribed as an acquired acility) Stage III, 10 cm tic area, small amount for. There was no evid or evidence of the pres wer leg prior to the Stage III pressure ulce	x 9cm, of ence of sure					
	On March 21, 2007 face-to-face intervie Employee #6 who in returned from the h place. Skin assess by the treatment nu assessment form for residents skin cond something, they foll nurse. When we ob	at approximately 3:00 w was conducted with ndicated, "The resider ospital with the immobi ments are done on adr rse. There is not a dai or the CNAs to docume ition. If a CNA sees ow up with it by telling oserved the wound, it was	nt ilizer in mission ily ent a					
	infected." The facility staff faile skin under the immo resulted in the deve which was initially of Stage III pressure u reviewed on March 2 B. A Stage IV (post treatment to the righ March 20, 2007 at 2 moaned and jerked when the right leg w	ed to assess the reside obilizer which subseque lopment of a pressure bserved and identified lcer. The record was 20, 2007. debridement) wound t lower leg was observ :15 PM. The resident throughout the treatme as touched. The treatme failed to stop the treat	ently ulcer as a red on ent ment					
	directed, "Oxycodon as needed for pain."	dated February 16, 200 e 10 mg orally every 4						
	moaned and jerked when the right leg w nurse [Employee #6 and assess the resid A physician's order o directed, "Oxycodon as needed for pain." tion Administration	throughout the treatme as touched. The treatme failed to stop the treat dent for pain. dated February 16, 200 e 10 mg orally every 4	ment tment	BC)4Q11	If continuation s	heet 21	

03/22/2007

(X5) COMPLETE

DATE

3/23/07

5/6/07

5/6/07 &

on-going

5/6/07 &

on-going

(X3) DATE SURVEY

COMPLETED

Health Regulation Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING B. WING 095021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **1330 MASSACHUSETTS AVENUE NW** SUNRISE AT THOMAS CIRCLE WASHINGTON, DC 20005 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX **REGULATORY OR LSC IDENTIFYING INFORMATION)** TAĠ TAG DEFICIENCY) L 052 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 1.B Administration Record (MAR), the resident This resident will be assessed and received OxvContin 40mg at 9:00 AM on March given pain meds one hour before 20, 2007. There was no evidence that additional wound care. Nurse will complete pain medication was administered prior to the & document a pain assessment wound treatment. prior to, and during wound care. The care plan was reviewed and failed to include If resident exhibits pain, approaches and goals related to pain related to the Stage IV pressure ulcer to the right lower leg. There was no evidence that the resident's pain 2. was assessed prior to and during the wound All residents receiving pain meds treatment. There was no evidence that additional prior to treatments have been pain medication was administered prior to or during the wound treatment in response to the reviewed to ensure proper care resident's discomfort. The record was reviewed &/or documentation. March 20, 2007. 3. Director of Nursing will audit care to ensure & / or documentation.

C. Facility staff failed to adequately supervise the resident who had a history of multiple fails 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 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.

ealth Regulation Administration TATE FORM

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BO4011

If continuation sheet 22 of 36

	PRINTED: 04/04/2007
,	FORM APPROVED

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM		A. BUILD	· · · · ·	(X3) DATE COMPL			
· .	· ·	095021		B. WING		03/2	22/2007		
AME OF F	PROVIDER OR SUPPLIER		STREET ADE	RESS, CITY	, STATE, ZIP CODE				
SUNRISI	E AT THOMAS CIRCL			ASSACHUSETTS AVENUE NW NGTON, DC 20005					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF CON (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE		
L 052	Continued From pa	ge 22		L 052		· · · · · · · · · · · · · · · · · · ·			
	nain Resident was	assessed from head	to toe				···· ·		
		onsciousness). Unabl		:					
		ge of Motion) due to pa							
· · · ·,		rature (T) 98.3, Pulse				· · · · ·			
		, and (Blood Pressure)							
		ximetry) 97% R/A (Roo							
		57mg/dl. Resident had				· ·			
1		r 10:00 PM Oxycontin							
		sisted resident into w/o				~			
		she] was unable to sta ware and stated that re			(1) C ware plan for resider	nt #1			
		ergency room (ER) to			revised with new approa	ches			
· [on. Resident left unit			to prevents falls.		<u>3/28/07</u>		
		esponsible party made							
	и								
					(2)Care plans for all the	residents			
		nual Minimum Data Se			with history of falls wer	e			
		ated October 6, 2006,			reviewed to determine if	new			
		I Functioning and Struc			approaches were required	d.	<u>3/30/07</u>		
		oom/ corridor was cod							
		Toilet use was coded for					••		
	coded for "Fell past	e. Section J, "Accidents	s, was		(3)Director of Nursing				
[]	coded for Pell past	J 1-100 days	· · ·		will review plans at care	plan	· .		
· [A physician's note d	lated December 29, 20	06		meeting to ensure any res	sident with			
		oldresident at the Lo		· · · · · · · · · · · · · · · · · · ·	history of falls has been r	eviewed.	5/06/07		
		ho had sustained a fal					on going		
		femur. Pt. (patient) is		[
		Open reduction and int			(4)Director of Nursing of	r i i			
		is transferred back her			designee will report to Q		· · · ·		
		n) Pt. was ambulator e/she] says [he/she] ha			Committee on care		· · ·		
	pain but the current r		au		status re: falls.		5/06/07		
		spnea. [Resident] say:	s .			CETRE C	on going		
		he] is better. Patient h		· · · · · · · · · · · · · · · · · · ·					
	unctional decline an			· · · · · · · · · · · · · · · · · · ·					
	·								
		at approximately 2:30 F				}	• •		
		v was conducted with t				· .			
r	esident who indicate	ed that [he/she] remem	Dered						

Health F	Regulation Administr	ation): 04/04/200 APPROVEI
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE S COMPL	
	ч. — н	095021	, ·	B. WING	·	03/2	2/2007
		000021	STREET AD	DRESS. CITY.	STATE, ZIP CODE	03/2	212001
	E AT THOMAS CIRCL	E	1330 MAS		ITS AVENUE NW		
(X4) ID PRÉFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLETE DATE
L 052	Continued From pa			L 052			·
	going to the bathroo	om, was standing at t	the sink				
· · · · · · · · · · · · · · · · · · ·	stumbled back, fell without help.	e in preparation for b and was unable to ge	et up				
		at approximately 4:5					•
	Employee #9, who day of the incident.	view was conducted v indicated, " I was he The resident was in	re the the				
	summoned me to th	Certified Nurse Aide) ine room. CNA report the floor. I went to th	ed that			•	
	bathroom and noted floor. I assessed he	the resident on the ler by dong ROM to [h	bathroom is/her]	·. }			
· .	right leg because it l	e] did not tolerate RO hurt. MD on call was icated for pain. The	notified.	: .		- · ·	
· · [gave an order to ser 911 to rule out a frac	nd the resident to the cture. The resident w pom]. POA (power of	ER via vas sent				
· · ·		d. [He/she] left via si		· · · ·			
1	the resident had falle January 30, Februar	t #1's record revealed en as follows for 2006 y 3, June 28 and Oct	6: ober 16,				•
	2006. There were no these falls.	o injuries associated v	with				، جو بر ا
	14, 2004 and last rev	d "Falls" was initiated viewed by facility staf here was no evidence	fon				· .
t t	he care plan was re	vised to include addit es to prevent falls afte	ional				
S V	who subsequently fe	lent #1 with a history Il and sustained a fra	cture to				· · ·
. 10	ne right temur. The l	record was reviewed		· ·	March 1997		

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER		(X2) MULT	IPLE CONSTRUCTION	(X3) DATE COMPL	
	OF CORRECTION	IDENTIFICATION NUM	BEK:	A. BUILDI	NG		•
		095021	STREET ADD	RESS. CITY.	STATE, ZIP CODE	037	22/2007
	E AT THOMAS CIRCL			SACHUSE	TTS AVENUE NW		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY F SC IDENTIFYING INFORMAT		ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLET DATE
L 052	Continued From pa			L 052			:
· - 	March 20, 2007.	• • • • • • • • • • • • • • • • • • •	···· · · · ·	· · · · · · · · · · · · · · · · · · ·		· · · · · · · · · · · · · · · · · · ·	
		ed to assess and admi Resident #7 prior to a \$					
}	wound treatment.				2 A. This resident will be ass given pain med 1 hour before w		
		ng of the resident prior ne rèsident was moanil			care. Nurse will complete & do	cument	
	groaning, and sayin	g "ouch." Employee #	6 failed		a pain assessment prior to, & du wound care. If resident exhibits		
	to assess the reside	ent for pain prior to initi ht.	ating		nurse will stop treatment, notify physician, obtain pain med order		
. (The wound treatme	nt for a Stage IV sacra	1		medicate resident prior to resur	ning	
.	pressure ulcer was	observed on March 21	, 2007 🏅		wound care. Nurse(Treatment N responsible for wound care will		
(continued to moan,	the treatment, the resi groan and say "ouch" nd tightly to the arm of	and		administer pain med.		3/23/07
· (·	staff member assist	ing with the wound trea	atment.		B. Nursing staff will consistently		
	and assess the resid	e failed to stop the trea dent ' s pain.	tment		& adequately assess & medicate focument for resident #7		5/6/07.&
	A face-to-face interv	view was conducted wit	th the		See above.	J	on-going
	treatment nurse on I	March 21, 2007 at PM. He/she stated, "1	The		2. All residents receiving pain m	eds prior to	
	resident was admini	stered pain medication		1	reatments, all residents with disc neds, all residents with orders for	ontinued or splints,	
.]ı	responsibility for adr	ge. " However, the ninistering medications	s both		& one resident on G-Tube feedin	g have	•
		eded medication was nurse [medication nurse]	se].		been reviewed to ensure proper c locumentation		5/6/07
· [.		lers dated and signed renewed February 8, g:	2007	4	Director of Nursing will audit nsure & / or documentation.		5/6/07 & on-going
	po (orally) TID (three	0 mg II (two) caps (100 times daily) for pain.		Г	Director or Nursing or Designe eport to QA Committee on outcoudits of pain meds, discontinued	omes of	· ·
	Roxanol 5 mg po eve or pain	ery 4 hours PRN (as no	eeaea)	8	plints, G Tube feedings, & any o	other	2 15 26m a
· .		R lacked evidence that	t pain		ssues Director of Nursing deten re relevant to quality care.		5/6/07 & on-going

(X5) COMPLETE DATE

5/6/07

(X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED **IDENTIFICATION NUMBER:** A. BUILDING B. WING 095021 03/22/2007 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **1330 MASSACHUSETTS AVENUE NW** SUNRISE AT THOMAS CIRCLE WASHINGTON, DC 20005 SUMMARY STATEMENT OF DEFICIENCIES **PROVIDER'S PLAN OF CORRECTION** IÐ (X4) ID EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX **REGULATORY OR LSC IDENTIFYING INFORMATION)** CROSS-REFERENCED TO THE APPROPRIATE TAG TAG **DEFICIENCY**) Continued From page 25 L 052 L 052 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. 1. Record lacked evidence resident A review of Resident #2 's interim order form was ever reweighed after previously dated March 13, 2007 at 7:00 AM revealed the reported weight gain. No edema, No following order, "Weigh resident to verify weight negative outcome. Patient discharged status. (He/she has had significant weight gain to home on 4/1/07 in much improved 7.8% [one] month). " condition. 2.All residents' weights have been A review of the resident's weight record, nurses' reviewed to ensure no similar notes, and nutritional progress notes lacked evidence that the resident was reweighed as situation exists and to ensure proper ordered. proper care &/or documentation. 5/6/07 A face to face interview was conducted with the 3.DON or designee will audit care to Director of Nursing on March 21, 2007 at 1:20 5/6/07 & ensure proper care &/or documentation. PM. He/she acknowledged that there was no on-going evidence that the resident was reweighed as 4.DON or designee will report to QA ordered. This record was reviewed March 20, Committee on outcomes of weight 2007. audits and any other issues DON 4. Facility staff failed to follow physician's orders determines are relevant to quality 5/6/07 & regarding Resident #3's G-tube (gastrostomy care. on-going tube) feedings. A. Facility staff failed to follow physician's orders regarding Resident #3's G-tube (gastrostomy tube) feedings lealth Regulation Administration TATE FORM 6899

Health Regulation Administration

BO4011

If continuation sheet 26 of 36

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPL IDENTIFICATION N		(X2) MUL A. BUILDI	TIPLE CONSTRUCTION	(X3) DATE COMPL	
		095021		B. WING		03/2	22/2007
AME OF F	ROVIDER OR SUPPLIER				, STATE, ZIP CODE		
SUNRISI	E AT THOMAS CIRCL	E		SSACHUSE GTON, DC	TTS AVENUE NW 20005		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCI MUST BE PRECEDED B SC IDENTIFYING INFORM	YFULL	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
L 052	Continued From pa	ge 26		L 052			1
	The resident was ol his/her G-tube conn March 21, 2007 at 1	ected to a feeding 0:00 AM, 11:00 AM	pump on I and				
· · · ·	12:00 PM. The feed there was no entera	I feeding in the atta	iched bag.				
• • •	A physician's order Resource Diabetic v hrs or until total volu	ia g-tube at 50 mls	/ hr x 20				
	According to the Ma Administration Reco designated that the " (stopped) at 12:00 4:00 AM.	ord (TAR), the facilit	y had be " down		4.1 On 3/21/07 G Tube feed not given at times on TAR. I negative outcome. Proper tin followed.	No	3/29/07
	The night nurse's ini March 2007 TAR inc was stopped at 12:0	licating that the tub	e feeding		 No other residents on G- Att residents on G-Tube fee 		
	According to the MD 2007, in Section K, the resident received tube feedings.	" Oral/Nutritional St	atus, "		Future will be reviewed to en care &/or documentation.	isure proper	5/6/07
· · · ·	A face-to-face interv nurse [Employee #3] 21, 2007 at 2:00 PM tube feeding at 12:30 have been hung at 4	was conducted on . He/she státed, ") PM. The new bag	March I hung the		3. Director of Nursing will au ensure & / or documentation.		5/6/07 & on-going
·	There was no evider resident experienced Although it was docu Administration Recon administered at 4:00 observation, it was d feeding was administ	l any untoward effe mented on the Tree d that the tube feed AM, through intervi etermined that the t	cts. atment ding was iew and		4. DON or designee will rep Committee on outcomes of G & any other issues DON deter relevant to quality care.	Tube audits	5/6707 & on-going
.	5. During wound tre				· · · · · ·		

. .

un d

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU 095021		(X2) MULTI A. BUILDIN B. WING _	PLE CONSTRUCTION G		SURVEY LETED
NAME OF F	PROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, S	STATE, ZIP CODE		
SUNRISI	E AT THOMAS CIRCL	E	1330 MAS WASHING		TS AVENUE NW 0005		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	n Should Be E appropriate	(X5) COMPLE DATE
L 052	Continued From pa Residents #1, 7 and [Employee #6] failed	9, the treatment nu		L 052		· · · · · · · · · · · · · · · · · · ·	
	per the physician's of A wound treatment	order.					
	observed on March physician's order da directed, Right leg w normal saline solutio cover with gauze da	20, 2007 at 2:15 PM ted February 16, 200 /ound Stage 4: clean on and apply Hydrog	. A)7 ise with				
	A wound treatment f on March 21, 2007 a order dated March 5 sacral ulcer Stage IV and apply Hydrogel.	at 1:30 PM. A physici , 2007 directed, Clea / with normal saline :	an's anse solution		 Bottle containing ac (with old label covered discarded. No other bottles have been 	d) was	<u>03/21/07</u> 03/29/07
	A wound treatment f on March 21, 2007 a physician's order dat sacral ulcer with non	t 2:30 PM. According ed February 1, 2007	gtoa		3 DON or designee will aud assessments of residents v immobilizers. DON or designee will insp	vith pect	
	The treatment nurse contained in a bottle product name. The	with white tape acrosproduct name, "Carra	ss the a Klenz",		treatment cart to ensure no 4 DON or designee will rep		05/06/07 on-goin
	was evident through no writing on the whi A face-to-face intervi	te tape.			Committee on immobilize cart audit outcomes.	r and treatment	<u>05/06/07</u> on-going
. · · · t . · · · c . ·	treatment nurse at th observation. He/she was the same as nor	e time of the wound was asked if Carra I mal saline solution.	(lenz The			• • • •	
r t	nurse replied, "\No, t normal saline into thi he spray. That's wh Carra Klenz." There	s bottle, so that I cou I put the tape over t	ld use the			•	
S	contents of the spray solution.	bottle was normal sa			angering and a second sec	· · · · · · · · · · · · · · · · · · ·	
6	Facility staff licens	ed nurses failed to		· · · ·			

Health Regulation Administration

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MUL A. BUILD B. WING		(X3) DATE SURVE COMPLETED	Y
		095021				03/22/20	07
NAME OF F	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY	, STATE, ZIP CODE		
SUNRIS	E AT THOMAS CIRCL	E ·		SSACHUSI GTON, DC	ETTS AVENUE NW 20005	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE CO	(X5) MPLETE DATE
L 052	Continued From page	ge 28		L 052			
	administer medication ordered by the physic	on to two (2) residen ician.	ts as				I
· · · ·		rch 20, 2007, the me] was observed adm dent JH1 at approxin	inistering				
	9:00 AM. After the r physician's orders w discovered that the r administered three (ere checked. It was medication nurse					
	medications to resid resident received on and Prandin 0.5 mg	ent JH1 for 9:00 AM. e tablet of Lisinopril	2.5 mg		1. A. Patient now receiving con		· · ·
	0.4mg. According to the phy	sician's orders, Resi	dent JH1	•	meds. New Nurse #5 trained in pass.	med 3/23	/07
	was ordered Aggren mg and Lovenox 40 Administration Reco	mg. The Medication	i _		B. Patient now receiving inhaler medications as ordered. Nurse #		-
	medications were to However, the medica	be administered at 9 ation nurse was not c	00 AM.	· ·	trained in med pass.	3/23	/07
	administering the afc during the medication		ations		2. All MARS reviewed to ensur all patients receiving proper med	ls.	(07.0
• •	A face-to-face intervi DON on March 20, 2 AM. He/she explaine than a week ago.	007 at approximately	/ 11:30		Competency test will be given to med nurses. 3. Director of Nursing or Desig	on-g	/07 & oing
	B. On Wednesday, M			· · ·	monitor med pass compliance. Pharmacy will schedule med pas	. }	7&
.	approximately 9:15 A [Employee #3] was of medications to Resid not administered to R	bserved administerin ent JH2. Spiriva inha	ng aler was	:	observations/training. 4. Director of Nursing or Design	on-ge	
	's order read, " Spiriv puff qd for COPD ". / Spiriva was to be adn	va 18mcg w/handihal According to the MAI	ler one R,		will report to QA Committee on Pass Compliance.		
1	A face-to-face intervie medication nurse on I		ith the				

Health Regulation Administration

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If continuation sheet 29 of 36

	Regulation Administra TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE		(X2) MULT		OATE SURVEY
	OF CORRECTION	IDENTIFICATION NU		A. BUILDIN		OMFLLTED
		095021		B. WING		03/22/2007
	PROVIDER OR SUPPLIER		STREET AD	DRESS CITY	STATE, ZIP CODE	0312212001
	E AT THOMAS CIRCL	F	1330 MAS	SACHUSE	TTS AVENUE NW	
		· · ·	WASHING	STON, DC 2		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
L 052	Continued From page	ge 29		L 052	······	
	stated that he/she d) AM. The medicatio id not know that the i		.*	1. Employee counseled regarding t importance of washing/sanitizing ha	
	was to be given.			· · ·	between med passes.	3/23/07
L 091	3217.6 Nursing Fac	ilities		L 091	2. All licensed staff in-serviced on	
	•	ol Committee shall er			importance of washing/sanitizing between med passes. Director of	· ·
	that infection control implemented and sh			1	Nursing observed staff to ensure	
	services, including h	ousekeeping, pest c	ontrol,		improper technique was isolated.	
	laundry, and linen su		ice with		Sanitizing product will be kept on	
• .	the requirements of This Statute is not n	net as evidenced by:			med cart.	3/30/07
	Based on observation				3. Director of Nursing will monitor	
1. 1. A.	that proper procedur				staff to ensure med passes are proper	
	control the spread of	communicable dise	ases as		Pharmacy called to observe/train	3/30/07
	evidenced by: failure wash his/her hands a				staff for proper med pass technique.	on going
•	residents and closed				4. Director of Nursing or Designee	1
	packages were store		room		will report to QA Committee on med	3/30/07 &
·	floor. This observation presence of the Adm Environmental Service	inistrator and the Dir	ector of		observation outcome.	on going
					1.Boxes were picked up off carpet	ΞÎ.
	The findings include:				& placed on shelf.	3/22/07
	1. The medication n				2.All supply areas were inspected	·
	wash his/her hands a		(2)		to ensure no other boxes were on	
•	residents during med	lication pass.			the floor.	3/22/07
	On March 20, 2007 a				3.Director of Housekeeping will	:
	while observing the n medication nurse [En				inspect supply areas to ensure all	· ·
	sanitize his/her hands			,	boxes are off the floor & will	5/6/07 &
	administering medica		1 and		record in unit log box.	on going
	#4.					
	2. Closed boxes and	opened packages of	fnads	. * •	4.Director of Housekeeping will repo	
	diapers and washclot				to QA Committee on outcome of aud	its. on going

lealui	Regulation Administra	ation	<u> </u>		<u> </u>		_
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM		(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE S COMPL	SURVEY ETED
		005024		B. WING		0.24	0/0007
		095021			, STATE, ZIP CODE	03/2	2/2007
	PROVIDER OR SUPPLIER				ETTS AVENUE NW		
UNRIS	E AT THOMAS CIRCL	E		TON, DC		•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY I SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE , (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLE DATE
L 091	Continued From pa	ge 30		L 091			
· · .		om on the second flo packages observed a 007.				· · · · · · · · · · · · · · · · · · ·	/
		ion was acknowledge nental Services and th				···· ` · · · · · · · · · · · · · · · ·	
L 099	3219.1 Nursing Fac	lities		L 099			
· · ·	from spoilage, safe served in accordance forth in Title 23, Sub Regulations (DCMR This Statute is not r	I be clean, wholesom for human consumpti e with the requirement title B, D. C. Municipa), Chapter 24 through net as evidenced by:	ion, and nts set al n 40.		 Can openers cleaned & sanit Dishwasher slats cleaned 	ized.	3/22/07
	it was determined th adequate to ensure served in a safe and	ns during the survey at dietary services we that foods were prepa sanitary manner as can openers, dishwa	ere not ared and		& sanitized. 3. Hotel pans cleaned, sanitized		3/22/07
	slats, hotel pans, she insects (roaches) on the refrigerator, clea floor, marred and da	eet pans, chinaware, a shelf, unlabeled fo ning equipment store maged walls and exit	dead ood in d on the doors,		& air dried.		3/22/07
	and temperatures in floor serving area we (F). These observa 20, 2007 between 8: observed by the Foo	re 86 degrees Fahre tions were made on M 45 AM and 3:30 PM a	nheit March	· · · · · · · · · · · · · · · · · · ·	 4. Sheet pans cleaned, sanitized & air dried. 5. Chinaware cleaned, sanitized 		3/22/07
	The findings include:				& air dried.		3/22/07
•	1. Can openers in the preparation areas we edges with food debr (2) of two (2) can ope	re soiled on the cuttin is and metal shaving		,	6. Two dead roaches removed. All food removed & all shelf surfaces in cabinet cleaned.		3/22/07
	2. Slats on the clean			······	7. All food items discarded.		3/22/07

	ROVIDER OR SUPPLIER E AT THOMAS CIRCL SUMMARY STA	-	STREET AD	A. BUILDI B. WING		· · · · · · · · · · · · · · · · · · ·		
UNRISE	E AT THOMAS CIRCL							
UNRISE	E AT THOMAS CIRCL	-					03/	22/2007
(X4) ID PREFIX								
RÉFIX	SUMMARY STA			TON, DC				
- <u>-</u>		TEMENT OF DEFICIENCIES MUST BE PRÉCEDED BY FI SC IDENTIFYING INFORMATI		ID PREFIX TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLE DATE
L 099	Continued From page	ge 31		L 099				
	and mineral deposit	S						
	3. 14 of 16 hotel pa	ns size 14 " x 24 " x 3	2" and	· .	.			
[seven (7) of 11 hote	l pans size 14 " x 6 "	x 10 "		}	8-All mop, broetre & dest		
]		ed soiled with grease, et and ready for reuse				pans properly hung. Janito		
· .	debris and stored w	et and ready for reuse	•		. .	closet floor cleaned.		3/22/0
		ns were observed soil		, · · ·				
	grease and stored w	et and ready for reuse	э.		ł	9. Baseboard tiles on 2 wal	Īe	
	5. Chinaware was of	oserved soiled with for	bc		· .	replaced.	19	5/6/07
		ashed as follows: five (
		ation bowls, 16 of 26 s	soup					1
•	bowls, and six (6) of	11 plates.				10.Exit doors in rear of kite	hen	
		cts (roaches) were ob s in the stainless steel				repaired & painted.		5/6/07
	in the cook 's prepa		Cabinet			*		
		•				11.Director of Maintenance	0	
		ruit, bread, and salads				proposals for air supply ven airconditioning is on, the te		
	food items observed	ator in three (3) of six ((0)	Í		should be correct.	mporature	5/6/07
		· · · ·						
		nt such as mops, broc tored on the floor of th		· · .		2. All other food service are		
		main kitchen. The co		.		inspected to ensure some co do not exist elsewhere.	nditions	4/13/07
		uneven in one (1) of o	ne (1)		•	do not exist elsewhere.		
j	anitorial closet obse	ved.				3. Food Service Director or		
). Walls in the pot a	nd pan wash area and	the			Designee will inspect all for		
- a	area near the juice di	spenser were marred	and			Areas monthly to ensure con		ļ: .
		g baseboard tiles in two	vo (2)			& prevent recurrence of abo conditions.	ve	5/6/07
	of two (2) walls obser	vcų.				AMA BEVALD,	· · · · ·	on goin
		ear of the kitchen wer				4. Food Service Director or	-	
		l in three (3) of three (3) exit	· [will report to QA Committee		
d	loors observed.	1000 - 1		· · ·		inspections outcomes.	· · · · · · · · · · · · · · · · · · ·	5/6/07
1	1. Temperatures in	the main kitchen and	the					on going

BC 4Q11

	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIE		(X2) MUL1		(X3) DATE S COMPL	
ND PLAN	OF CORRECTION		NBER:	A. BUILDI	NG		
		095021		B. WING		02/2	2/2007
		T 095021	STREET AF		STATE, ZIP CODE	0.312	2/2007
AME OF F	ROVIDER OR SUPPLIER				TTS AVENUE NW		
SUNRISE	EAT THOMAS CIRCL	E		GTON, DC 2			• .
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLET DATE
L 099	Continued From pa	ge 32		L 099		- ·	
	degrees F [tempera degrees F]. Both a	ture range should be reas lacked air supply	71 - 81 / vents.			· ····	 -
. *	The aforementioned	d observations were					
[acknowledged by th	e Food Service Direc	tor at			· .	· ·
	the time of the tour.	· · ·				·	
L 163	3227.14 Nursing Fa	cilities		L 163			
	Destruction of contr	olled substances sha	ll be				
	witnessed by two (2) licensed nurses and	la				
	resident's medical re	otation shall be made ecord.	in the		• .	• • • •).
		net as evidenced by:		-			
	Based on staff inten documents, it was d failed to complete th	etermined that facility	staff	,			
	Discontinued Contro	olled II-V Substances"	form as				
	per facility policy.						
	The findings include	•	ļ				
		complete the "Destru		. }	1. "Destruction of Discontin	ued	·
	Discontinued Contro per facility policy.	lled II-V Substances"	form as		Controlled II-V Substances" is now being completed per fa	form cility	5/06/07
		tipulates, "Destruction	on of		policy.		
	controlled substance	s shall be witnessed		· · · [2. DON has audited medicati	on	5/06/07
	(2) licensed nurses	0			destruction system to ensure r	10	5/00/07
		and procedure, " Col		· · ·	similar issues exist.		
·	' The controlled dan	" section IIE:1 d. stip gerous substance	· · · · · · · · · · · · · · · · · · ·		3. DON or designee will audi	t drug	5/06/07
		ired by the Division o each time controlled		· · · · · · · · · · · · · · · · · · ·	destruction system to ensure to no similar issue recurs in the fu	ensure iture.	on going
	are destroyed. " (3)	The form must be sig	gned by				
1	a witness. The form	must also include the			4. DON or designee will report QA Committee on results of dr		5/06/07 on going
	method of destruction	n and the date the dru	ugs 👘	1.1	destruction audit.		n Pomk

Tealur	Regulation Administra				· · · · · · · · · · · · · · · · · · ·	T	
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		A BUILDIN	IPLE CONSTRUCTION G	(X3) DATE COMP	
		095021		B. WING		03/	22/2007
NAME OF I	PROVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·	STREET ADD	RESS, CITY,		· · ·	
SUNRIS	E AT THOMAS CIRCL	E		SACHUSET TON, DC 2	TS AVENUE NW 0005		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLE DATE
L 163	Continued From pa	 ae 33		L 163			
••• ···	Division of Drug Co			······································			
·;	the "Destruction of Substances " form	was requested. The	olled [I-V form did				
	not document the M contain two (2) sign Morphine Sulfate 15	atures for the destruction of the destruction of the state of the stat	ction of			, X	
	Morphine Sulfate 20 The policy and form 20, 2007.		March				
L 168	3227.19 Nursing Fac	cilities		L 168		· ·	• .
	The facility shall labe accordance with cur principles, and includ and cautionary instru- date.	rently accepted profe	essional ccessory				
·	This Statute is not n Based on observatio multi-dose vials and determined that facil initial opened multi-d	n of four (4) of six (6 review of facility poli ity staff failed to date	i) cy, it was and		1.Opened vials discarded. Opened vials labeled (dated & initialed).		3/23/07
	The findings include: The facility 's policy				2. All multidose vials have been checked to assure opened vials		
•	Ampules of Injectable IIIA:3, stipulates, " T	e Medications " sect he date opened and	ion the		dated & initialed.	are	3/23/07
	initials of the first per recorded on multidos label or on an access	e vials either on the	vial		3. Director of Nursing or Designation will inspect vials monthly to end open vials are labeled (dated &	isure	5/6/07 &
	purpose. " On March 20, 2007, a	at approximately 10:4	45 AM,		initialed)		on going
	during the inspection area, four (4) of six (6 were observed in the	of the medication sto b) opened multi-dose	orage		4. Director of Nursing will report to QA Committee regarding visions outcome	ม	576/07 & on going

Health Regulation Administration STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED **IDENTIFICATION NUMBER:** A BUILDING B. WING 095021 03/22/2007 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **1330 MASSACHUSETTS AVENUE NW** SUNRISE AT THOMAS CIRCLE WASHINGTON, DC 20005 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **REGULATORY OR LSC IDENTIFYING INFORMATION)** CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) L 168 Continued From page 34 L 168 opened the vials. The medication included: Novolin-R Insulin R4662612 1 2. Lantus Insulin R4692293 Novolin-R Insulin R4677044 3. Novolin-R Insulin-R16922300 4. L 999 DC CODE L 999 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) 1. Oriminal back-ground check employees before the date of hire. results are now being obtained 3/27/ prior staff begin work. The findings include: Facility staff failed to obtain a criminal 2. Staff records have been reviewed background check for two (2) employees before to ensure no other staff began working the date of hire. without criminal background checks. DON or Designee is monitoring According to the 22 District of Columbia "Destruction of Discontinued Municipal Regulations (DCMR), 4701.2 "Each 5/06/07 Controlled II-V Substances" form facility shall obtain a criminal background check, per facility policy. on going 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 3. New QA tool developed and Nursing (DON) [employee #1] revealed a hire department heads will be held date of February 26, 2007. A criminal background accountable for reporting issues check was completed on March 23, 2007. The 5/06/07 to the OA Committee. criminal background check did not reveal any on going criminal convictions. 4. QA Committee will be responsible 5/06/07 B. The personnel record of the licensed Registered Nurse (RN) [employee #2] revealed a for monitoring compliance on going hire date of March 15, 2007. A criminal alth Regulation Administration ATE FORM 6899 BO4Q11 If continuation sheet 35 of 36

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ÍATEMEN ND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU	ER/CLIA IMBER:	(X2) MULT A. BUILDIN B. WING		(X3) DATE S COMPLI	URVEY ETED
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
L 999	Continued From pa	ge 35		L 999			
	background check 2007. The criminal reveal any criminal	was completed on M background check di	arch 22, id not				
	A face-to-face inter	view was conducted I with the Human Re		· · · · · · · · · · · · · · · · · · ·			· · · ·
i.		were not done for th nire." The records w					
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