

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

PRINTED: 07/12/2006
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 095019	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 06/29/2006
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NAME OF PROVIDER OR SUPPLIER

GRANT PARK CARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

**5000 BURROUGHS AVE. NE
WASHINGTON, DC 20019**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS A follow-up survey to the annual recertification survey (April 14, 2006) was conducted on June 28 through June 29, 2006. The following deficiencies were based on observations, staff and resident interview and record review. The sample size was 18 with 132 supplemental residents. The census was 282 on the first day of survey.	{F 000}		
F.170 SS=D	483.10(i)(1) MAIL The resident has the right to privacy in written communications, including the right to send and promptly receive mail that is unopened. This REQUIREMENT is not met as evidenced by: Based on record review and staff and resident interviews for one (1) supplemental resident, it was determined that facility staff failed to ensure that Resident W1 received his/her mail unopened The findings include: The resident was admitted to the facility on March 25, 2006. The admission MDS (Minimum Data Set) dated April 3, 2006 Section B4 coded the resident as independent for cognitive skills for daily decision making. A face-to-face interview was conducted with the resident on June 28, 2006 at 4:20 PM. He/She stated, "I received a check and it was opened. I asked [social worker's name] about it. [Social worker said that he/she would have to ask	F 170	483.10(i)(1) Mail 1. Resident W1 receives mail unopened. Resident received written apology on behalf of Grant Park Care Center. 2. Review of mail received will be conducted for being unopened by Administrator & or SS. 3. Social Services, Business Offices & Receptionist were re-educated on the resident's right to receive unopened mail. 4. Administrator/designee to QI monitor weekly x4. Monthly resident interviews and Resident Council regarding opening of mail to be conducted. Findings to be reported to the facility FLC meetings.	7/31/06

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

[Signature]

Exec. Dir

7-21-06

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

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F 170	<p>Continued From page 1</p> <p>downstairs. That was my first check. I had to sign for it. I only got the check, there wasn't an envelope."</p> <p>A face-to-face interview was conducted with the social worker on June 28, 2006 at 4:20 PM. He/She stated, "They had it [check] downstairs. That was [resident 's] first check; most have envelopes. The social worker stated that he/she knew of no reason why the check would have been opened and that it was received by him/her opened.</p> <p>A face-to-face interview was conducted with the Executive Assistant Office Manager on June 28, 2006 at 5:45 PM. He/She stated, "I put resident's mail into bundles and put them into the social worker's boxes. I take all other mail back to the business office. I don't know anything about that check [Resident W1 's check]." The record was reviewed on June 28, 2006.</p>	F 170		
{F 253} SS=C	<p>483.15(h)(2) HOUSEKEEPING/MAINTENANCE</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations during the survey period, it was determined that housekeeping and maintenance services were not adequate to ensure that the facility was maintained in a safe and sanitary manner as evidenced by: floors stained in rooms and common areas, HVAC</p>	{F 253}		

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{F 253}	<p>Continued From page 2</p> <p>control panel doors not secured, gum on the concrete surfaces at the front entrance, soiled and stained privacy curtains, and marred and scarred doors, soiled baseboards and marred and scarred furnishings in residents' rooms and common areas. These observations were made in the presence of the Directors of Housekeeping and Maintenance and nursing staff.</p> <p>The findings include:</p> <p>1. Floor surfaces were soiled with wax and accumulated debris in the following areas:</p> <p>2nd Floor - 2 South pantry in one (1) of six (6) observations on June 28, 2006 at approximately 2:30 PM.</p> <p>3rd Floor - Room 302 in one (1) of seven (7) observations on June 28, 2006 at approximately 4:00 PM.</p> <p>4th Floor - Rooms 402 and 411 in two (2) of eight (8) observations on June 28, 2006 at approximately 3:15 PM.</p> <p>5th Floor - Rooms 502 and 524 in two (2) of eight (8) observations on June 28, 2006 between 11:25 AM and 1:00 PM.</p> <p>2. HVAC control panel doors were not secure in the following areas:</p> <p>5th Floor - rooms 515, 517, 5 North Day Room and 536 in four (4) of eight (8) observations on June 28, 2006 at 12:05 PM.</p> <p>3. Gum was observed on the concrete surfaces at</p>	{F 253}	<p>483.15(h)(2) Housekeeping/Maintenance</p> <p>1. Floor surfaces cleaned and wax build up removed from 2 south pantry, rooms 302, 402, 411, 502, & 524.</p> <p>HVAC control panel doors are secured in rooms 515, 517, 536 & 5 North Day Room.</p> <p>Gum removed from concrete surfaces at main entrance on July 25, 2006.</p> <p>Privacy curtains in rooms 215, 221, 302,309,410,434, 532 & 536 are clean & without stains.</p> <p>Doors in rooms 210,253, 2 south utility rooms, room 411, 427 & 429 have been repaired & repainted.</p> <p>Baseboard surfaces have been replaced or cleaned in 3 North pantry, 3 North soiled utility room, 4 South utility room, 5 North soiled utility room.</p> <p>New Resident room and common area furniture has been ordered. Furnishings in 2 South Day Room & room 230, North Day room, room 302, 334 & 353, 4th floor, 4 South Day Room & 5 South Day Room have been repaired or scheduled to be replaced.</p> <p>Facility Administrator will notify the State Agency of any changes in Plan of Correction.</p> <p>2. Environmental rounds of entire facility will be conducted for cleanliness of floors & wax build up, HVAC control panel doors being secured, gum on side walks or floors, rooms for doors being marred or scarred, baseboards being soiled/stained, furnishings being in good repair & stained/soiled privacy curtains. Appropriate actions taken on findings. Privacy curtains ordered on July 21, 2006.</p> <p>3. Staff educated on identifying & reporting of housekeeping & maintenance issues. Walking rounds to be conducted by Administrator & Housekeeping, & Maintenance monthly.</p> <p>Maintenance director or designee will check maintenance log for areas requiring housekeeping and/or maintenance follow up.</p> <p>4. Environmental rounds will be conducted for housekeeping & maintenance issues by Administrator and/or maintenance director and/or housekeeping and/or unit managers and/or DON/ADON monthly. Findings reported to facility FLC.</p>	7/31/06

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{F 253}	<p>Continued From page 3</p> <p>the main entrance at 9:30 AM on June 28, 2006 in one (1) of one (1) observation.</p> <p>4. Privacy curtains were soiled and stained in the following areas:</p> <p>2nd Floor - rooms 215 and 221 in two (2) of eight (8) observations on June 28, 2006 at approximately 2:30 PM.</p> <p>3rd Floor: rooms 302 and 309 in two (2) of seven (7) observations on June 28, 2006 at 4:00 PM.</p> <p>4th Floor - rooms 410 and 434 in two (2) of eight (8) observations on June 28, 2006 at 3:15 PM.</p> <p>5th Floor - rooms 532 and 536 in two (2) of eight (8) observations on June 28, 2006 at 12:05 PM.</p> <p>5. Entrance and bathroom doors were marred and scarred in the following areas:</p> <p>2nd Floor - rooms 210, 253 and 2 South utility room in three (3) of six (6) observations on June 28, 2006 at 2:30 PM</p> <p>4th Floor - rooms 411, 427 and 429 in three (3) of eight (8) observations on June 28, 2006 at 3:15 PM.</p> <p>This was a repeated deficiency from the annual recertification survey completed April 14, 2006. Facility staff failed to supply invoices to indicate doors were ordered by the compliance date of May 29, 2006, prior to the end of this survey.</p> <p>6. Baseboard surfaces were observed soiled and stained in the following areas:</p>	{F 253}			

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{F 253}	<p>Continued From page 4</p> <p>3rd Floor - 3 North pantry and 3 North soiled utility room in two (2) of seven (7) observations on June 28, 2006 at approximately 4:00 PM.</p> <p>4th Floor - 4 South clean utility room in one (1) of eight (8) observations on June 28, 2006 at approximately 3:15 PM.</p> <p>5th Floor - 5 North soiled utility room in one (1) of eight (8) observations on June 28, 2006 approximately 12:05 PM.</p> <p>7. Furnishings in residents' rooms and day rooms were marred and scarred in the following areas:</p> <p>2nd Floor: 2 South Day Room in four (4) of 13 chairs and five (5) of 15 tables, 2 North Day room in eight (8) of 10 chairs and five (5) of five (5) tables, and room 230 in one (1) of eight (8) observations on June 28, 2006 between 2:30 PM and 3:15 PM.</p> <p>3rd Floor: 3 North Day room in four (4) of four (4) tables and nine (9) of nine (9) chairs, rooms 302, 334 and 353 in three (3) of seven (7) observations on June 28, 2006 at approximately 4 :00 PM.</p> <p>4th Floor: 4 South Day Room in 15 of 15 chairs and five (5) of five (5) tables on June 28, 2006 at 3:15 PM.</p> <p>5th Floor: 5 South Day Room in eight (8) of 15 chairs and four (4) of five (5) tables on June 28, 2006 at 12:05 PM.</p> <p>The facility failed to notify the State Agency of a</p>	{F 253}		
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{F 253}	Continued From page 5 change in the plan of correction of the annual certification survey completed April 14, 2006 regarding marred furniture and repair of baseboards. According to the plan of correction for marred and scared furnishings, " All chairs and tables identified in [rooms cited] will be repaired by 5/29/06 ... The maintenance supervisor and staff will make a list of damaged chairs and tables including the ones which are beyond repair and forward the list to the Director of Engineering who will monitor the process and forward a copy of the problems and corrections to the quarterly [quality assurance] meeting. " According to the plan of correction for baseboards, " All baseboards identified [rooms cited] will be checked and glued back to the wall by 5/28/06 ... A telephone interview with the facility administrator and the State Agency was conducted on July 5, 2006 at 10:10 AM. The administrator stated, "Furnishings that could be repaired were repaired. There were some furnishings that were not repairable and a decision was made to replace those furnishings. Some baseboards were marred and had to be replaced. I was not aware that I needed to notify the State Agency because we were unable to repair furnishings and the base boards and chose to replace items."	{F 253}		

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{F 278} SS=D	<p>483.20(g) - (j) RESIDENT ASSESSMENT</p> <p>The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by :</p> <p>Based on observation, interview and record review for two (2) of 18 sampled residents, it was determined that facility staff failed to accurately code one (1) resident with a restraint and one (1) resident for height on the Minimum Data Set (MDS) assessment. Residents #9 and 10.</p>	{F 278}		

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{F 278}	<p>Continued From page 7</p> <p>The findings include:</p> <p>1. The facility inaccurately coded Resident #9 on the MDS with a trunk restraint.</p> <p>A review of Resident #9's record revealed a quarterly MDS completed June 2, 2006 that coded the resident in Section P " Restraints and Devices " with a trunk restraint.</p> <p>A face-to-face interview with the resident was conducted on June 27, 2006 at 9:40 AM. The resident was observed wearing a seat belt. When quarried about the seat belt, the resident stated, " This is for when I have seizures. It keeps me in the chair. " The resident demonstrated fastening and unfastening the seat belt without prompting.</p> <p>A face-to-face interview was conducted with the MDS coordinator on June 27, 2006 at 10:15 AM. He/she acknowledged that the MDS was coded inaccurately. The record was reviewed June 27, 2006.</p> <p>2. Facility staff failed to accurately code Resident #10's height on the MDS.</p> <p>A review of Resident #10's record revealed that an annual MDS assessment completed March 10, 2006 coded the resident in Section K2a, "Height " as 65 inches.</p> <p>An admission MDS assessment (post hospitalization) completed May 17, 2006 coded the resident's height as 70 inches in Section K2a.</p> <p>A quarterly MDS assessment completed June 14,</p>	{F 278}	<p>483.20(g)-(j) Resident Assessment</p> <p>1. Using the MDS Correction Policy an MDS modification for resident #9 was completed to correct restraint coding on July 19, 2006.</p> <p>Using the MDS Correction Policy an MDS modification for resident #10 was completed to correct height coding on July 19, 2006.</p> <p>2. The MDS Correction Policy will be used to correct other findings based on review. Residents with restraints have been identified & review conducted of resident's with restraints for correct coding on MDS & appropriate modifications made. All resident's were re-heighted & appropriate modifications made.</p> <p>3. DON/designee to QI monitor MDS of residents with restraints for correct coding monthly.</p> <p>DON/designee to QI monitor MDSs for current heights being coded on MDS.</p> <p>4. Findings reported to FLC. And appropriate action will be taken on findings.</p>	7/31/06
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{F 278}	Continued From page 8 2006 coded the resident's height as 72 inches in Section K2a . A face-to-face interview was conducted with the Clinical Manager on June 28, 2006 at 11:30 AM. He/she acknowledged that the heights were inaccurately coded. The record was reviewed on June 28, 2006.	{F 278}		
{F 279} SS=D	483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by Based on observation, interview and record	{F 279}		

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{F 279}	<p>Continued From page 9</p> <p>review for two (2) of 18 sampled residents, it was determined that facility staff failed to initiate a care plan for one (1) resident for a pressure ulcer, pain and nine (9) or more medications and for one (1) resident for Hospice Residents #7 and 14</p> <p>The findings include:</p> <p>1. Facility staff failed to develop a care plan for a pressure ulcer, pain and receiving more than nine (9) medications for Resident # 7.</p> <p>A. Facility staff failed to develop a care plan for a pressure ulcer.</p> <p>A review of Resident #7's medical record revealed that he/she was admitted to the facility on March 27, 2006. The 30 days Medicare, Minimum Data Set (MDS) completed on April 24, 2006. The resident was coded in Section M1a, "Skin Condition" for a Stage II pressure ulcer.</p> <p>A review of Resident # 7's initial care plan, dated April 8, 2006, revealed that there was no evidence that a care plan for pressure ulcer was developed.</p> <p>B. Facility staff failed to develop a care plan for pain for Resident # 7.</p> <p>A review of Resident #7's medical record revealed a physician's orders dated June 10, 2006 included, "Ibuprofen 600mg two times daily for Osteoarthritis, Acetaminophen with codeine one (1) tablet every four hours as needed for pain</p> <p>"</p> <p>A review of Resident # 7's initial care plan</p>	{F 279}	<p>483.20(d), 483.20(k)(1) Comprehensive Care Plans</p> <ol style="list-style-type: none"> Resident # 7 has care plan for nine (9) more meds. Pressure ulcer & pain. Resident # 14 has care plan for hospice integrating hospice services in to plan of care Residents with 9 or more meds identified and MR review conducted for care plans for nine (9) or more meds & pain management, wound & skin clinical program. Hospice residents have been identified and MR review conducted for hospice care plan. Licensed staff in-serviced on integrating hospice care into care plan for hospice residents and care planning nine (9) or more meds. Unit Management/designee to QI monitor hospice residents' medical records and care plans for hospice care plan monthly. Appropriate actions taken on findings. Findings reported to FLC. UM/designee to review for monthly care plans reflecting nine (9) meds. Appropriate actions taken on findings. Findings reported to FLC. 	7/31/06

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{F 279}	<p>Continued From page 10</p> <p>problems dated April 8, 2006 revealed that there was no evidence that a care plan for pain was developed.</p> <p>C. Facility staff failed to develop a care plan for nine (9) or more medications for Resident #7.</p> <p>A review of Resident #7's medical record revealed that he/she was admitted to the facility on March 27, 2006. The 30 day Medicare MDS, completed on April 24, 2006, coded the resident in Section O, "Number of medications" as 11.</p> <p>A review of Resident #7's initial care plan problems dated April 8, 2006 revealed that there was no evidence that a care plan for nine (9) or more medications was developed.</p> <p>A face-to-face interview was conducted with the Unit Manager on June 29, 2006 at 11:30 AM. He/she acknowledged that a care plan for a pressure ulcer, pain and nine (9) or more medications should have been developed. The record was reviewed June 29, 2006.</p> <p>2. A review of Resident #14's record revealed that facility staff failed to include a Hospice plan of care from the Hospice interdisciplinary team. This was a repeated deficiency. The facility failed to follow their plan of correction for the recertification survey completed April 14, 2006.</p> <p>According to the plan of correction for the recertification survey completed April 14, 2006, "1 . [residents] care plans were updated to reflect hospice upon obtaining an order for hospice care. A comprehensive care plan will be developed and placed on the resident's chart."</p>	{F 279}		

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

PRINTED: 07/12/2006
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 095019	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 06/29/2006
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{F 279}	<p>Continued From page 11</p> <p>The record included a plan of care for the problem "Hospice" with approaches listed. The interdisciplinary team did not include Hospice staff. Hospice services documented visits to the resident June 1 through 28, 2006 [17 times].</p> <p>According to the contract between the facility and the Hospice agency, page 5, revised 9/05, "... Hospice plan of care means a written plan established, maintained, reviewed, and modified, if necessary, by a hospice interdisciplinary team ..."</p> <p>The record was reviewed on June 28, 2006.</p>	{F 279}		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/12/2006
FORM APPROVED
OMB NO. 0938-0391

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{F 280} SS=D	<p>483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview and record review for one (1) of 18 sampled records, it was determined that facility staff failed to update Resident #13's care plan for restraints.</p> <p>The findings include:</p> <p>Facility staff failed to review and revise the plan of care for Resident #13 for the use of restraints as per facility policy.</p> <p>According to the facility's policy, "Restraint Management," policy number 9.3.2, dated August 2004 under " Overview: 11. Review and revise plan for restraint reduction and/or elimination with</p>	{F 280}	<p>483.20(d)(3), 483.10(k)(2) Comprehensive Care Plans</p> <ol style="list-style-type: none"> 1. Resident # 13 has care plan updated to reflect restraint. Restraint Data Collection & Evaluation, Side Rail Screen, and Restraint Reduction are current. 2. Residents with restraints have been identified and reviewed. Medical Record review will be conducted for care plan (s) reflecting current restraint. Medical record review will be conducted for current restraint form. 3. Nurses in-serviced on Restraint Clinical Program. 4. UM/designee to QI monitor residents with restraints for care plan reflecting current restraint and restraint forms are current monthly. Appropriate actions taken on findings. Findings reported to FLC. 	7/31/06
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/12/2006
FORM APPROVED
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER GRANT PARK CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 5000 BURROUGHS AVE. NE WASHINGTON, DC 20019	
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{F 280}	Continued From page 13 the interdisciplinary team at least quarterly." A review of Resident #13's record revealed that the following forms were not updated after March 1, 2006: "Restraint Data Collection and Evaluation, Side Rail Screen, and the Plan of Care: Restraint Reduction." A face-to-face interview was conducted on June 27, 2006 at 2:40 PM with the Assistant Unit Manager. He/she acknowledged that the restraint forms (cited above) should have been reviewed June 1, 2006. The record was reviewed on June 27, 2006.	{F 280}		
{F 281} SS=D	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review for one (1) of 18 sampled residents, it was determined that staff failed to follow the facility's policy for a resident with multiple falls and failed to follow the facility's policy for care of a resident after a fall for Resident #8. The findings include: According to the facility's policy, " Falls Risk Reduction & Management ", policy number 3.2.1, dated August 2004, the procedure documented the following: "A fall is defined as an unplanned/ uncontrolled change in position to a lower level.	{F 281}		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 095019	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 06/29/2006
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{F 281}	<p>Continued From page 14</p> <p>A resident/patient found on the floor requires an investigation to determine if a fall occurred. Procedure - 2. Evaluate resident/patient for any additional injury which would require medical intervention. Evaluation includes but is not limited to: ...Neurological assessment if suspected head injury. 3. Document clinical findings... 1. Communicate risk factors and interventions to the care giving team. A resident/patient who has previously fallen 2 or more times in the last 6 months will be identified with a "star" symbol. Place the "star" symbol(s) in easily identifiable areas near the resident/patient (i.e. bed, wheelchair, walker etc.)..."</p> <p>According to the nurses' " Progress Notes" dated June 9, 2006 at 2200 (11:00 PM), " Resident was observed on the floor at 2035. He/she stated that he/she was trying to push his/her wheelchair towards the wall and he/she landed on the floor from his/her bed. He/she denied pain upon assessment. No apparent injury observed. MD [medical doctor] made aware. Resident is his /her own responsible party. Resident instructed to call for help whenever needed. Vs [vital signs] 97.3 (temperature -degrees Fahrenheit), 78 [pulse], 18, [respirations], 123/60 [blood pressure]. "</p> <p>According to a nurse's note date June 22, 2006 at 0630 (6:30 AM), " Resident was observed on the left side of the bed sitting on the floor. ROM [range of motion] was done on upper and lower extremities. No pain noted; no bruising or injuries apparent ..."</p> <p>Observations on June 28, 2006 at 10:15 AM and 3:45 PM and June 29, 2006 at 10:50 AM of the</p>	{F 281}	<p>483.20(k)(3)(i) Comprehensive Care Plans</p> <ol style="list-style-type: none"> 1. Resident # 8 has falling star sign/symbol @ entry way of room. Policy & Procedure manual is on unit. 2. Residents with falls/fall history have been identified & have falling stars @ entry way of room. 3. Nurses/CNAs in-serviced on Fall Management Clinical Program. 4. Unit Manager/designee to QI monitor residents with falls for following policy: neurological checks & falling stars @ entry way of room monthly. Appropriate action taken on findings. Findings reported to FLC. <p>7/31/06</p>

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

PRINTED: 07/12/2006
FORM APPROVED
OMB NO. 0938-0391

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{F 281}	<p>Continued From page 15</p> <p>resident's room revealed that there was no falling star sign/symbol over the entry way into the room, resident 's bed or closet.</p> <p>There was no evidence in the progress note to document if the resident was asked if he/she hit his/her head after falling from the bed, and a neurological assessment was not conducted.</p> <p>A face-to-face interview was conducted on June 28, 2006 at 11:05 AM with the Assistant Unit Manager. He/she acknowledged that a neurological check is done when there is an unwitnessed fall.</p> <p>A face-to-face interview was conducted on June 28, 2006 at 1:15 PM with the Director of Nursing. He/she</p> <p>The Director of Nursing (DON) was knowledgeable of the facility policy; however the facility staff was inconsistent with the facility policy as to when to conduct a neurological check on residents that have fallen. The acknowledged that a neurological check is done when there is a fall and the staff nurse determines if the resident hit his/her head. They are not done every time someone falls. Additionally, the staff member was unable to locate the policy and procedure manual on the unit. The record was reviewed on June 28, 2006.</p>	{F 281}		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/12/2006
FORM APPROVED
OMB NO. 0938-0391

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{F 309} SS=D	<p>483.25 QUALITY OF CARE</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, staff interview and record review for three (3) of 18 sampled residents, it was determined that facility staff failed to: administer insulin per physician's order for two (2) residents, and assess one (1) resident for pain management. Residents #2, 7, and 14.</p> <p>The findings include:</p> <p>1. A review of Resident #2's record revealed that facility staff failed to administer Insulin according to physician's orders.</p> <p>The physician's order directed, Insulin Novolin 70/30 inject 60 units SQ every morning for Diabetes Mellitus".</p> <p>A review of the June 2006 MAR/TAR (Medication Administration Record/Treatment Administration Record) revealed that the 7:00 AM dose of Insulin was not administered on June 12 and 20, 2006. The back of the MAR under the heading "Medication Exception and Hold Notes" indicated that the insulin was "held" for June 12, 2006 and "not given" for June 20, 2006. A reason was not included.</p>	{F 309}	<p>483.25 Quality of Care</p> <ol style="list-style-type: none"> Resident # 2 receives insulin per physician orders. Resident # 7 has been reassessed for pain and MD notified of frequent requests for pain meds. Resident # 14 receives insulin per physician orders if dialysis rescheduled physician will be notified. Resident # 16 receives dialysis per physician order. Residents receiving insulin have been identified. Residents receiving insulin will have MAR reviewed for receiving insulin as ordered. Residents receiving dialysis have been identified. Residents receiving dialysis will be reviewed for receiving dialysis as ordered. Residents receiving pain medication have been identified and reviewed. Residents reassessed for pain management & physician notified as needed. Nurses reeducated on pain management, med. administration, physician notification. UM/designee to QI monitor MARs monthly for insulin administered as ordered. UM/designee to QI monitor MARs monthly for pain med administration & frequency of use to ensure physician notified. Unit Manager/designee to QI monitor monthly dialysis residents receiving dialysis as ordered to ensure physician notified. Appropriate action taken based on findings. Findings reported to FLC. 	7/31/06

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

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FORM APPROVED
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 095019	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 06/29/2006
NAME OF PROVIDER OR SUPPLIER GRANT PARK CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5000 BURROUGHS AVE. NE WASHINGTON, DC 20019		
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{F 309}	<p>Continued From page 17</p> <p>The nurses' progress notes were reviewed for June 2006 and failed to include evidence of notification of the physician on the above mentioned dates. The record was reviewed on June 28, 2006.</p> <p>2. Facility staff failed to adequately assess Resident #7 for pain.</p> <p>A review of Resident #7' s medical record revealed that physician's orders dated June 10, 2006 included, "Ibuprofen 600 mg two times daily for Osteoarthritis, Acetaminophen with codeine one tablet every four hours as needed for pain."</p> <p>A review of the MAR revealed that the resident was medicated with Ibuprofen twice daily for pain as ordered. However, for the month of June 2006 the resident had requested Acetaminophen with codeine 20 times as follow: June 1 through 4, 5, 6 , 10 through 19, 21 and 26 through 28, 2006. There was no evidence that the physician had been notified about resident's frequent request for pain medication.</p> <p>A face-to-face interview was conducted with the Unit Manager on June 29, 2006 at 11:30 AM. He/ she acknowledged that someone should have notified the physician to discuss the resident's pain management. The record was reviewed June 29, 2006.</p> <p>3. A review of Resident #14's record revealed that facility staff failed to administer Insulin according to physician's orders.</p> <p>The physician's order directed, "Lantus Insulin 25 units SQ (subcutaneously) every evening for</p>	{F 309}		

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

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FORM APPROVED
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{F 309}	<p>Continued From page 18</p> <p>Diabetes Mellitus" .</p> <p>A review of the June 2006 MAR/TAR revealed that Lantus Insulin was not administered at 4:00 PM to the resident on the following dates: June 3 , 4, 5, 9, 12, 13, 15, 17 and 22, 2006. The back of the MAR under the heading "Medication Exception and Hold Notes" included the following reasons for holding the administration of the insulin: Decreased blood sugar and decreased appetite.</p> <p>The nurses' progress notes were reviewed for June 2006 and failed to include evidence of notification of the physician on the above mentioned dates. The record was reviewed on June 28, 2006.</p> <p>4. Facility staff failed to ensure that Resident #16 received a dialysis treatment on June 20, 2006.</p> <p>A review of Resident #16's record revealed a nurse's note dated June 20, 2006 at 2:00 PM, " Resident couldn't go to dialysis because the elevator was not working."</p> <p>A face-to-face interview with the charge nurse was conducted on June 28, 2006 at 10:55 AM. the charge nurse stated, "The elevator wasn't working at the time of [Resident #16's] appointment. The resident had to go to dialysis the next day."</p> <p>A face-to-face interview with administrative nursing staff was conducted on June 28, 2006 at 11:00 AM. He/she stated, "The elevator was shut down at noon for about 15 minutes. Then it was working again."</p>	{F 309}		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/12/2006
FORM APPROVED
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{F 309}	Continued From page 19 A face-to-face interview was conducted with the dialysis center unit clerk on June 28, 2006 at 11:15 AM. The dialysis center is located on the first floor of the facility. The unit clerk stated, "We will take patients up to an hour late. I remember that day. [Resident #16] was scheduled for 11 o'clock in the morning. I called the unit several times to bring the patient down to us. [Resident #16] finally came down about 1 o'clock. By that time, there was no appointment open for [his/her] treatment. We dialyzed the patient the next day."	{F 309}		
{F 323} SS=D	483.25(h)(1) ACCIDENTS The facility must ensure that the resident environment remains as free of accident hazards as is possible. This REQUIREMENT is not met as evidenced by: Based on observations during the survey period, it was determined that facility staff failed to provide safety from environmental hazards as evidenced by: a television cable in an ambulating area and a dislodged metal strip on a corridor door. The findings include: 1. During the environmental tour, a television cable was observed in the ambulating areas of room 515 in one (1) of one (1) observation on June 28, 3006 at approximately 11:25 AM. 2. On June 27, 2006 at 9:00 AM, the bottom	{F 323}	483.25 (h)(1) Accidents 1. Television cable has been placed out of ambulating area of room 515. Vertical metal strip on corridor double doors near Rehab Dept has been repaired/secured 2. Room to room rounds will be conducted for television cables being in ambulating areas. Appropriate action taken. Rounds conducted of center doors for door frames needing repair. Appropriate action taken. 3. Staff in-serviced on reporting television cables requiring relocation due to ambulation hazard & maintaining a safe room environment. Staff in-serviced on identifying and reporting maintenance issues 4. Maintenance Dir/designee to conduct environmental rounds monthly for television cables in ambulating areas & door frames. Appropriate action taken on findings & findings reported to FLC.	7/31/06

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

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OMB NO. 0938-0391

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{F 323}	Continued From page 20 quarter of a vertical metal strip on the corridor double doors near the Rehabilitation Department was observed unsecured from the door frame.	{F 323}		
{F 324} SS=D	<p>483.25(h)(2) ACCIDENTS</p> <p>The facility must ensure that each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on an isolated observation and staff interview during the survey period, it was determined that facility staff failed to place a mat by the bedside as a fall precaution floor mats for Resident A1.</p> <p>The Findings include:</p> <p>During a tour of the second floor on June 29, 2006 at 9:00 AM, Resident A1 was still in his /her bed. According to the Unit Manager, Resident A1 had a history of falls. "He/she is being placed on fall precautions with floor mats at the bedside at all times while resident is in bed."</p> <p>A review of the care plan, last updated on May 24, 2006, revealed a care plan problem, "Falls Risk." An approach for this care plan problem included placing a mat at the bedside when the resident was in the bed.</p> <p>On June 29, 2006 at 9:00 AM Resident A1's floor mats were placed along the wall while he/she was in bed.</p>	{F 324}	<p>483.25 (h)(2) Accidents</p> <ol style="list-style-type: none"> 1. Resident A1 has fall mat in place as indicated while in bed. 2. Residents with fall mats identified. Review of residents identified will be conducted for fall floor mats in place as care planned. Appropriate action taken on findings. 3. Nurses/CNA in-serviced on use of fall floor mats. 4. UM/designee to monitor residents with fall floor mats monthly for fall floor mats in place as care planned. Appropriate action taken on findings. Findings reported to FLC. 	7/31/06

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

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NAME OF PROVIDER OR SUPPLIER GRANT PARK CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5000 BURROUGHS AVE. NE WASHINGTON, DC 20019		
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{F 325} SS=E	<p>483.25(i)(1) NUTRITION</p> <p>Based on a resident's comprehensive assessment, the facility must ensure that a resident maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, staff interview and record review for two (2) of 18 sampled residents and five (5) supplemental residents, it was determined that the nutritionist/dietician failed to initiate goals and approaches and/or follow-up on recommendations for residents with weight loss and failed to follow the plan of correction for the annual recertification survey completed April 14, 2006. Residents #5, 10, S1, S2, W2, W3 and W4</p> <p>The findings include:</p> <p>1. A review of Resident #5's record revealed that the nutritionist/dietician failed intervene when the resident experienced significant weight loss and follow up on a recommendation for Beneprotein powder.</p> <p>The resident was admitted to the facility on April 20, 2006. The "Weight Record" included the following weights: April 20, 2006 - 187 pounds (lbs.) May 2006 - 177 lbs. June 2006 - 170.4 lbs. The resident had a 16.6 pound weight loss in two</p>	{F 325}	<p>483.25 (i)(1) Nutrition</p> <ol style="list-style-type: none"> Resident # 5 re-weighed & receives protein as ordered. Resident # 10 re-weighed & reassessed by nutritionist/dietician, resident # 10 receives health shakes as ordered. Resident 51 re-weighed & reassessed by nutritionist/dietician & appropriate intervention ordered as indicated. Resident 52 re-weighed & reassessed & appropriate intervention ordered. Resident W2 re-weighed & reassessed by nutritionist/dietician, appropriate interventions ordered. Resident W3 re-weighed & reassessed by nutritionist/dietician, appropriate interventions ordered. Resident W4 re-weighed & reassessed by nutritionist/dietician, appropriate interventions ordered. Nutritionist/dietician follows the plan of correction for survey 6/29/2006 @. Residents with significant weight loss as indicated by July weights reassessed for interventions. List of residents with weight maintained for review @ PAR mtgs. weekly. Residents re-weighed and residents with significant weight loss reviewed in weekly PAR mtg. for appropriate intervention. ADON/designee to QI monitor significant wt losses for nutritionist/dietician assessment and intervention monthly. Findings reported to FLC. 	7/31/06

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

PRINTED: 07/12/2006
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 095019	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 06/29/2006
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{F 325}	<p>Continued From page 22</p> <p>(2) months.</p> <p>The nutritionist's and/or dietician's progress notes revealed the following:</p> <p>April 21, 2006, "...admitted to [facility] on 4/20/06 ... Recommend diet as stated and Beneprotein powder 1 scoop x3 daily for low albumin ..."</p> <p>May 3, 2006, "Update note. PO (by mouth) intake 50%. Talked to [resident]: stated "I am not a big eater" ..."</p> <p>June 14, 2006, "Resident readmitted to this facility 6/12/2006 ... No reweight on readmission and ... No eating or drinking problem voiced or noted this time. Recommend continue diet Mechanically Altered, low fat/cholesterol with consistent carbohydrate."</p> <p>The physician's orders were reviewed for April through June 2006. The orders were not inclusive of Beneprotein powder. There was no evidence from review of the MARs/TARs (Medication Administration Record/Treatment Administration Record) that the resident received Beneprotein powder since his/her admission to the facility.</p> <p>A face-to-face interview was conducted with the nutritionist on June 28, 2006 at 2:20 PM. He/She acknowledged the lack of reweights for the resident. He/She stated that the CNAs (Certified Nursing Assistants) give him/her a copy of the monthly weights.</p> <p>The record was reviewed on June 28, 2006.</p> <p>2. A review of Resident #10's record revealed that the nutritionist/dietician failed to adequately</p>	{F 325}		
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{F 325}	<p>Continued From page 23</p> <p>assess and provide interventions when the resident had a significant weight loss and follow up on recommendations for Health Shakes.</p> <p>The resident was admitted to the facility May 4, 2005. The admission MDS (Minimum Data Set) Section K2 (height and weight) listed a weight of 179 pounds. The quarterly MDS listed the following weights in Section K2: September 5, 2005 - 176 lbs. December 6, 2006 - 152 lbs. March 10, 2006 - 132 lbs. June 14, 2006 - 131 lbs. The resident lost a total of 48 pounds since admission to the facility.</p> <p>The nutritional assessments included the following information: The " Initial Nutrition Assessment " dated May 4, 2005, " Ht: (height) 6 ' [six feet] estimated. Wt: 179.8 ... IBW (Ideal Body Weight) 178# [pounds]. Diet order/Rationale: Consistent Carbohydrate, low fat/cholesterol ... "</p> <p>Readmission note dated September 13, 2005, " ...weight 168.8 #... Recommend continue diet regimen prior to hospital. Consistent Carbohydrate, low fat/cholesterol ... "</p> <p>Readmission note dated November 23, 2005, " Wt: 152 #... 28# reduction last 180 days ... Recommend Pureed diet. Resident remain at moderate nutritional risk ... "</p> <p>Readmission note dated February 14, 2006, " Weight on readmission 132.4# indicating 44# reduction in last 180 days ... Recommend continue diet prior to hospital, Pureed, low</p>	{F 325}		
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PRINTED: 07/12/2006
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{F 325}	<p>Continued From page 24</p> <p>Potassium. Health Shake each meal ... "</p> <p>Readmission note dated June 14, 2006, " ... [Resident has lost 46 pounds since last visit ... Recommend puree low potassium diet order with Health Shake BID (two times a day). [Resident] lost 2 pounds in the last 1 month ..." This was the last nutritional assessment found in the record.</p> <p>The physician order sheets for February through June 2006 were reviewed. The Health Shakes that were recommended by the nutritionist on February 14 and June 14, 2006 were not included in the order sheets.</p> <p>The MARs/TARs were reviewed from February through June 2006. Health Shakes were not included.</p> <p>An observation was made of the resident's breakfast tray on June 29, 2006 at 7:40 AM. There was no Health Shake on the tray, nor was a Health Shake listed on the diet order sheet that accompanies the tray. The record was reviewed on June 28, 2006.</p> <p>3. The facility nutritionist failed to monitor Resident S1's weight and initiate interventions to prevent further weight loss.</p> <p>A review of Unit 2 North's "Monthly Weights" revealed that Resident S1 weighed 147.2 pounds in April, 2006, 144.4 pounds in May, 2006 and 140.2 pounds in June 2006.</p> <p>An annual assessment was completed by the nutritionist on May 5, 2006. He/she noted a decline in nutritional status and weight reduction.</p>	{F 325}		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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{F 325}	<p>Continued From page 25</p> <p>The recommendation was to continue with the current diet and supplements and follow-up as needed.</p> <p>There was no assessment of Resident S1's nutritional status for June 2006. The resident's name did not appear in the high risk log book. The record was reviewed June 29, 2006.</p> <p>4. The facility nutritionist failed to monitor Resident S2's weight and initiate interventions to prevent further weight loss.</p> <p>A review of Unit 2 South's "Monthly Weights" revealed that Resident S2 weighed 109.6 pounds in May, 2006 and 104.3 pounds in June 2006.</p> <p>According to the initial nutritional assessment completed May 4, 2006, the resident was described as a "...high nutritional risk ..."</p> <p>There was no assessment of Resident S2's nutritional status for June 2006. The resident's name did not appear in the nutritionist's high risk log book. The record was reviewed June 29, 2006.</p> <p>5. A review of Resident W2's record revealed the nutritionist/dietician failed to assess and provide interventions when the resident lost weight.</p> <p>A review of Resident W2's weight record revealed the following: May 2006 - 192.6 lbs. June 2006 - 186, reweight 186 lbs. The resident lost 6.6 pounds in one month. There had been no nutritional intervention since the recording of the June 2006 weight. The</p>	{F 325}		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/12/2006
FORM APPROVED
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{F 325}	<p>Continued From page 26</p> <p>nutritionist failed to maintain a log of these residents as per the above cited plan of correction . The record was reviewed on June 29, 2006.</p> <p>6. A review of Resident W3's record revealed the nutritionist/dietician failed to assess and provide interventions when the resident lost weight.</p> <p>A review of Resident W3's weight record revealed the following: May 2006 - 201.8 lbs. June 2006 - 194.8 lbs. The resident lost seven (7) pounds in one month. The last nutritional assessment found in the record was dated April 21, 2006. The nutritionist failed to maintain a log of these residents as per the above cited plan of correction. The record was reviewed on June 29, 2006.</p> <p>7. A review of Resident W4's record revealed the nutritionist/dietician failed to assess and provide interventions when the resident lost weight.</p> <p>A review of Resident W4 ' s weight record revealed the following: January 2006 - 102.8 lbs. April 2006 - 97.3 lbs. June 2006 - 95.2 lbs. The quarterly MDS dated February 16, 2006 listed a weight of 101 pounds in Section K2b (oral and nutritional status) and the annual MDS dated May 11, 2006 listed a weight of 97 in Section K2b.</p> <p>The resident lost 7.6 pounds since January 2006. The last nutritional assessment in the record was dated May 12, 2006 and indicated that the " weight was within normal range " and " no noted problems to adjust diet order " . According to the</p>	{F 325}		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/12/2006
FORM APPROVED
OMB NO. 0938-0391

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{F 325}	<p>Continued From page 27</p> <p>physician's order sheet and MAR, the resident was receiving Health Shakes with meals for nutritional support before February 2006. The resident's weight continued to decrease with no other interventions provided. The nutritionist failed to maintain a log of these residents as per the above cited plan of correction. The record was reviewed on June 29, 2006.</p> <p>8. The nutritionist/dietician failed to follow the plan of correction from the annual relicensure survey completed April 14, 2006.</p> <p>This is a repeated deficiency from the annual certification survey completed April 14, 2006. The plan of correction included, "The Nutritionist will meet weekly with team managers to discuss any sudden weight change planned or unplanned. The Nutritionist will create high risk group book for those resident 's who are on tube feeding or weights are 100 lbs. or less."</p> <p>A face-to-face interview was conducted on June 28, 2006 at 2:30 PM with the nutritionist. He/she was asked if a weekly meeting was held with facility team managers to discuss sudden weight changes and if a high risk book was maintained for residents who are on tube feedings or weights are 100 lbs. or less. The nutritionist responded, "I do my special charting" and presented the survey team with a green binder.</p> <p>A review of the green binder revealed that five (5) residents were listed. There was no listing of residents on tube feedings or residents with weights that were 100 lbs. or less.</p>	{F 325}		

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

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OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER GRANT PARK CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5000 BURROUGHS AVE. NE WASHINGTON, DC 20019
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{F 325}	<p>Continued From page 28</p> <p>The survey team requested a current Roster/ Sample Matrix (form 802) which describes resident characteristics for all residents in the facility. The 802 identified 47 residents with weight issues (loss or gain).</p> <p>The surveyor requested a separate list of residents with weight loss throughout the facility from the Director of Nursing. 13 residents were identified by the facility.</p> <p>A. A review of 2 North and 2 South "Monthly Weights" revealed five (5) residents weighing less than 100 pounds. The nutritionist failed to maintain a log of these residents as per the above cited plan of correction</p> <p>According to the Resident/Sample Matrix (802) there were five (5) residents for unit 2 North and 2 South who required tube feedings. The nutritionist failed to maintain a log of these residents as per the above cited plan of correction</p> <p>B. According to the Resident/Sample Matrix (802) there were seven (7) residents for unit 3 North and 3 South who required tube feedings. The nutritionist failed to maintain a log of these residents as per the above cited plan of correction</p> <p>3 South identified two (2) residents that were below 100 pounds. The nutritionist failed to maintain a log of these residents as per the above cited plan of correction.</p> <p>C. According to the Resident/Sample Matrix (802) there were 13 residents for unit 4 North and 4</p>	{F 325}		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/12/2006
FORM APPROVED
OMB NO. 0938-0391

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{F 325}	Continued From page 29 South who required tube feedings. The nutritionist failed to maintain a log of these residents as per the above cited plan of correction There were two (2) residents identified on 4 North weighing under 100 pounds. The nutritionist failed to maintain a log of these residents as per the above cited plan of correction. D. According to the Resident/Sample Matrix (802) there were eight (8) residents for unit 5 North and 5 South who required tube feedings. The nutritionist failed to maintain a log of these residents as per the above cited plan of correction	{F 325}		
{F 329} SS=D	483.25(I)(1) UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. This REQUIREMENT is not met as evidenced by Based on observation and record review for one (1) of 18 sampled residents, it was determined that facility staff failed to adequately monitor Resident #4 behavior.	{F 329}	(I)(1) Unnecessary Drugs 1. Resident # 4's behavior medication monitoring record will reflect agitated behaviors requiring administration of Ativan.. Nursing notes will reflect evidence of agitated behaviors requiring administration of Ativan as indicated. 2. Residents receiving psychoactive meds identified. Behavior med monitoring records reviewed for documentation of behaviors. 3. Licensed staff in-serviced on completing documentation of behaviors requiring administration of psychoactive meds. 4. UM/designee to QI monitor psychoactive medication monitoring record monthly for documentation of behaviors requiring psychoactive meds. Appropriate follow up on findings. Findings reported to FLC.	7/31/06

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
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{F 329}

Continued From page 30

The findings include:

A review of the "Psychoactive Medication Monitoring Record" for June 2006 indicated no agitated behaviors as evidenced by zeros entered for the entire month and on all shifts.

The physician's order sheet revealed an order dated April 24, 2006 for Ativan inject 2 mg IM (intramuscularly) every 8 hours PRN (when needed) for agitation.

The MAR/TAR (Medication Administration Record /Treatment Administration Record) for June 2006 was reviewed and revealed that Ativan 2 mg IM was administered to the resident on June 11, 2006 at 2:00 AM.

There was no nurse's note for June 11, 2006 regarding the resident's behavior. There was no documented evidence in the record that the resident exhibited agitated behaviors on June 11, 2006 that required the administration of Ativan. The record was reviewed on June 28, 2006.

{F 329}

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

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FORM APPROVED
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F 353 SS=E	<p>483.30(a) NURSING SERVICES - SUFFICIENT STAFF</p> <p>The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.</p> <p>The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:</p> <p>Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.</p> <p>Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and record review of nurse staffing for four (4) of six (6) days, sufficient nursing staff was not available to meet residents needs.</p> <p>The findings include:</p> <p>A review of the Roster/Sample Matrix (form 802) provided by the facility on June 28, 2006 revealed the following: 161 Incontinent residents 89 Residents with swallowing difficulty</p>	F 353	<p>483.30 (a)Nursing Services-Sufficient Staff</p> <ol style="list-style-type: none"> 1. Facility provides 3.5 nursing hours per resident day. Facility has contracted for agency nursing & has hired staff. 2. Review of staffing levels will be conducted for providing 3.5 nursing hours per day. 3. Staff involved in staffing/scheduling in-serviced on 3.5 minimum standard and calculating staffing. 4. DON/designee to review monthly staffing for meeting 3.5 nursing hours. 4. Admin/designee to QI monitor nursing staff levels monthly. Findings reported to FLC. 	7/31/06
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CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER GRANT PARK CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 5000 BURROUGHS AVE. NE WASHINGTON, DC 20019	
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F 353	Continued From page 32 77 Residents with behavior issues Each of the above identified categories of residents requires additional nursing monitoring and assistance. Six days of nurse staffing were reviewed: May 30, 31, June 1, 2, 3 and June 28, 2006. Four (4) of the six (6) days reviewed failed to provide residents with 3.5 nursing hours per resident per day. A face-to-face interview with the Director of Nursing (DON) was conducted on June 28, 2006 at 1:30 PM. He/she presented the surveyor with an advertisement from the local newspaper identifying open nursing positions. The Don stated, "I have been advertising and I have hired new CNAs. But we still haven't filled all our positions." The surveyor asked if the facility employed outside agency nursing staff. The Don stated, "No, I guess we'll have to do that."	F 353		
F 386 SS=D	483.40(b) PHYSICIAN VISITS The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines; which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by	F 386	483.40 (b) Physician Visits 1. Residents # 13 and 17 have current orders signed by physician. 2. MR review conducted for current orders being signed by physician. Physician contacted regarding any orders needing to be signed. 3. Unit clerks and Unit Managers in-serviced on frequency of physician visits and signing order requirement. Unit managers to flag MR needing physician order to be flagged for signing. Medical staff meeting conducted 7/19/06 & Medical Director & Physicians educated on physician visit scheduled & signing orders. 4. Unit clerks/designee to QI MR for timeliness of signing physician order monthly. Physicians to be contacted based on findings for appropriate follow-up. Findings reported to FLC.	7/31/06

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

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FORM APPROVED
OMB NO. 0938-0391

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F 386	<p>Continued From page 33</p> <p>Based on record review for two (2) of 18 sampled records, it was determined that the physician failed to visit every 60 days. Residents #13 and 17.</p> <p>The findings include:</p> <p>1. The physician failed to sign current orders for Resident #13.</p> <p>A review of Resident #13's "Physician's Progress Notes" revealed a progress note signed by the physician on April 22, 2006.</p> <p>A review of Resident # 13's Physician Order Sheets dated, April 2006 documented that the physician signed the orders on April 6, 2006. There was no physician signature documented on the May 2006 and June 2006 " Physician Order Sheet " at the time of the record review. Although the physician was in the visit the resident, he/she failed to sign the physician order sheets. Subsequently, the medical director signed the May 2006 and June 2006 "Physician Order Sheets" on June 28, 2006 after the surveyor's review. The record was review on June 28, 2006.</p> <p>2. The physician failed to sign current orders for Resident #17.</p> <p>A review of Resident #17's "Physician's Progress Notes" revealed a progress note signed by the physician on June 4, 2006.</p> <p>A review of Resident # 17's "Physician Order Sheet" dated, April 2006 documented that the physician signed the orders on April 10, 2006. There was no physician signature documented on the May 2006 and June 2006 "Physician Order Sheet" at the time of the record review. Although</p>	F 386		

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

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F 386	Continued From page 34 the physician was in the visit the resident, he/she failed to sign the physician order sheets. Subsequently, the medical director signed the May 2006 and June 2006 "Physician Order Sheets" on June 28, 2006 after the surveyors review. The record was review on June 28, 2006.	F 386		
F 387 SS=D	483.40(c)(1)-(2) FREQUENCY OF PHYSICIAN VISITS The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. This REQUIREMENT is not met as evidenced by: Based on record review for one (1) of 18 sampled residents, it was determined that the physician failed to visit Resident #10 every 60 days. The findings include: The resident was admitted to the facility on May 4, 2005. The annual MDS (Minimum Data Set dated March 10, 2006 included the following diagnoses in Section I; Diabetes Mellitus, Hypertension, Peripheral Vascular Disease, Missing Limb, Aphasia, Cerebrovascular Accident and Hemiplegia/Hemiparesis. The last physician's progress note found in the record was dated March 23, 2006.	F 387	483.40 (c)(1)-(2) Frequency of Physician Visits 1. Resident # 10 has received physician visit. 2. MR review will be conducted for physician visits occurring once every 30 days for the first 90 days after admission and at least once every 60 days. Unit managers/designee to contact physicians regarding findings and need to make a visit. 3. Unit managers and unit clerks in-serviced on frequency of physician visits. Medical staff meeting conducted on 7/19/06. Medical Director & Physicians educated on physician visit schedule & signing of orders. A copy of the policy was given to each PMD during this meeting. 4. Unit clerks/designee to QI monitor MR for timeliness of physician visits monthly. Physicians contacted based on findings. Findings reported to FLC.	7/31/06

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F 387	Continued From page 35 The record was reviewed on June 28, 2006.	F 387		
{F 432} SS=D	<p>483.60(e) STORAGE OF DRUGS AND BIOLOGICALS</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation of the medication refrigerator on 4 North, it was determined that the facility staff failed to maintain the temperature between 36 and 46 degrees Fahrenheit (F) and consistently record refrigerator temperatures and follow the plan of correction for the recertification survey completed April 14, 2006.</p> <p>The findings include:</p> <p>This was a repeated deficiency from the recertification survey of April 14, 2006. The plan of correction documented the following: "...3. The</p>	{F 432}	<p>483.60 (e) Storage of Drugs and Biologicals</p> <ol style="list-style-type: none"> 1. Medication refrigerator on 4 north has been replaced and new thermometer purchased. Medication refrigerator 4 north has temp maintained between 36° - 46° F. 2. Check of all medication refrigerators will be conducted for temperatures being maintained between 36° - 46° F. 3. Unit managers, nurses in-serviced on required refrigerator temperatures. Temp log maintained. Problems with temps with med refrigerator logged in maintenance log. 4. UM/designee or Maintenance Director to QI monitor medication refrigerators monthly for temps @ 36° - 46° F. Findings reported to FLC. 	7/31/06

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

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{F 432}	<p>Continued From page 36</p> <p>temperature will be checked on refrigerators nightly by the night nurse. Any problems will be noted in the Engineering log book for repair or replacement."</p> <p>On June 28, 2006 at 1:30 PM, the medication refrigerator and the "Refrigerator Log" on 4 North was inspected. The thermometer readings revealed the following:</p> <table border="1"> <thead> <tr> <th>Date</th> <th>Temperature</th> <th>Adj</th> </tr> </thead> <tbody> <tr> <td>June 13, 2006</td> <td>34 degrees F</td> <td>No</td> </tr> <tr> <td>June 14, 2006</td> <td>No recording</td> <td></td> </tr> <tr> <td>June 20, 2006</td> <td>34 degrees F</td> <td>No</td> </tr> <tr> <td>June 21, 2006</td> <td>34 degrees F</td> <td>adj</td> </tr> <tr> <td>June 23, 2006</td> <td>No recording</td> <td></td> </tr> <tr> <td>June 27, 2006</td> <td>No recording</td> <td></td> </tr> </tbody> </table> <p>(Adj = adjusted temperature)</p> <p>On June 28 at 1:30 PM the surveyor observed the temperature of the medication refrigerator was 38 degrees F. There was no recording of the temperature reading on the "Refrigerator Log" at this time for June 28, 2006.</p> <p>On June 29, 2006 at 9:45 AM, the medication refrigerator and the "Refrigerator Log" on 4 North was inspected. The temperature reading of the refrigerator was 38 degrees F. At this time a temperature was observed to be entered for June 27, 2006 of 36 degrees F.</p> <p>On June 29, 2006 the 4 North Maintenance Log book was reviewed and there was no evidence that the maintenance department was notified of any problems with the refrigerator temperatures on 4 North.</p>	Date	Temperature	Adj	June 13, 2006	34 degrees F	No	June 14, 2006	No recording		June 20, 2006	34 degrees F	No	June 21, 2006	34 degrees F	adj	June 23, 2006	No recording		June 27, 2006	No recording		{F 432}		
Date	Temperature	Adj																							
June 13, 2006	34 degrees F	No																							
June 14, 2006	No recording																								
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CENTERS FOR MEDICARE & MEDICAID SERVICES

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{F 441} SS=D	<p>483.65(a) INFECTION CONTROL</p> <p>The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations during the survey period, it was determined that facility staff failed to prevent the spread of infection as evidenced by: a licensed practical nurse (LPN) walking on one (1) resident's floor mat, not following the manufacturer's recommendation for the Barbicide solution, soiled lift straps and clogged ice machines and failed to follow the plan of correction for the annual recertification survey completed April 14, 2006. Resident A1</p> <p>The findings include:</p> <p>1. During a tour of the facility unit on June 29, 2006 at 8:45 AM, a licensed practical nurse was observed walking on Resident A1's floor mat. The LPN walked on the floor mats on both sides of the resident's bed. The LPN came to the room to turn and reposition the resident. The resident was in no acute distress.</p>	{F 441}	<p>483.65 (a) Infection Control</p> <ol style="list-style-type: none"> 1. Floor mats are maintained, Barbicide solution was changed out, soiled lift straps replaced & clogged ice machine cleaned or repaired water standing in tray removed. A1 floor mat sanitized and will be replaced, new lift straps ordered 7/24/06. 2. Facility floor mats checked, lift straps checked, facility ice machines checked & cleaned or repaired Barbicide checked & replaced. 3. Staff educated re-infection control practices: walking on mats, maintaining Barbicide solution, maintaining of ice machine & replacement of soiled lift straps. 4. UM/designee to QI fall floor mats, soiled lift straps monthly. <p>Barbicide monitored for particles and being replaced after every use & hair dresser in center weekly.</p> <p>Maintenance director/designee to QI ice machines for proper functioning Appropriate action taken on findings reported to FLC.</p>	7/31/06	

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

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{F 441}	<p>Continued From page 38</p> <p>A face-to-face interview with the Unit Manager was conducted on June 29, 2006 at 9:00 AM. He/she said that the LPN should not have walked on the floor mat. He/she added that he/she was going to conduct an in-service with all the unit staff.</p> <p>2. Facility staff failed to follow the manufacturer's recommendations for the Barbicide solution.</p> <p>Particles were observed suspended in the Barbicide solution in the beauty shop in one (1) of one (1) observation at 9:30 AM on June 28, 2006. This is a repeated deficiency from the annual certification survey completed April 14, 2006.</p> <p>According to the plan of correction for the previous citation, an in-service was conducted on May 24, 2006 that directed staff to, "Dump the Barbicide and check under the sink for items every Friday."</p> <p>According to the manufacturer's recommendation, printed on the label of the Barbicide bottle, "Beauty/Barber Instruments and Tools ...Fresh solution should be prepared daily or more often if solution becomes diluted or soiled."</p> <p>3. Mechanical lift straps on units 2 South and 3 North were soiled and stained in two (2) of four (4) observations on June 28, 2006 between 2:30 PM and 4:00 PM.</p> <p>According to the plan of correction for the annual recertification survey completed April 14, 2006, "Nursing and Housekeeping staff will be inserviced on the procedures to assure hydraulic straps are</p>	{F 441}		

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

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{F 441}	Continued From page 39 cleaned." 4. Ice machines were observed to be clogged and water was standing in the tray in the 3 South and 4 South pantry in two (2) of eight (8) observations on June 28, 2006 between 3:15 PM and 4:00 PM.	{F 441}		
{F 456} SS=F	483.70(c)(2) SPACE AND EQUIPMENT The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, facility staff failed to follow the plan of correction for the annual recertification survey completed April 14, 2006 as evidenced by an inoperative steamer. The findings include: During the tour of the main kitchen on June 28, 2006, the double decker steamer was observed as inoperable. This is a repeated deficiency from the standard Federal Survey completed April 14, 2006. The plan of correction for the standard Federal Survey was as follows: "1. The double decker has a work order in place for repairs. 2. All cooking equipment have been looked at and placed on a schedule for service, if needed. 3. [Facility] Maintenance Dept. will maintain the maintenance of the steamer. 4. [Facility]	{F 456}	483.70 (c)(2) Space and Equipment 1. Double decker steamer replaced. 2. Cooking equipment checked for needed repair or replacement if not functioning. 3. Dietary staff in-serviced on process for reporting needed repair or replacement of kitchen equipment. 4. Admin/designee to QI monitor kitchen equipment monthly for needed repair and/or replacement. Findings reported to FLC.	7/31/06

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

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{F 456}	Continued From page 40 Maintenance will maintain a log book for any request made by the Dietary Dept." Completion date was "5/29/06." A face-to-face interview was conducted with the Director of Dietary Services on June 28, 2006 at approximately 11:30 AM. He/she stated that [company] came in to repair the steamer but could not do the electrical work. [Another company] came in to repair the steamer, but could not do the plumbing work. [Another company] was installing the steamer on June 29, 2006. Work orders were requested of the Administrator and Director of Dietary Services to determine if the facility had responded timely to the repair of the steamer. After multiple requests, there was no evidence that facility responded to the repair of the steamer by the plan of correction completion date of May 29, 2006.	{F 456}	483.75 Administration 1. Administrator ensures Plan of Correction for survey 6/29/2006 (R) are followed.	7/31/06
{F 490} SS=E	483.75 ADMINISTRATION A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by Based on observation, interview and record review, it was determined that the Administrator failed to ensure that the plan of correction for the annual recertification survey completed April 14, 2006 was followed and that the facility was	{F 490}	Administrator conducts environmental rounds to ensure facility maintained in sanitary condition. Administrator facilitates processes to integrate the care of residents. 2. Administrator reviews Plan of Correction, conducts rounds for sanitary conditions and resident care. 3. Administrator conducts in-service to Dept Heads and facility staff regarding Plan of Correction. 4. Administrator reviews Plan of Correction process for compliance.	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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{F 490}	Continued From page 41 maintained in a sanitary manner. The findings include: 1. The Administrator failed to ensure that the plan of correction for the standard Federal Survey completed April 14, 2006 was followed in the following areas: CFR 483.15, F253, CFR 483.20, F 279, CFR 483.25, F325, CFR 483.55, F432, CFR 483.65, F441 and CFR 483.70, F456. 2. The Administrator failed to ensure that the facility was maintained in a sanitary manner. CFR 483.15, F 253. 3. The Administrator failed to integrate the care of residents. CFR 483.20, F278 and F281 and CFR 483.25, F309.	{F 490}		
{F 492} SS=D	483.75(b) ADMINISTRATION The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. This REQUIREMENT is not met as evidenced by: Facility staff failed to maintain 3.5 nursing hours per resident for four (4) of six (6) days reviewed. The findings include:	{F 492}	483.75 (b) Administration 1. Facility provides 3.5 nursing hours per resident day. Facility contracted with Agency & utilizes Agency as needed. Facility has hired additional staff. 2. Review of staffing levels will be conducted for providing 3.5 nursing hours per day. 3. Staff involved in staffing/scheduling in-serviccd on 3.5 minimum standard and calculating staffing. DON/designee to review daily staffing for meeting 3.5 nursing hours. 4. Admin/designee to QI monitor nursing staff levels. Findings reported to FLC.	7/31/06

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

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{F 492}	Continued From page 42 According to 22 DCMR 3211.3, "Beginning no later than January 1, 2005, each facility shall employ sufficient nursing staff to provide a minimum daily average of 3.5 nursing hours per resident per day." The Nursing Daily Staffing Sheets were requested for May 30, 31, June 1, 2, 3 and June 28, 2006 were reviewed with the Director of Nurses (DON) on June 28, 2006. The staffing sheets revealed the following daily average of nursing hours per day as follows: <table border="1"> <thead> <tr> <th>Dates</th> <th>Nursing hours</th> </tr> </thead> <tbody> <tr> <td>May 30, 2006</td> <td>3.18</td> </tr> <tr> <td>May 31, 2006</td> <td>3.56</td> </tr> <tr> <td>June 1, 2006</td> <td>3.28</td> </tr> <tr> <td>June 2, 2006</td> <td>3.25</td> </tr> <tr> <td>June 3, 2006</td> <td>2.70</td> </tr> <tr> <td>June 28, 2006</td> <td>3.5</td> </tr> </tbody> </table> The DON acknowledged that staffing was below 3.5 nursing hours per resident per day. This was a repeated deficiency from the standard Federal Survey completed April 14, 2006.	Dates	Nursing hours	May 30, 2006	3.18	May 31, 2006	3.56	June 1, 2006	3.28	June 2, 2006	3.25	June 3, 2006	2.70	June 28, 2006	3.5	{F 492}		
Dates	Nursing hours																	
May 30, 2006	3.18																	
May 31, 2006	3.56																	
June 1, 2006	3.28																	
June 2, 2006	3.25																	
June 3, 2006	2.70																	
June 28, 2006	3.5																	

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

PRINTED: 07/12/2006
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 095019	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 06/29/2006
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NAME OF PROVIDER OR SUPPLIER GRANT PARK CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5000 BURROUGHS AVE. NE WASHINGTON, DC 20019
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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{F 493} SS=E	<p>483.75(d)(1)-(2) GOVERNING BODY</p> <p>The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and the governing body appoints the administrator who is licensed by the State where licensing is required; and responsible for the management of the facility</p> <p>This REQUIREMENT is not met as evidenced by :</p> <p>Based on observation, interview and record review, it was determined that the Governing Body failed to ensure that: the plan of correction for the annual recertification survey completed April 14, 2006 was followed and that the facility was maintained in a sanitary manner.</p> <p>The findings include:</p> <p>1. The Governing body failed to ensure that the plan of correction for the standard Federal Survey completed April 14, 2006 was followed in the following areas: CFR 483.15, F253, CFR 483.20, F 279, CFR 483 . 25, F325, CFR 483.55, F432, CFR 483.65, F441 and CFR 483.70, F456.</p> <p>2. The Governing Body failed to ensure that the facility was maintained in a sanitary manner. CFR 483.15, F 253.</p> <p>3. The Governing Body failed to integrate the care of residents. CFR 483.20, F278 and F281 and CFR 483. 25, F309.</p>	{F 493}	<p>483.75 (d)(1)-(2)Governing Body</p> <ol style="list-style-type: none"> The Governing Body ensures the Plan of Correction is followed. The Governing Body reviews Plan of Correction, conducts rounds for sanitary conditions and resident care. Administrator conducts in-service to Dept Heads and facility staff regarding Plan of Correction. Administrator reviews Plan of Correction process for compliance through Team meetings. 	7/31/06
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F 502 SS=D	<p>483.75(j)(1) LABORATORY SERVICES</p> <p>The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.</p> <p>This REQUIREMENT is not met as evidenced by :</p> <p>Based on observation, interview and record review for one (1) of 18 sampled records, it was determined that facility staff failed to obtain a laboratory test as per physician's orders. Resident #9.</p> <p>The findings include:</p> <p>A review of Resident #9's record revealed a physician's order dated May 14, 2006, "Chem [Chemistry]-17 (May)." There was no evidence that the laboratory test had been obtained for May 2006.</p> <p>A face-to-face interview was conducted with the Assistant Clinical Manager on June 27, 2006 at 3: 50 PM. After reviewing the record and contacting the laboratory, he/she acknowledged that the laboratory test was not done for May 2006. The record was reviewed June 71, 2006.</p>	F 502	<p>483.75 (j)(1) Laboratory Services</p> <ol style="list-style-type: none"> 1. Resident # 9 has had Chem 17 lab test obtained. Chem 17 drawn: 6/30/06 2. Resident's with lab work identified and review conducted of MR for lab work being obtained as ordered. Appropriate action taken based on findings. 3. Nurses in-serviced on process for ordering lab & follow up using 24-hour report. 4. UM/designee to QI monitor lab tests monthly for being obtained as ordered. Appropriate action taken based on findings. Findings reported to FLC. 	7/31/06	