

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

PRINTED: 10/16/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 095030	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/12/2014
NAME OF PROVIDER OR SUPPLIER SIBLEY MEM HOSP RENAISSANCE			STREET ADDRESS, CITY, STATE, ZIP CODE 6255 LOUGHBORO ROAD NW WASHINGTON, DC 20016		
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F 309	<p>Continued From page 20</p> <p>loss overall since admission ...on 8/4 with 10 pound weight loss seen in the last 7 days (from 8/20). Overall weight loss is 10.77% in less than one month - significant ...appetite poor but showing signs of improvement ...feeding assistance, regular diet, ensure complete tid [three times daily], " F ' real milkshake [daily], option of 6 small meals per day ... "</p> <p>Resident #258 was admitted with skin impairment assessed at the sacrum, a bony prominence located at the base of the spine [common site for pressure ulcers]. Nursing staff failed to consistently assess and document a description of the resident ' s altered skin particularly since the impairment was located at a site commonly associated with pressure-related tissue necrosis. The nursing assessments recorded lacked information related to size, shape, characteristics, wound bed and the condition of surrounding tissues. [ref. Cuddigan Pressure Ulcers In America 20001]. The nursing staff failed to identify the clinical basis of the skin impairment [e.g. pressure-related versus non-pressure-related] and recorded contrasting assessments as evidenced by nursing entries that read: "Stage 2 pressure ulcer "versus" redness of the sacrum."</p> <p>Nursing staff failed to notify the physician of the Resident #258's alteration in skin integrity. A period of approximately two (2) weeks [8/4/ - 17/14] lapsed before a wound consultation was requested. The staff applied skin barrier cream to the affected site for the period of August 4 through August 21, 2014 [date wound consult done] with progressive worsening of the affected site.</p>	F 309			

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F 309	Continued From page 21 Facility staff failed to implement necessary care and services for the management of skin impairment for Resident #258. The resident was moderately impaired nutritionally and was receiving chemotherapy and radiation therapy. The skin impairment progressively worsened and progressed to a stage 2 pressure ulcer. The record was reviewed September 11, 2014. 2. Facility staff failed to clarify physician ' s orders for oral supplements to include the dose for administration for Resident #29. A review of the physician's order on the 'Oral Supplement Order' form dated August 21, 2014 revealed the following order: "Oral Supplements (Nutrition) Ensure Complete three times daily (or with each meal) for supplement" A review of the 'Medication Administration Record' [MAR] dated August 21, 2014 revealed the following order: "Oral Supplements (Nutrition) Ensure Complete three times daily (or with each meal) for supplement" The order lacked evidence of the dose or amount of Ensure Complete to be administered to Resident #29. A face-to-face interview was conducted with Employee #4 on September 9, 2014 at approximately 10:50 AM. He/she acknowledged the aforementioned findings.	F 309	Response to F309 #2, F309 #3, F309 #4 and F309 #5 (483.25): 1. There are no further corrective actions as the residents have been discharged to the home. The RN/LPNs involved will be identified by 10/27/14 and counseled by DON by 11/12/14. 2. Other residents having the potential to be affected by the same deficient practice will be identified through 20 random audits per month, for four months, of staff involved. 3. The following systemic changes will be put in place to ensure the deficient practice will not recur: a. During the facility QIS survey the facility Nurse Practitioner changed the Electronic Health Record (EPIC) field for individual physician oral supplement orders to default to a value of (1) can/bottle b. An expedited EPIC Optimization ticket to make the oral supplement amount question a hard stop was placed on 10/20/14 and was completed by 10/24/14. c. Documentation workshop to include documentation of oral supplement and dose for administration for RN/LPN staff will be completed by 11/12/14.	11/12/14	10/20/14 10/24/14 11/12/14

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F 309	<p>Continued From page 22</p> <p>Facility staff failed to clarify the physician order for the oral supplement to include the dose for administration. The clinical record was reviewed on September 9, 2014.</p> <p>3. Facility staff failed to clarify physician 's orders for oral supplements to include the dose for administration for Resident #279.</p> <p>A review of the physician's order on the 'Oral Supplement Order' form dated September 4, 2014 revealed the following order:</p> <p>"Oral Supplements (Nutrition) Ensure Complete three times daily (or with each meal) for supplement. Pt. [Patient] prefers strawberry"</p> <p>A review of the MAR dated September 4, 2014 revealed the following order:</p> <p>"Oral Supplements (Nutrition) Ensure Complete three times daily (or with each meal) for supplement. Pt. prefers strawberry"</p> <p>The order lacked evidence of the dose or amount of Ensure Complete to be administered to Resident #279.</p> <p>A face-to-face interview was conducted with Employee #4 on September 9, 2014 at approximately 10:50 AM. He/she acknowledged the aforementioned findings.</p> <p>Facility staff failed to clarify the physician order for the oral supplement to include the dose for administration. The clinical record was reviewed on September 9, 2014.</p>	F 309	<p>Continued Response to F309 #2, F309 #3, F309 #4 and F309 #5 (483.25):</p> <p>4. The facility Nurse Practitioner will monitor performance through monthly random audits. Staff will be re-educated if non-compliance is found. The quality assurance process will be utilized to maintain and sustain 90% or above compliance. The findings will be presented at the quarterly meeting of the Renaissance Compliance & Quality Assurance Committee.</p> <p>5. The corrective action will be completed on or by 11/12/14.</p>	11/12/14	

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F 309	<p>Continued From page 23</p> <p>4. Facility staff failed to clarify physician 's orders for oral supplements to include the dose for administration for Resident #280.</p> <p>A review of the physician's order on the 'Oral Supplement Order' form dated September 9, 2014 revealed the following order:</p> <p>"Oral Supplements (Nutrition) Vital 1.0 every morning for supplement"</p> <p>A review of the MAR dated September 9, 2014 revealed the following order:</p> <p>"Oral Supplements (Nutrition) Vital 1.0 every morning for supplement"</p> <p>The order lacked evidence of the dose or amount of Vital 1.0 to be administered to Resident #280.</p> <p>A face-to-face interview was conducted with Employee #4 on September 9, 2014 at approximately 10:50 AM. He/she acknowledged the aforementioned findings.</p> <p>Facility staff failed to clarify the physician order for the oral supplement to include the dose for administration. The clinical record was reviewed on September 9, 2014.</p> <p>5. Facility staff failed to clarify physician 's orders for oral supplements to include the dose for administration for Resident #281.</p> <p>A review of the physician's order on the 'Oral Supplement Order' form dated September 3, 2014 revealed the following order:</p>	F 309			

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F 309	<p>Continued From page 24</p> <p>"Oral Supplements (Nutrition) Ensure Complete three times daily (or with each meal) for supplement "and "Oral Supplements (Nutrition) Magic Cup three times daily (or with each meal) for supplement"</p> <p>A review of the MAR dated September 3, 2014 revealed the following order:</p> <p>"Oral Supplements (Nutrition) Ensure Complete three times daily (or with each meal) for supplement" and "Oral Supplements (Nutrition) Magic Cup three times daily (or with each meal) for supplement"</p> <p>The order lacked evidence of the dose or amount of Ensure Complete and Magic Cup to be administered to Resident #281.</p> <p>A face-to-face interview was conducted with Employee #4 on September 9, 2014 at approximately 10:50 AM. He/she acknowledged the aforementioned findings.</p> <p>Facility staff failed to clarify the physician order for the oral supplement to include the dose for administration. The clinical record was reviewed on September 9, 2014.</p> <p>6. Facility staff failed to administer insulin to Resident #273 in accordance with the physician 's order.</p> <p>A review of the electronic medical record revealed that on September 5, 2014 at 1712 [5:12 PM] the resident's blood glucose reading was "237".</p>	F 309	<p>Response to F309 #6 (483.25):</p> <ol style="list-style-type: none"> 1. There are no further corrective actions as the resident has been discharged to the home. The RN/LPNs involved will be identified by 10/27/14 and counseled by DON by 11/12/14. 2. Other residents having the potential to be affected by the same deficient practice will be identified through 20 random medication administration (with sliding scale insulin orders) audits per month, for four months, of staff involved. 3. The following systemic change will be put in place to ensure the deficient practice will not recur: <ol style="list-style-type: none"> a. Documentation workshop to include double checking of high alert medications including the documentation of the correct amount of insulin administered on Sliding Scale by 11/12/14 4. Two Quality Compliance Coordinators will monitor performance through monthly random audits. Staff will be re-educated if non-compliance is found. The quality assurance process will be utilized to maintain and sustain 90% or above compliance. The findings will be presented at the quarterly meeting of the Renaissance Compliance & Quality Assurance Committee. 5. The corrective action will be completed on or by 11/12/14. 	11/12/14	
				11/12/14	
				11/12/14	

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F 309	Continued From page 25 The physician ' s order transcribed on the Medication Administration Record [MAR] for September 2014 read as follows: "If finger stick blood glucose 201-250 mg/dl then give 3 units [of insulin]. " The MAR for September 2014 revealed that nursing staff administered four (4) units of insulin on September 5, 2014 at " 1829 " [6:29 PM]. According to the prescribed insulin schedule, the resident should have received three (3) units of insulin. There was no evidence the resident sustained any adverse effect. A face-to-face interview was conducted with Employee #3 on September 10, 2014 at approximately 2:30 PM who acknowledged the findings. Facility staff failed to administer insulin in accordance with physician ' s orders. The record was reviewed September 10, 2014.	F 309	Response to F371 #1 (483.35(i)) : 1. Open and undated items were discarded on 9/8/14. 2. Daily monitoring by management will identify other patients having the potential to be affected by the same practice. 3. The following systemic change will be put in place to ensure the deficient practice will not recur: All production staff will be in-serviced during a production meeting by 10/24/14 on the requirement that all items, once opened, must be labeled and dated before being placed into the freezer on the tray line. 4. This practice will be monitored daily by the Chef, Sous Chef, or manager on duty for compliance. The quality assurance process will be utilized to maintain and sustain 90% or above compliance. The findings will be presented at the monthly managers meeting. 5. Corrective action completed by 10/24/14.	9/8/14	10/24/14
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371		10/24/14	

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F 371	Continued From page 27	F 371	Continued Response to F371 #3 (483.35(i)): 4. This practice will be monitored daily by the Chef, Sous Chef, or manager on duty for compliance. The quality assurance process will be utilized to maintain and sustain 90% or above compliance. The findings will be presented at the monthly managers meeting.	
F 386 SS=D	483.40(b) PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS 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: Based on record review for one (1) of 21 sampled residents, it was determined that the physician failed to review the total program of care for Resident #258 as evidenced by failing to accurately assess the status of the resident 's skin. The findings include: A review of the History and Physical (H&P) for Resident #258 signed by the physician on August 4, 2014, under the section labeled ' skin ' read, " no rashes or lesions noted. " Subsequent physician progress notes recorded between the periods of August 5 through September 1, 2014, under the section(s) labeled	F 386	5. Corrective action completed by 10/24/14. Response to F371 #4 483.35(i) : 1. Cited deep fat fryers were cleaned by 9/15/14. 2. Daily monitoring by management will identify other patients having the potential to be affected by the same practice. 3. The following systemic change will be put in place to ensure the deficient practice will not recur: All production staff will be in-serviced during a production meeting by 10/24/14 on the requirement that all equipment must be appropriately cleaned before being used. 4. This practice will be monitored daily by the Chef, Sous Chef, or manager on duty for compliance. The quality assurance process will be utilized to maintain and sustain 90% or above compliance. The findings will be presented at the monthly managers meeting. 5. Corrective action completed by 10/24/14	10/24/14 9/15/14 10/24/14 10/24/14

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F 386	<p>Continued From page 28</p> <p>' integumentary ' and/or skin read, " no rash, " " no rashes, wound without inflammation or redness. "</p> <p>However, the clinical record revealed the resident was admitted with altered skin integrity as evidenced by the following nursing entries:</p> <p>August 4, 2014 (admission date) at 1606 (4:06 PM), " sacral redness, barrier cream applied. "</p> <p>August 4, 2014 1945 (7:45 PM), " blanchable redness on sacrum, cream applied. "</p> <p>August 5, 2014 at 8:30 AM, " redness to sacrum, blanchable barrier cream applied "</p> <p>August 6, 2014 at 10:00 AM, " applied barrier cream to perianal and sacrum for redness "</p> <p>On August 21, 2014, the physician prescribed an antifungal wound treatment regimen subsequent to a wound care specialist consultation dated August 21, 2014 that read as follows:</p> <p>August 21, 2014 6:21 PM [wound specialist initial consult] " requested to see patient by staff for assessment of redness to buttocks and gluteal cleftskin is red on both buttocks with mild skin denudement ...indicative of a yeast infection. In addition, the patient has a small 1.0 x 1.0 cm open area in upper gluteal cleft which is moisture associated skin damage (MASD) due to patient ' s incontinence. This is not a pressure ulcer ...apply Nystatin powder to yeast infection on medial buttocks and perineal area ...apply silver powder to small wound due to MASD and cover with Calazime skin barrier cream light coating</p>	F 386	<p>Response to F371 #5 (483.35(i)):</p> <ol style="list-style-type: none"> The water filter was repaired on 10/23/14. Daily monitoring by management will identify other patients having the potential to be affected by the same practice. The following systemic change will be put in place to ensure the deficient practice will not recur: A work order was placed the week of 9/12/14 to fix the leaking water filter. The quality assurance process was utilized and the leaking water filter was repaired on 10/23/14. Corrective action completed on 10/23/14 <p>Response to F371 #6 (483.35(i)):</p> <ol style="list-style-type: none"> No direct impact identified to patients from the deficient practice of the floor to the walk-in dairy refrigerator and the floor to the walk-in freezer being loose and uneven and presenting a tripping hazard. Daily monitoring by management will identify other patients having the potential to be affected by the same practice. The following systemic changes will be put in place to ensure the deficient practice will not recur: <ol style="list-style-type: none"> Two vendors have been contacted to bid on repairing the flooring. All staff will be in-serviced on being aware of the floor in both areas and using caution when going into both walk-ins by 10/24/14. 	10/23/14	10/23/14	9/12/14	10/23/14	10/23/14	10/24/14

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F 386	Continued From page 29 only.." The physician failed to review the total plan of care for Resident #258 as evidenced by failure to accurately assess the resident ' s skin. The record was reviewed September 11, 2014.	F 386	Continued Response to F371 #6 (483.35(i)): 4. Tripping hazards will be monitored daily by the Chef, Sous Chef, or manager on duty for compliance. The findings will be presented at the monthly managers meeting. 5. Corrective action will be completed by 11/30/14.	11/30/14	
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the	F 431	Response to F386 (483.40(b)): 1. There are no further corrective actions as the resident has been discharged to the home. The physician involved will be identified by 10/27/14 and counseled by the Medical Director by 11/12/14. 2. Other residents having the potential to be affected by the same deficient practice will be identified through 20 random audits per month, for four months, of the physician involved. 3. The following systemic change will be put in place to ensure the deficient practice will not recur: a. A physician meeting will be scheduled for 11/11/14 to review the process to accurately assess and document the status of the resident's skin. 4. The facility Nurse Practitioner will monitor performance through monthly random audits. The physician will be re-educated if non-compliance is found. The quality assurance process will be utilized to maintain and sustain 90% or above compliance. The findings will be presented at the quarterly meeting of the Renaissance Compliance & Quality Assurance Committee. 5. The corrective action will be completed on or by 11/12/14.	11/12/14	
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F 431	<p>Continued From page 30</p> <p>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 record review and interview, it was determined that facility staff failed to act when it was determined that two (2) of two (2) medication refrigerators failed to meet acceptable temperatures.</p> <p>The findings include:</p> <p>A review of the facility's Medication Storage policy No. 03-11-18 last reviewed September 2014 stipulated, " 8. Medications are stored in a manner that meets manufacture requirements ...b. A thermometer between 2 and 8 degrees Centigrade or 36 and 46 degrees Fahrenheit; ii) If the temperature is out of range, an adjustment is made and it is rechecked in 15 to 30 minutes. iii) If the temperature is still out of range (or there is a more obvious malfunction), Plant Operations/Maintenance is notified for repairs and Pharmacy is notified to arrange for alternate drug storage. "</p> <p>A review of the facility 's medication refrigerator temperature logs for unit 3 South revealed the following:</p> <p>July 19, 2014 from 0113 hours [1:13 AM] to 0500 hours [5:00 AM], the temperature range was between 30 -34 degrees Fahrenheit. No resolution recorded when the temperature was out of range.</p>	F 431	<p>Response to F431 (483.60(b), (d), (e):</p> <ol style="list-style-type: none"> 1. Medication Refrigerators on 3North and 3South were within approved range at the time this issue was identified during the DC DOH QIS Survey. Prior month temperatures had been out of range with poor documentation of actions taken. 2. The Pharmacy staff are notified of out of range medication refrigerator temperatures via a color change of the Pyxis Console monitor. Other residents having the potential to be affected by the same deficient practice will be identified through re-education of all involved pharmacy staff as to their role in monitoring for out of range temperatures as well as appropriate actions to follow in the resolution and documentation of actions taken to ensure that no additional residents are impacted. An email was sent to all pharmacy staff on 9/10/14 reiterating the required steps to be followed and the need for timely intervention. 	9/10/14	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/16/2014
FORM APPROVED
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER SIBLEY MEM HOSP RENAISSANCE			STREET ADDRESS, CITY, STATE, ZIP CODE 6265 LOUGHBORO ROAD NW WASHINGTON, DC 20016		
(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 431	Continued From page 31 August 4, 2014 from 0720 hours [7:20 AM] to 2337 hours [11:37 PM], the temperature range was between 28-37degrees Fahrenheit. No resolution recorded when the temperature was out of range. August 5, 2014 from 0032 hours [12:32 AM] to 2319 hours [11:19 PM], the temperature range was between 31-38 degrees Fahrenheit. No resolution recorded when the temperature was out of range. August 6, 2014 from 0019 hours [12:19 AM] to 1008 hours [10:08 AM], the temperature range was between 31-37degrees Fahrenheit. No resolution recorded when the temperature was out of range. August 7, 2014 from 1839 hours [6:39 PM] to 1939 hours [7:39 PM], the temperature range was between 31-37degrees Fahrenheit. No resolution recorded when the temperature was out of range. August 8, 2014 from 0805 hours [8:05 AM] to 0905 hours [9:05 AM], the temperature range was between 30-39 degrees Fahrenheit. No resolution recorded when the temperature was out of range. August 9, 2014 from 0028 hours [12:28 AM] to 0133 hours [1:33 AM], the temperature range was between 30-43 degrees Fahrenheit. No resolution recorded when the temperature was out of range. There was no evidence that facility staff implemented corrective action(s) to resolve the	F 431	Continued Response to F431 (483.60(b), (d), (e): 3. The following systemic changes have been put in place to ensure the deficient practice will not recur: a. The "Refrigerator Temperature out of Range for Pharmacy Workflow" guideline was updated on 9/10/14 to include the need for documentation and re-education was provided to the staff to all pharmacy staff as an attachment to the previously noted email. b. Policy 03-11-18, Medication Storage and Handling, has been updated to reflect the requirement to fully and accurately document all actions taken when a medication refrigerator falls out of range. The policy was approved by the Pharmacy and Therapeutics Committee on 10/21/2014 and is now pending final approval and signature by the Hospital Policy Committee and senior leadership. However, all content of the policy has been enforced with staff since 9/10/14.	9/10/14	10/21/14
				9/10/14	

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

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F 431	Continued From page 32 out-of-range refrigerator temperatures on the aforementioned dates. A face-to-face interview was conducted on August 11, 2014 at approximately 9:47 AM with Employee #13. He/she acknowledged the findings. The records were reviewed on September 11, 2014.	F 431	Continued Response to F431 (483.60(b), (d), (e): 4. The Informatics Pharmacist and Informatics Pharmacy Technician are charged with oversight of the medication refrigerator temperature monitoring process. Pharmacy leadership will monitor compliance monthly through review of temperature monitoring logs for six months, verifying that any out of range refrigerators have appropriate supporting documentation for appropriate actions taken. Monitoring results will be reported at subsequent Renaissance Compliance & Quality Assurance Committee meetings. 5. The corrective action was completed by 10/21/14		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their	F 441			10/21/14

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

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F 441	<p>Continued From page 33</p> <p>hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations, staff interview and record review for two (2) of 21 sampled residents, it was determined that facility staff failed to implement measures as to prevent the spread of infection as evidenced by: failure to utilize infection control practices to prevent the potential for cross contamination during a wound treatment and failure to practice proper hand hygiene during the administration of a respiratory treatment. Residents' #280 and 281.</p> <p>The findings include:</p> <p>1. The facility staff failed to consistently utilize accepted standards of infection control practices while performing a wound treatment for Resident #280.</p> <p>A review of the History and Physical examination dated August 29, 2014 revealed Resident #280 was admitted status post " Left Total Hip Arthroplasty. "</p> <p>A review of the physician ' s wound treatment order dated September 8, 2014 directed the</p>	F 441	<p>Response to F441 #1 and #2 (483.65):</p> <ol style="list-style-type: none"> 1. There are no further corrective actions as the residents have been discharged to the home. The RN and Respiratory Therapist will be counseled by 11/12/14. 2. Other residents having the potential to be affected by the same deficient practice will be identified through weekly hand hygiene audits (10 observations per week) conducted by the Infection Preventionist. 3. The following systemic changes will be put in place to ensure the deficient practice will not recur: <ol style="list-style-type: none"> a. Weekly hand hygiene audits conducted by the Infection Preventionist b. Hand hygiene audits will continue until hand hygiene compliance is maintained at 90% for 3 consecutive months. A follow -up audit will be conducted for one month after the 90% target is reached to ensure sustainability. c. The Infection Preventionist will counsel non-compliant staff at the time of the missed hand hygiene opportunity. d. Continued monthly hand hygiene audits by secret observers (10 observations/week) 4. The quality assurance process will be utilized to maintain and sustain 90% or above compliance. The findings will be presented at the quarterly meeting of the Renaissance Compliance & Quality Assurance Committee. 5. The corrective action will be completed on or by 11/12/14. 	11/12/14

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 096030	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/12/2014
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F 441	<p>Continued From page 34 following:</p> <p>" Every other day and PRN [as needed], cleanse coccyx ulcer with saline, apply silver powder and cover with foam dressing, change three times a week and as needed. "</p> <p>On August 8, 2014 at approximately 1:35 PM, a wound care observation was made. Employee #5 cleansed Resident #280 ' s wound, then proceeded to obtain and apply the clean dressing to the resident ' s wound, without changing his/her gloves or sanitizing his/her hands.</p> <p>A face-to-face interview was conducted with Employee #5 on September 8, 2014 at approximately 1:40 PM. He/she acknowledged the aforementioned findings.</p> <p>Employee #5 failed to demonstrate accepted standards of infection control practices as to prevent the potential for cross contamination as evidenced by failing to change gloves and sanitize hands between the removal of a soiled dressing, wound cleansing and the application of a clean dressing.</p> <p>2. Facility staff failed to utilize proper hand hygiene practices when he/she coughed while administering a respiratory treatment to Resident #281.</p> <p>A review of the History and Physical for Resident #281 dated September 3, 2014 revealed the resident was admitted with Cardiopulmonary Disease Exacerbation and Pneumonia.</p> <p>Physician ' s orders dated September 3, 2014</p>	F 441			

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

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OMB NO. 0938-0391

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F 441	Continued From page 35 directed the following : " Ipratropium (Atrovent) [bronchodilator] 0.02% [concentration] nebulizer solution 0.5mg [milligrams] every 6 hours for pneumonia " On August 9, 2014 at approximately 10:08 AM, Employee #6 was observed administering a nebulizer [device that turns a liquid form to a spray form] treatment to the resident. Employee #6 coughed into his/her right hand as he/she was preparing the resident's medication for use. He/she continued to give the medication to the resident without washing or sanitizing his/her hands. Employee #6 failed to follow proper hand hygiene practices when he/she failed to wash/sanitize hands after coughing into his/her hand during the administration of a nebulization treatment.	F 441	Response to F492A (483.75(b): 1. Practitioners who were found deficient during the survey had PPDs completed prior to the close of the survey, 9/12/14. 2. Other residents having the potential to be affected by the same deficient practice will be identified through reconciliation and identification of providers who have not had PPD as of 11/2013 by 10/24/14. 3. The following systemic changes will be put in place to ensure the deficient practice will not recur: a. Implement annual screening certification form by 10/24/14, to be returned by practitioners by 11/30/14. b. Practitioners who are non-compliant will not be able to attend residents. 4. The quality assurance process will be utilized to maintain and sustain 100% compliance. The findings will be presented at the quarterly meeting of the Renaissance Compliance & Quality Assurance Committee, starting on 10/28/14. 5. The corrective action will be completed on or by 11/30/14.	9/12/14	10/24/14
F 492 SS=D	483.75(b) COMPLY WITH FEDERAL/STATE/LOCAL LAWS/PROF STD 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: A. Based on record review and staff interview for two (2) of 12 physician personnel records reviewed, it was determined that the facility	F 492		10/28/14	11/30/14

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

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F 492	<p>Continued From page 36</p> <p>failed to provide annual certification of freedom from communicable disease in accordance with Title 22 District of Columbia Municipal Regulations (DCMR), Section 3207, Physician Services and Medical Supervision of Residents.</p> <p>The findings include:</p> <p>The 22 District of Columbia Municipal Regulations (DCMR) 3207.2 (h) for Nursing Facilities: stipulate, "Ensure that attending medical professionals who treat residents in the facility have current District of Columbia licenses, U.S. Drug Enforcement Agency and D.C. Controlled Substance registration on file in the facility, along with initial and annual certification of their freedom from communicable diseases."</p> <p>A review of Physician #1's health record revealed that he/she was last screened for tuberculosis on April 17, 2013.</p> <p>A review of Physician #2's health record revealed that he/she was last screened for tuberculosis on December 6, 2012.</p> <p>A face-to-face interview was conducted with Employee #17 on September 10, 2014 at approximately 4:00 PM. He/she stated that the hospital regulations require screenings every two (2) years. After reviewing the requirements for skilled nursing facilities, he/she acknowledged the findings and implemented measures to ensure compliance. The records were reviewed on September 10, 2014.</p> <p>B. Based on observation and record review for</p>	F 492			

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

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FORM APPROVED
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F 492	<p>Continued From page 37</p> <p>one (1) of 21 sampled residents, it was determined that facility staff failed to give notification of at least seven (7) calendar days prior to a room change for Resident #226, as stipulated in D. C. Law 44DCMR§44-1003.02, Discharge, Transfer and Relocation of Residents.</p> <p>The findings include:</p> <p>According to 44DCMR§44-1003.02: "...the oral and written notice shall be given at least 21 calendar days before a proposed discharge or transfer from the facility and at least 7 calendar days before a proposed relocation within the facility ..."</p> <p>A review of the clinical record for Resident #226 revealed the following inter-facility transfer form dated August 4, 2014: " Notice of Discharge or Transfer from a Nursing Facility or Relocation within a Nursing Facility "</p> <p>The form included the following:</p> <p>" ...1) This proposed action is a (d) Relocation;</p> <p>2) The specific reason(s) for this action is as follows - ' The other patients are complaining that their sleep is being disrupted with loud talking.'</p> <p>3) You are scheduled to be discharged, transferred or relocated on or by 8/4/14 [same date as notice];</p> <p>4) Your destination is [room number recorded]...</p> <p>- Pt (patient) refused to sign stating that [he/she] doesn't sign any papers."</p>	F 492			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 492	Continued From page 38 There was no evidence that the resident received at least a seven (7) day notice prior to his/her relocation to another room within the facility. In addition, there was no evidence that the resident's responsible party was notified and/or gave consent to relocate the resident. Facility staff failed to give notification to at least seven (7) calendar days to Resident #226 prior room change. The clinical record was reviewed September 10, 2014.	F 492	Response to 492B (483.75(b): 1. No harm was sustained to the resident as a result of this deficient practice and the resident is still in the facility. The RN will be identified by 10/27/14 and counseled by the DON by 11/12/14. 2. Other residents having the potential to be affected by the same deficient practice will be identified through weekly auditing of the completion of the 6108 form by the Administrative Service Representatives (ASR). Note that the resident or decision maker may waive the 7 calendar day notice prior to a room change and is to be noted on the form by the signature. 3. The following systemic changes will be put in place to ensure the deficient practice will not recur: a. Documentation workshop to include 1) Review Resident Rights; 2) Review use of 6108 form; and 3) Review role of the POA and Guardianship completed by 11/12/14. b. Weekly audits by the ASRs. Non-compliance will be reported to the two Quality Compliance Coordinators for follow-up with the non-compliant staff. 4. The quality assurance process will be utilized to maintain and sustain 90% or above compliance. The findings will be presented at the quarterly meeting of the Renaissance Compliance & Quality Assurance Committee. 5. The corrective action will be completed on or by 11/12/14.	11/12/14	
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 21 sampled residents, it was determined that facility staff failed to accurately document the type of catheter used for Resident # 276.	F 514		11/12/14	11/12/14

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 514	<p>Continued From page 39</p> <p>The findings include:</p> <p>Facility staff failed to accurately document the type of catheter applied to Resident #276 on the nurse's flow sheets.</p> <p>According to the nursing assessment record, Resident #276 was admitted on September 3, 2014 with an [external] "Texas" catheter in place for urinary incontinence.</p> <p>A review of nursing assessments dated September 4, 2014 at 1925 hours, September 5, 2014 at 0800 hours, and on September 6, 2014 at 0830 revealed staff documented that the resident had an indwelling "Foley" catheter in place.</p> <p>There was no evidence of an order for the use of an indwelling Foley catheter for Resident #276.</p> <p>A face-to-face interview was conducted with Employee #3 on September 11, 2014 at approximately 11:00 AM regarding the aforementioned finding. Employee #3 acknowledged that nursing staff documented the incorrect type of catheter on the flow sheets on three (3) occasions.</p> <p>Facility staff failed to accurately document the type of catheter used for Resident # 276. The clinical record was reviewed on September 11, 2014.</p>	F 514	<p>Response to F514 (483.75(l) (1):</p> <ol style="list-style-type: none"> There are no further corrective actions as the resident has been discharged to the home. The RN will be identified by 10/27/14 and counseled by DON by 11/12/14. Other residents having the potential to be affected by the same deficient practice will be identified through 20 random audits per month, for four months, of staff involved. The following systemic change will be put in place to ensure the deficient practice will not recur: <ol style="list-style-type: none"> Education for all staff to review the Electronic Health Record documentation. Staff will be instructed to select "external catheters" under the Urinary Catheter field and to document in the comment section the type of external catheter. This education will be completed by 11/12/14. Two Quality Compliance Coordinators will monitor performance through monthly random audits. Staff will be re-educated if non-compliance is found. The quality assurance process will be utilized to maintain and sustain 90% or above compliance. The findings will be presented at the quarterly meeting of the Renaissance Compliance & Quality Assurance Committee. The corrective action will be completed on or by 11/12/14. 	11/12/14	11/12/14