					DMB NO. 09
46.0	M. AT LONG TO	THE PRESENTATION OF THE CASE OF THE PROPERTY O			-2-(14.72 -1474) -3440 -474
	A following nursely and confortable interest or sometimes and and manufactured services and another process of sometimes and an additional analysis of some services and an interest or sometimes or sometimes and an interest or sometimes and an inter	10			
_		285019			05/16/20
OR ST	NOVICEN OF SURFYER		100		
LINT I	PARK CARE CENTER				
igily (S)	men in her elected a section	ter metapepeak on hard missage within		principal district of all from branch	68 1 ROSS 8
нэээ	A follow-op survey to completely Acril 6 18 2006 The follow- ocservesons recom- interviews The sam three 13- supplement	of the securitication acrossy 2009 was conducted on June ong deficiencies were based on treview and faculty staff pie size was To residents and dat resident		plan of correction does not a admit of plan agreement by a provider with the statement of defaces are. The plan of an awayance and an executed be as required by plantation of h	onstille he of rection cause it
		EXESTING MADE IT CONC.		and Stars begularates	
5a=U				1 Prive case was replaced in cosms 201, 205, 228, 227	
	This PEPULINEMEN	is not met as evidenced by		and 4 to. Wall guards have	
	four it was determined that the facility manner as a bases in 11 of 12 and will justify in 2 and will justify in 2 and justif	ed the facility staff felled (c) by was maintained in a sate and syldended by damaged, cover orders rooms, and so (f) of 12		utility room 2 south dining roo	ern Exy
				2 Facility round was completed	to 2015
	AM to 12:30 PM and	2 00PM to 4 00 PM on June		1 Ktalermannes & Homosteeping	
	ine lingings include			environmenta rounds Addition	late (
	folidwing preas resid				rrection re
	n (14-1)				
	following areas inch	observed damaged in the His 2 Ni clinari utility instin. (2 C or elevator area, 2nd floor		the the safety manager with wor	

PRINTED: 07/09/2009 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	15		LE CONSTRUCTION	(X3) DATE SU COMPLE	IRVEY TED
		095019	B. WIN				R 8/2009
	PARK CARE CENTER			5	EET ADDRESS, CITY, STATE, ZIP CODE 000 BURROUGHS AVE. NE VASHINGTON, DC 20019	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES F BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD BI REFERENCED TO THE APPROPRIATE DE	E CROSS-	(X5) COMPLETION DATE
{F 000} {F 253} SS=D	completed April 9, 2 18, 2009. The follow observations, record interviews. The same three (3) supplement 483.15(h)(2) HOUSE The facility must promaintenance service sanitary, orderly, and This REQUIREMENT Based on observation tour, it was determinensure that the facility sanitary manner as a bases in 11 of 32 reswall guards in comments.	o the recertification survey 2009 was conducted on June ving deficiencies were based on I review and facility staff ple size was 18 residents and	{F 0		Preparation and/or execution of plan of correction does not conadmission or agreement by the provider with the statement of deficiencies. The plan of corresponding and/or executed because required by provision of Fedural State regulations. F 253 1. Cove base was replaced in rooms 203, 205, 228, 229, 230, 305, 311, 320, 322, 402, and 436. Wall guards have been replaced in 2 North clean utility room, 2 south dining room 1st, 2nd, 3rd, and 4th floor elevator areas and rooms 416, 419, and 5	nstitute e ection is nuse it deral	7/08/09
	AM to 12:30 PM and 18, 2009 in the present 14. The findings include: 1. Cove Base was of following areas: resident.	our was conducted from 11:00 I 2:00PM to 4:00 PM on June ence of Employees #12, 13 and observed damaged in the dent rooms 203, 205, 228, 229, 322, 402 and 436 in 11 of 32			2.Facility round was completed to identify other areas of concern. 3.Maintenance & Housekeeping have been re-educated on conductive environmental rounds. Additional painters & maintenance staff have been employed to complete corrof identified areas. Daily 5x wee	staff ucting al ve rection	7/15/09
	resident rooms. 2. Wall guards were following areas: room Dining Room, 1st floor	observed damaged in the ns 2 N clean utility room, 2 S or elevator area, 2nd floor			environmental rounds are conductive by the safety manager with work initiated for correction at time of discovery.	ers f	(X6) DATE

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
-			CONTRACTOR AND A PROPERTY.			R
		095019	B. WING	9	06/	18/2009
	PARK CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 5000 BURROUGHS AVE. NE WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHOU REFERENCED TO THE APPROPRIAT	LD BE CROSS-	(X5) COMPLETION DATE
{F 253} {F 278} SS=D	elevator area, 3rd florelevator area in six (observed and rooms of 32 rooms observed Employees #12, 13 a findings at the time of 483.20(g) - (j) RESID The assessment muresident's status. A registered nurse massessment with the health professionals. A registered nurse massessment is competed in the competency of the second second individual who assessment must signate portion of the assessment in a residency of the control of the second individual who assessment must signate portion of the assessment in a residency of the control of the second individual who assessment must signate portion of the assessment in a residency of the control of the second individual who assessment must signate portion of the assessment in a residency of the control of the second in a residency of the control of the second in a residency of the control of the second in the control of the second i	por elevator area, 4th floor (6) of 12 common areas (5) 416, 419 and 515 in three (3) (a) and 14 acknowledged the (b) the observations. DENT ASSESSMENT (b) st accurately reflect the (c) nust conduct or coordinate each (appropriate participation of (c) nust sign and certify that the (d) leted. (c) completes a portion of the (g) and certify the accuracy of	{F 25	4.Tracking/trending of environments will be reported to the QI/RM committee.	rly lave lure with ry as lucated ling RN l MDS's late lordinator	6/18/09 7/15/09 7/15/09
	knowingly causes an material and false sta assessment is subject	ses another individual to certify a alse statement in a resident subject to a civil money penalty of \$5,000 for each assessment.		4. Results will be report to the QI/RM committee.	e monthly	
	and false statement.	t does not constitute a material Γ is not met as evidenced				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		095019	B. WING	**************************************	06/18	
	PARK CARE CENTER		5	REET ADDRESS, CITY, STATE, ZIP CODE 5000 BURROUGHS AVE. NE WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD B REFERENCED TO THE APPROPRIATE DE	E CROSS-	(X5) COMPLETION DATE
{F 278}	by: Based on record rev (1) of 18 sampled re facility staff failed to registered nurse (RI Minimum Data Set A completed for Resid	riew and staff interview for one sidents, it was determined that obtain the signature of a N) certifying that the quarterly assessment (MDS) was ent #12.	{F 278}	F286 1. 15 months of MDS's are Resident #12's chart. 2. Current Resident charts been reviewed for 15 month MDS's on medical record.	have 7	7/08/09 7/15/09
F 286 SS=D	revealed that the R2 assessment coordin Assessment Referent 5, 2009. A face-to-face interved Employee #15 at ap 18, 2009. He/she st completed last mont signatures." The re 2009. 483.20(d) RESIDEN A facility must mainta	terly MDS for Resident # 12 signature for the RN ator was missing. The nce Date on the MDS was June few was conducted with proximately 1:20 PM on June ated, "The MDS was h. I am waiting to get all of the cord was reviewed on June 18, TASSESSMENT - USE ain all resident assessments previous 15 months in the	F 286	3. MDS staff have been reon the Federal requirement maintain 15 months of MDS medical record. Resident ca coordinator will review utilizing the RAI process. 4. Results will be reported monthly QI/RM committee.	to 's on ire	7/15/09
*	Based on record revi (1) of 18 sampled res facility staff failed to					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SUI COMPLET	
			A. BUILDI	The state of the s	- 1	R
		095019	B. WING_		06/1	8/2009
	PARK CARE CENTER		s	TREET ADDRESS, CITY, STATE, ZIP CODE 5000 BURROUGHS AVE. NE WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY INTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD B REFERENCED TO THE APPROPRIATE DE	E CROSS-	(X5) COMPLETION DATE
F 286	A review of the clinic revealed the followin quarterly MDS Febru March 10, 2008; qua quarterly MDS Septe February 23,2009. T	cal record for Resident #12	F 28	F309 1. Resident #1 is receiving medication as ordered. Res #13 appointment has been scheduled for 7/16/09.		7/08/09
	Employee #15 at ap 18, 2008. During the	iew was conducted with proximately 1:20 PM on June e interview, a copy of the MDS for May, 2009 was		 Current Resident medic Orders and orders for consult have been reviewed with conformation taken as indicated. 	ltations	7/15/09
	completion date of M signatures. Employe completed MDS was He/she stated, "The month. I am waiting	ented a copy of an MDS with a May 5, 2009, but without any se #15 was asked why the s not in the resident's record. It is MDS was completed last to get all of the signatures record." The record was 3, 2009.		 Licensed nurses have be reeducated on medication o transcription, medication administration, timely follow up of consultation orders. 	order	7/15/09
{F 309} SS=D	provide the necessar maintain the highest and psychosocial we	receive and the facility must ry care and services to attain or practicable physical, mental, ell-being, in accordance with the essment and plan of care.	{F 309	 Tracking/trending of env rounds will be reported to the QI/RM committee. 		
	This REQUIREMEN	Γ is not met as evidenced by:				
		ew and staff interview for one sidents, it was determined that ered				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SU COMPLE	
		095019	B. WING		1	R 8/2009
	OVIDER OR SUPPLIER	į.	50	EET ADDRESS, CITY, STATE, ZIP CODE 00 BURROUGHS AVE. NE ASHINGTON, DC 20019		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE I	BE CROSS-	(X5) COMPLETION DATE
	failed to schedule ar one (1) resident. Resone (1) resident. Resone (1) resident. Resone (1) resident. Resident #1. A physician's telephorate (1) and (2) and (3) and (4) and (4) and (5) and (5) and (6) and	ations to one (1) resident and appointment at a pain clinic for sidents #1 and 13. It to follow physician's orders for one order, signed and dated on ed "D/C [Discontinue] Vitamin C d [twice daily], D/C Zinc tab po re Multivite 1 [one] tab po [by pplement." It approximately 10:50 AM, approximately 10:50 AM, approximately 10:50 gm tablet or mg capsule to the resident. In the resident #1, approximately 10:50 gm tablet or mg capsule to the resident. It ication Pass worksheet was approximately to mg capsule to the resident. It ication Pass worksheet was approximately 10:50 gm tablet or mg capsule to the resident. It ication Pass worksheet was approximately 10:50 gm tablet or mg capsule to the resident. It ication Pass worksheet was approximately 10:50 gm tablet or mg capsule to the resident. It is in the resident #1 approximately 10:50 and 18, ly 11:00 AM with Employees #7 and 10:00	{F 309}			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		095019	B. WING _		R 06/18/2009
American Marie Marie	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)		REET ADDRESS, CITY, STATE, ZIP CODE 5000 BURROUGHS AVE. NE WASHINGTON, DC 20019 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIATE DE	CROSS- COMPLÉTION
{F 309}	[please] send patien Specialist for uncontright leg." There was record indicating that scheduled. According to Section Data Set (MDS) with Date of May 25, 200 daily. A review of the physe 2009 revealed two of first order which was "Gabapentin 400 mg mouth four times a done Neuropathic Pain." The second order was This order prescribed W/APAP 100-650 -IE mouth every 12 hours Review of the Medical (MAR) for June 2009 received Darvocet N 1, 2, 5, 6, 8, 9, 10, 13 for June 3, 4, 7, 11, 13. The resident also refour times daily for June 3, 4, 7, 11, 13. A face-to-face interviolem Scheduled. He scheduled. He second received Darvocet N 1, 2, 5, 6, 8, 9, 10, 13 for June 3, 4, 7, 11, 13.	to Pain Management rolled pain on left shoulder and is no documentation in the to the appointment was a J2 of the quarterly Minimum an Assessment Reference of the resident complains of pain dician's order sheet for June roders for pain medications. The dated June 3, 2009 prescribed capsule -IE Neurontin 1 cap by ay (0600, 1000, 1800, 2200) for as also dated June 3, 2009. If "Propoxyphene NAPS Darvocet-N 100 1 tablet by as a needed for mild pain." ation Administration Record revealed that the resident one tablet once daily for June 3, and 14 2009 and twice daily 2 and 15, 2009. Derived Neurontin 400 mg 1 cap and 14 through June 17, 2009. Derived Neurontin 400 mg 1 cap and 14 through June 17, 2009. Derived Neurontin 400 mg 1 cap and 14 through June 17, 2009. Derived Neurontin 400 mg 1 cap and 14 through June 17, 2009. Derived Neurontin 400 mg 1 cap and 15, 2009. Derived Neurontin 400 mg 1 cap and 15, 2009. Derived Neurontin 400 mg 1 cap and 15, 2009. Derived Neurontin 400 mg 1 cap and 15, 2009. Derived Neurontin 400 mg 1 cap and 15, 2009. Derived Neurontin 400 mg 1 cap and 15, 2009. Derived Neurontin 400 mg 1 cap and 15, 2009. Derived Neurontin 400 mg 1 cap and 15, 2009. Derived Neurontin 400 mg 1 cap and 15, 2009. Derived Neurontin 400 mg 1 cap and 15, 2009. Derived Neurontin 400 mg 1 cap and 15, 2009. Derived Neurontin 400 mg 1 cap and 15, 2009.	{F 309}	1. Toilets were secured to the floor in the bathroom of roo 228, 229, 427, and 526. The door to room 506 has a cover to conceal exposed electrical wire. The oxygen concentrator in 524 is now plugged in a sock preventing the cord from be in the path way where reside and staff walk. Extension chords are no long in rooms 209, 524, 526, and 2. Facility round was complete to identify other areas of concentrator in 524 is now plugged in a sock preventing the cord from be in the path way where reside and staff walk. Extension chords are no long in rooms 209, 524, 526, and 526 in rooms 209, 524, 526, and 527 in rooms 209, 524, 526, and 528 in rooms 209, 524, 526, and 529 in rooms 209, 524, 526, a	room set sing ents ger 534. sed 7/15/09 ern. sing 7/15/09 on sunds. has safety ed for

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	LE CONSTRUCTION	(X3) DATE SUP COMPLET	RVEY
		095019	B. WING			R 8/2009
	PARK CARE CENTER		50	EET ADDRESS, CITY, STATE, ZIP CODE 100 BURROUGHS AVE. NE ASHINGTON, DC 20019		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD B REFERENCED TO THE APPROPRIATE DE	E CROSS-	(X5) COMPLETION DATE
{F 309} {F 323} SS=D	that it gets schedule record was reviewed 483.25(h) ACCIDEN The facility must ensenvironment remains is possible; and each supervision and assist accidents. This REQUIREMEN Based on observation tour, it was determine ensure that the environment bathrooms, doors that lacked a cextension cords in for and one (1) of three the cord in a walking. The environmental to AM to 12:30 PM and 18, 2009 in the present. The findings include: 1. Toilets in resident floor in rooms 228, 232 resident bathroom.	d as soon as possible." The d on June 18, 2009. ITS AND SUPERVISION Bure that the resident as free of accident hazards as a resident receives adequate astance devices to prevent T is not met as evidenced by: In such that facility staff failed to comment was hazard free as a such of 32 unsecured toilets in one (1) of 32 resident room cover for electrical wires, bur (4) of 32 resident rooms, (3) oxygen concentrators with area. Sour was conducted from 11:00 2:00 PM to 4:00 PM on June ence of Employees #12, 13 and	{F 309} {F 323}	4. Tracking/trending of envirounds will be reported to the QI/RM committee.	2290	
	2. The door to room	506 lacked a cover to			£.	

NAME OF PROVIDER OR SUPPLIER GRANT PARK CARE CENTER SUMMARY STATEMENT OF DEFIDIENCIES SODE BURROUGHS AVE. NE WASHINGTON, DC 20019	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	100.00000000000000000000000000000000000	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
MAKE OF PROVIDER OR SUPPLIER GRANT PARK CARE CENTER CACH DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY TAGY TO PREFIX TAGY				PANTASCON SATA	25,100	9	R
GRANT PARK CARE CENTER S000 BURROUGHS AVE. NE WASHINGTON, DC 20019			095019	B. WING_		06/1	8/2009
Face Preferix TAG Candinated From page 7 Continued From page 7 Conceal exposed electrical wiring in one (1) of 32 resident room doors observed. This is a repeat deficiency from the recertification survey completed on April 9, 2009. 3. An oxygen concentrator in room 524 was plugged into an electrical socket opposite the resident using the device, resulting in the cord being in the path way where residents and staff walked in one (1) of three (3) concentrators observed. Employees #12, 13 and 14 acknowledged the findings at the time of the observations. F 332 SS=D The facility must ensure that it is free of medication error rates of five percent or greater. Fris Requirement of the facility was free of a medication error rate of five percent (5%) or greater. Resident #1 The findings include:				S	5000 BURROUGHS AVE. NE		
conceal exposed electrical wiring in one (1) of 32 resident room doors observed. This is a repeat deficiency from the recertification survey completed on April 9, 2009. 3. An oxygen concentrator in room 524 was plugged into an electrical socket opposite the resident using the device, resulting in the cord being in the path way where residents and staff walked in one (1) of three (3) concentrators observed. 4. Extension cords were observed in rooms 209, 524, 526, and 534 in four (4) of 32 resident rooms observed. Employees #12, 13 and 14 acknowledged the findings at the time of the observations. F 332 SS=D The facility must ensure that it is free of medication error rates of five percent or greater. F 332 Based on observation of one (1) of eight (8) medication passes, record review and staff interview, it was determined that facility staff failed to ensure that the facility was free of a medication error rate of five percent (5%) or greater. Resident #1 The findings include:	PREFIX	(EACH DEFICIENCY MUST	BE PRECEDED BY FULL REGULATORY	PREFIX	(EACH CORRECTIVE ACTION SHOULD B	E CROSS-	COMPLETION
based on two (2) errors out of 40 opportunities.	F 332 SS=D	conceal exposed eleresident room doors deficiency from the ron April 9, 2009. 3. An oxygen conceinto an electrical soot the device, resulting way where residents three (3) concentrate 4. Extension cords w 524, 526, and 534 in observed. Employees #12, 13 a findings at the time of the facility must enserror rates of five performance of the performance o	ectrical wiring in one (1) of 32 to observed. This is a repeat recertification survey completed intrator in room 524 was plugged object to opposite the resident using in the cord being in the path is and staff walked in one (1) of ors observed. Were observed in rooms 209, in four (4) of 32 resident rooms and 14 acknowledged the of the observations. CATION ERRORS Bure that it is free of medication recent or greater. This not met as evidenced by: In of one (1) of eight (8) record review and staff failed collity was free of a medication cent (5%) or greater. Resident		1. Medications are bein administered according physician order for Resident medication taken and indicated. 2. Current Resident medicated. 3. Licensed nurses have reeducated on medication order transcription, medication, administration, 4. Tracking/trending or orders and medication administration will be resident.	to dent #1. edication wed with as e been on dication f physician eported to	7/15/09 7/15/09

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		095019	B. WING		R 06/18/20	09
	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	5	PREET ADDRESS, CITY, STATE, ZIP CODE 1000 BURROUGHS AVE. NE VASHINGTON, DC 20019 PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD B REFERENCED TO THE APPROPRIATE DE	BE CROSS- COM	(X5) MPLETION DATE
F 332 {F 371}	June 9, 2009, director C tab po [by mouth] po [by mouth] daily, mouth] qd [daily] sure On June 18, 2009, addring the medication Employee #7 administration and Zinc Sulfate 220. The surveyor's Medicompared with the pand dated June, 200 medications were discompared with the pand dated June, 200 medications were discompared satisfacts authorities; and (2) Store, prepare, disanitary conditions This REQUIREMENT Based on observation determined that facili under sanitary conditione-half (1 ½) cases white, fuzzy growth, lettuce/cole slaw with	one order, signed and dated on ed "D/C [Discontinue] Vitamin bid [twice daily], D/C Zinc tab Give multivite 1 [one] tab po [by pplement." It approximately 10:50 AM, on pass for Resident #1, istered Vitamin C 500 gm tablet of mg capsule to the resident. Cation Pass worksheet was hysician's order sheet signed 19 both forms revealed that the scontinued on June 9, 2009.	F 332	F371 1. 1½ cases of mushy cuc with a white and yellow fuzzon the skin of the cucumber been discarded. Four 5-pound packages of stettuce with carrots and red with a "Use By" date of June have been discarded. Three 5-pound packages of lettuce with a 'Use By" date 11, 2009 have been discarded. Four 5-pound packages of cwith a "Use By" date of June have been discarded. One package of hot dog but touch and with a green, fuzzoubstance on the bottom of has been discarded. Four packages of hot dog but to touch, two packages with dates of June 7, 2009 and two sell by dates of June 14, 2000 been discarded. One loaf of bread with a white substance on the top crust of bread has been discarded.	ary growth ars have thredded cabbage at 11, 2009 ashredded of June and a sell by wo with 9 have the cyellow	8/09

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		095019	B. WING		1	R 8/2009
	PARK CARE CENTER		s	TREET ADDRESS, CITY, STATE, ZIP CODE 5000 BURROUGHS AVE. NE WASHINGTON, DC 20019	00/1	8/2009
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION SHOU REFERENCED TO THE APPROPRIAT	LD BE CROSS-	(X5) COMPLETION DATE
{F 371}	date and one (1) of o yellow colored subst	ge 9 one (1) loaf of bread with a tance on the top of the bread. s conducted on June 18, 2009 11:00 AM in the presence of	{F 37	 A walk through of the refrigerator was completed other items of concern. 	ted to identify	
	refrigerator: 1 ½ of 1 ½ cases of and yellow fuzzy grocucumbers. Four (4) of four (4) 5	mushy cucumbers with a white with on the skin of the -pound packages of shredded and red cabbage with a " Use		 Dietary Manager rethe importance of discar items. Dietary staff will "use By" dates on items refrigerator on weekly be discard as needed. Dietary Manager will findings to the monthly committee. 	ding expired monitor the in walk in asis and report	7/15/09
	Three (3) of three (3) shredded lettuce with 2009. Four (4) of four (4) 5 with a "Use By" date. One (1) of five (5) patouch and with a gree bottom of the buns. Four (4) of five (5) patouch, two (2) package 2009 and two (2) package 2009 and two (2) package 3009.	b) 5-pound packages of h a "Use By" date of June 11, b-pound packages of cole slaw of June 7, 2009. Cackages of hot dog buns hard to en, fuzzy substance on the cackages of hot dog buns hard to ges with sell by date of June 7, ckages with a sell by date of af of bread with a white-yellow				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SUI COMPLET	
			A. BUILDING			R
		095019	B. WING		06/1	8/2009
	PARK CARE CENTER		5	EET ADDRESS, CITY, STATE, ZIP CODE 000 BURROUGHS AVE. NE VASHINGTON, DC 20019		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD B REFERENCED TO THE APPROPRIATE DE	E CROSS-	(X5) COMPLETION DATE
{F 371}	Continued From pag	ge 10	{F 371}	F431		
	Employee #11 acknowledge time of the observation	owledged the findings at the ions.		Discontinued medicatio been removed from the me	\$4050 50c	6/18/09
{F 431} SS=D	F 431} 483.60(b), (d), (e) PHARMACY SERVICES		{F 431}	cart on Unit 2 North for Res	ident #1.	
33-0	2 5 5 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6		 Current Resident medical orders have been reviewed corrective action taken as in Licensed nurses have be 	with dicated.	7/15/09 7/15/09	
	labeled in accordance professional principle accessory and cautic expiration date where. In accordance with Stacility must store all compartments under	ce with currently accepted es, and include the appropriate onary instructions, and the		reeducated on medication of transcription, medication administration, and removing discontinued medication from medication carts. Unit Manawill monitor the carts weekly ensure discontinued drugs a removed from the carts.	order ong om agers y to	7/13/03
	permanently affixed controlled drugs liste Comprehensive Drug Act of 1976 and othe except when the faci drug distribution systems.	vide separately locked, compartments for storage of ed in Schedule II of the g Abuse Prevention and Control er drugs subject to abuse, lity uses single unit package tems in which the quantity d a missing dose can be readily		4. Tracking/trending of phy orders and medication administration will be report to the monthly QI/RM comm	ted	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING		R	
095019			B. WING		06/18/2009	
NAME OF PROVIDER OR SUPPLIER GRANT PARK CARE CENTER			5	STREET ADDRESS, CITY, STATE, ZIP CODE 5000 BURROUGHS AVE. NE WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES F BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD B REFERENCED TO THE APPROPRIATE DE	E CROSS-	(X5) COMPLETION DATE
{F 431}	This REQUIREMEN Based on observation medication carts and determined that facing discontinued medication and the second medication of the findings include on June 18, 2009, and the second medication of the second medicat	on of one (1) of five (5) d staff interview, it was lity staff failed to remove ation from the medication cart on the approximately 11:00 AM, tion of the medication pass for	{F 43	1. Protective floor mats for residents' in rooms 407, 413 and 436 were cleaned and a not stored on floor when be not occupied. 2. A walk through of each was completed to identify or	3, are ed is Unit ther	6/18/09 7/15/09
{F 441} SS=D	discontinued Vitamin mg from the medical mg from the medical A physician's telephoral June 9, 2009, directed tab po [by mouth] bid [by mouth] daily, Giv mouth] qd [daily] su A face-to-face interv 2009, at approximate #7 and 8. They ackn should have been rebeing discontinued. 483.65(a) INFECTION The facility must estage to the development of the develop	in C 500 mg and Zinc sulfate 220 tion cart. one order, signed and dated on ed "D/C [Discontinue] Vitamin C d [twice daily], D/C Zinc tab po e Multivite 1 [one] tab po [by pplement." iew was conducted on June 18, ely 11: 00 AM with Employees owledged that the medications emoved from the cart after ON CONTROL ablish and maintain an infection gned to provide a safe, table environment and to ment and transmission of an The facility must establish an gram under which it is, and prevents infections in the procedures, such as isolation an individual resident; and	{F 441	unoccupied beds with floor stored on the floor. 3. Housekeeping staff has re-educated on conducting environmental rounds. A new Housekeeping Director has been employed to complete corresof identified areas. Daily 5x environmental rounds are complete to by the safety manager with we initiated for correction at time discovery. 4. Results will be reported monthly QI/RM committee.	been w been ection week bonducted workers ne of	7/15/09

		IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
-			A. BUILDING		R		
095019		B. WIN	G	06/18/2009			
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	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFI TAG		BE CROSS-	(X5) COMPLETION DATE	
{F 441}	Corrective actions re This REQUIREMEN Based on observation tour, it was determine rooms observed, proon the floor next to the soiled. The environmental to AM to 12:30 PM and 18, 2009 in the presentation. The findings include Protective floor mats to the residents' und	Is not met as evidenced by: ons during the environmental ed that three (3) of 32 resident of tective floor mats were stored the residents' unoccupied bed our was conducted from 11:00 I 2:00 PM to 4:00 PM on June ence of Employees #12, 13 and is were stored on the floor next occupied bed soiled with	{F 4-	1. The following areas have treated for flying and craw 4 S training toilet, 4 S show 4 S janitor closet, 3 rd floor was public bathroom, room 320 shower room, and Room 20 Resident S 1 incident regard bugs was thoroughly invest the bed was cleaned by how staff and no bugs were four Resident S 1 does not have right lip. Staff thoroughly in the two other rooms identifune 16, 2009 with "bed Burone were found.	ling insects: rer room, woman's 0, 2 S 03. ding bed tigated, usekeeping nd. a swollen nvestigated fied on	7/08/09	
{F 469} SS=D	32 resident rooms of Employees #11, 12 a findings at the time of This is a repeat deficiency completed Ap 483.70(h)(4) PHYSIC CONTROL The facility must mai program so that the frodents.	and 13 acknowledged the of the observations.	{F 46	 Facility round was comidentify other areas of concorrective action taken as in Licensed staff has been 	ely eport", fully etermine s. itor the ensure led when	7/15/09 7/15/09	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		095019	B. WING		R		
NAME OF PROVIDER OR SUPPLIER GRANT PARK CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 5000 BURROUGHS AVE. NE WASHINGTON, DC 20019		18/2009	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION SH REFERENCED TO THE APPROPE	HOULD BE CROSS-	(X5) COMPLETION DATE	
{F 469}	Based on observation tour, it was determining tour, it was determining tour, it was determining to the main kitch areas and facility start Resident S1's swolled bite was the cause of the environmental to AM to 12:30 PM and 18, 2009 in the present 14. The findings include: 1. Flying and crawling following areas: 4 S training toilet at 14 S shower room at 14 S janitor closet at 13 S and floor woman's present 15 S shower room at 18 S and 18	ens during the environmental ed that flying and crawling ed in three (3) of 32 resident hen, and five (5) of 21 common off failed to fully investigate en lip to determine if an insect of the swelling. Our was conducted from 11:00 of 2:00PM to 4:00 PM on June ence of Employees #12, 13 and ence of Employee	{F 46	4. Results will be rep monthly QI/RM comm			

NAME OF PROMDER OR SUPPLIER GRANT PARK CARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 5000 BURROUGHS AVE. NE	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
RANT PARK CARE CENTER (#4) ID PRETRY TAG (#A) CONTINUED FROM INSTER PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (#A) CONTINUED FROM INSTER PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (#A) CONTINUED FROM INSTER PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (#A) CONTINUED FROM INSTER PRECEDED BY FULL REGULATORY OR PROVIDERS FLAN OF CORRECTION (#ACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (#A) CONTINUED FROM INSTER PROPRIATE DEFICIENCY) (#A) Continued From page 14 A face-to-face interview was conducted with Employee #16 on June 18, 2009 at 6.45 PM. He/she stated, "I looked at the bed. The linens were changed. The pilliow was not changed. I don't know if the bed and mattress were cleaned by housekeeping. I clidn't see any bugs on the bed." Although the incident was documented in the "Pest Sighting Log" on June 9, 2009, it was not documented on the "24 Hour Report" until June 12, 2009 as follows: "At 5 AM resident was observed with Inshirt print ips welling goes down" According to Employee #16, the "24 Hour Report" was discussed in the morning meeting that included all managers and administration. Additionally, Employee #16 stated that the above cited issue was discussed at a manager's meeting later that same day. However, Employee #3 stated that the/elshe was not informed that the cause of the resident's swollen lip was due to being "bitten by something." Entries into the "Pest Sighting Log" for June 16, 2009, included "Bed Bugs" in two (2) additional rooms. Face-to-face interviews were conducted on June 16, 2009 at 6.00 PM, with Resident S1, and S2 and F1, who were the residents of the two (2) additional rooms identified with bed bugs. The three (3) residents denied being bitten by "bugs." Resident			095019	B. WING		06/	7/7/1	
(F 469) (F	COSTA PARTICIPATO - CONTROL PROTECTO CONTROL SECURIO DE CONTROL SE CON		s	5000 BURROUGHS AVE. NE				
A face-to-face interview was conducted with Employee #16 on June 18, 2009 at 6:45 PM. He/she stated, "I looked at the bed. The linens were changed. The pillow was not changed. I don't know if the bed and mattress were cleaned by housekeeping. I didn't see any bugs on the bed." Although the incident was documented in the "Pest Sighting Log" on June 9, 2009, it was not documented on the "24 Hour Report" until June 12, 2009 as follows: "At 5 AM resident was observed with [his/her] right lip swollen. States something bite [bit] [him/her] while sleeping. Ice pack applied. Swollen [area] reduced at 5:30 am. (Physician) notified. Ordered Benadryl 25 mg po (orally) until right lip swelling goes down" According to Employee #16, the "24 Hour Report" was discussed in the morning meeting that included all managers and administration. Additionally, Employee #16 stated that the above cited issue was discussed at a manager's meeting later that same day. However, Employee #3stated that he/she was not informed that the cause of the resident's swollen lip was due to being "bitten by something." Entries into the "Pest Sighting Log" for June 16, 2009, included "Bed Bugs" in two (2) additional rooms. Face-to-face interviews were conducted on June 16, 2009 at 6:00 PM, with Resident S1, and S2 and F1, who were the residents of the two (2) additional rooms identified with bed bugs. The three (3) residents denied being bitten by " bugs." Resident	PREFIX	(EACH DEFICIENCY MUST	BE PRECEDED BY FULL REGULATORY	PREFIX	(EACH CORRECTIVE ACTION SH	OULD BE CROSS-	(X5) COMPLETION DATE	
	{F 469}	A face-to-face intervient Employee #16 on Judie He/she stated, "I lowere changed. The know if the bed and housekeeping. I didned the lowere changed in the lowere changed. The know if the bed and housekeeping. I didned the lowere changed in the lowere changed in the lowere change in	riew was conducted with une 18, 2009 at 6:45 PM. Oked at the bed. The linens pillow was not changed. I don't mattress were cleaned by n't see any bugs on the bed." It was documented in the "Pest ne 9, 2009, it was not "24 Hour Report" until June 12, to 5 AM resident was observed to swollen. States something bite sleeping. Ice pack applied. Seed at 5:30 am. (Physician) andryl 25 mg po (orally) until se down" If we #16, the "24 Hour Report" to morning meeting that included aministration. Additionally, and that the above cited issue was ager's meeting later that same loyee #3stated that he/she at the cause of the resident's to being "bitten by something." It Sighting Log" for June 16, Bugs" in two (2) additional was were conducted on June, with Resident S1, and S2 and sidents of the two (2) additional bed bugs. The three (3) ng bitten by "bugs." Resident	{F 469				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
					R	
095019			B. WING	3	06/18/2009	
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	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIATE DE	CROSS- COMPLÉTION	
{F 469}	Facility staff failed to cited incident to dete cause of Resident S facility staff failed to other rooms identifie	fully investigate the above ermine if an insect bite was the 1's swollen lip. Additionally, thoroughly investigate two (2) d on June 16, 2009 with "Bed was reviewed June 18, 2009.	{F 46	F514 1. The record for Resident Been updated to reflect curr of GYN results , evaluation o rape and inability to sleep.	ent status	
{F 514} SS=D	The facility must mai resident in accordanstandards and practi	ntain clinical records on each ce with accepted professional ces that are complete; ted; readily accessible; and	{F 5⁴	2. Current Resident charts reviewed for accurate docum of hospital visits results on mrecord.	nentation	
	information to identify resident's assessment services provided; the screening conducted notes.	y the resident; a record of the nts; the plan of care and e results of any preadmission by the State; and progress		3. Licensed Staff has been a educated on the importance documenting the results of his visits, test results, evaluation treatments and conditions of Resident record. Unit Mange	of ospital os, on the er will	
	Based on record revi (1) of 18 sampled res facility staff failed to a fatter returning from a hospital. Resident # The findings include: A review of Resident following nurse's note AM, "Resident transfe	ew and staff interview for one sidents, it was determined that document the resident's status in emergency transfer to the 3. #3's record revealed the e dated June 17, 2009 at 10:30		review records daily X 5 days to ensure compliance. 4. DON or designee will rev weekly and report findings to monthly QI/RM committee.	iew	
		ity to sleep and alleged rape by				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDIN	NG	R	
095019			B. WING _		06/1	8/2009
NAME OF PROVIDER OR SUPPLIER GRANT PARK CARE CENTER			REET ADDRESS, CITY, STATE, ZIP CODE 5000 BURROUGHS AVE. NE WASHINGTON, DC 20019			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION SHOU REFERENCED TO THE APPROPRIAT	LD BE CROSS-	(X5) COMPLETION DATE
{F 514}	PM) documented, "F stable condition with for blood pressure a No signs or symptor closely monitored dustaff members according to care." There was no documer record regarding the gynecological test, estable conditions with the conditions and the conditions are conditions as a stable conditions are conditions as a stable condition of the conditions are conditions as a stable condition of the conditions are conditions as a stable condition of the conditions are conditions as a stable condition of the conditions are conditions as a stable condition of the conditio	d June 17, 2009 at 2255 (10:55) Returned from [Hospital] in a orders to follow up with doctor and any concerning symptoms. In sof distress noted. Resident uring shift and assisted by two radingly. Will continue with plan mentation in the resident's results of the hospital's evaluation and treatment of the resident's inability to sleep.	{F 514]			
	Day shift (7:00 AM to transferred to [hospire valuation and treatment inability to sleep and nurse." Evening shift (3:00 F from [hospital] in sta (follow up) with doctor concerning symptom afebrile." Night shift (11:00 PM	our report were as follows: o 3:00 PM): "Resident tal] for gynecological test and ment due to complaint of alleged rape by a female PM to 11:00 PM): "Returned ble condition with orders to f/u or for blood pressure and any as. Remains stable and If to 7:00 AM): "Resident f/u appointment. No distress bally responsive."				
	record that facility staresults of the hospital claim of being raped A face-to-face intervi	ew was conducted with e 18, 2009 at 2:50 PM. He/she				9 P

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
	095019			3		06/1	R 18/2009
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 PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE		LD BE CROSS-	(X5) COMPLETION DATE	
{F 514}	telling us that [Reside found on the gyn exphone call because the next shift. The rit. I did tell them about A face-to-face intervent Employee #8 on Jurreviewed the resident there was no do resident's status about 100 miles in the control of the	dent #3] was okay. Nothing was am. I did not document the I passed the information onto next shift was suppose to write out it." Tiew was conducted with ne 18, 2009 at 1:30 PM. He/she nt's record and acknowledged ocumentation regarding the out the alleged rape after ospital. The record was	{F 51	14}			
2.	is.						