

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD02-0022	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/21/2009
--	--	--	--

NAME OF PROVIDER OR SUPPLIER KNOLLWOOD HSC	STREET ADDRESS, CITY, STATE, ZIP CODE 6200 OREGON AVE NW WASHINGTON, DC 20015
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

L 000 Initial Comments

An annual licensure survey and incident investigation (09-I-2429, DC00001737) was conducted on May 19 through 21, 2009. The following deficiencies were based on observations, staff and resident interviews and record review. The total sample was 15 residents based on a census of 58 on the first day of survey. There were 10 supplemental

L 000

This plan of correction is prepared and/or executed solely because it is required by the Provisions of Federal and State law. The plan of correction is ADF/Knollwood's credible Allegation of Compliance.

L 051 3210.4 Nursing Facilities

A charge nurse shall be responsible for the following:

- (a) Making daily resident visits to assess physical and emotional status and implementing any required nursing intervention;
- (b) Reviewing medication records for completeness, accuracy in the transcription of physician orders, and adherences to stop-order policies;
- (c) Reviewing residents' plans of care for appropriate goals and approaches, and revising them as needed;
- (d) Delegating responsibility to the nursing staff for direct resident nursing care of specific residents;
- (e) Supervising and evaluating each nursing employee on the unit; and
- (f) Keeping the Director of Nursing Services or his or her designee informed about the status of
 - A. Based on observation, staff interviews and record review for three (3) of 15 sampled

L 051

(X5) COMPLETE DATE

Health Regulation Administration
Barbara O. Custino, LNUHA
 LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE
Administrator

(X6) DATE
6/25/09

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD02-0022	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/21/2009
--	--	--	--

NAME OF PROVIDER OR SUPPLIER KNOLLWOOD HSC	STREET ADDRESS, CITY, STATE, ZIP CODE 6200 OREGON AVE NW WASHINGTON, DC 20015
---	---

(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)	
L 051	<p>Continued From page 1</p> <p>residents, it was determined that the charge nurse failed to initiate a care plan with appropriate goals and approaches for one (1) resident for skin tears, one (1) resident for self medication and one (1) resident for incontinence. Residents #5, 8 and 12.</p> <p>The findings include:</p> <p>1. The charge nurse failed to develop a care plan for skin tears for Resident #5. A review of Resident #5's nurses' notes revealed the following: April 4, 2009 at 7:05 PM: " CNA brought resident to nurses station reporting small skin tear right elbow ... " April 13, 2009 at 12:00 AM, "...CNA observed and reported skin tear right elbow area ..." April 20, 2009 at 11:50 PM, "...skin tear below the right knee ..."</p> <p>A review of the resident's care plan last updated March 12, 2009, revealed that The charge nurse failed to initiate a care plan with appropriate goals and approaches for skin tears.</p> <p>A face-to-face interview with Employee #4 was conducted on May 21, 2009 at 2:30 PM. He/she acknowledged that a care plan for skin tears should have been initiated. The record was reviewed May 21, 2009.</p> <p>2. The charge nurse failed to initiate a care plan for self administration of Baclofen for Resident #8.</p> <p>A review of the resident's clinical record revealed "Physician's Order Form" sheets for May 2008 through May 2009 dated and signed by the physician that directed:</p>	L 051	<p>It is ADF/Knollwood's policy and practice to initiate a care plan with appropriate goals and approaches for all residents.</p> <p>1(a) Resident #5's current care plan addresses appropriate goals and approaches for skin tears.</p> <p>1(b) Resident #8's current care plan addresses appropriate goals and approaches for self-medication of Baclofen three times daily.</p> <p>1(c) Resident #12's current continence status was care planned with appropriate goals and approaches.</p> <p>2(a) An audit was conducted to ensure that there were care plans developed for residents who sustained a skin tear.</p> <p>2(b) An audit on physician orders was conducted by the MDS coordinator and the audit revealed that there are no other residents who self medicate.</p> <p>2(c) Residents' continence status will be care planned using appropriate goals and approaches to manage the resident's incontinence. ADF/Knollwood has initiated the bladder and bowel program.</p> <p>3(a) The licensed nurses will be re educated to care plan residents who sustained a skin tear using appropriate interventions. The MDS Coordinator or designee will conduct a random audit every month X 6 to ensure compliance.</p>	<p>5/25/09</p> <p>5/25/09</p> <p>7/21/09</p> <p>7/21/09</p> <p>7/21/09</p> <p>7/21/09</p> <p>7/21/09</p>

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD02-0022	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/21/2009
--	--	--	--

NAME OF PROVIDER OR SUPPLIER KNOLLWOOD HSC	STREET ADDRESS, CITY, STATE, ZIP CODE 6200 OREGON AVE NW WASHINGTON, DC 20015
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	<p>Continued From page 2</p> <p>"Baclofen Tab [Tablet] 20 mg, take 1 tablet by mouth three times daily at 8AM, 4PM, and 12 midnight for muscle spasms may self administer. Origin [original order]: 05/05/2008 "</p> <p>" Please observe resident self administration of Baclofen weekly on Tuesday at 4 PM Orig [original order]: 09/15/2006 "</p> <p>According to monthly Medication Administration Records [MAR] from May 2008 through May 2009, the resident self administered Baclofen weekly on Tuesdays.</p> <p>The resident's clinical record lacked evidence that the charge nurse initiated a care plan with appropriate goals and approaches for self administration of Baclofen.</p> <p>A face-to-face resident interview was conducted with Resident #7 on May 20, 2009 at approximately 11:30 AM. The resident said "I have MS [Multiple Sclerosis] I can only do so much and therefore try to do as much as possible for myself. I like to administer my own medication but right now I administer Baclofen once a week. I am very involved in my plan of care, make my own physician appointments. Tomorrow is my care plan day and I have this funeral at 12:00 PM that I must attend. "</p> <p>A face-to-face interview was conducted on May 20, 2009 at approximately 2:00 PM with Employees #7 and 8. After reviewing the resident's record, they both acknowledged that the resident's clinical record lacked evidence that a care plan was initiated for self administration of Baclofen for the resident. The record was reviewed May 21, 2009.</p>	L 051	<p>3(b) Licensed nurses will be inserviced on care plans, to address goals and approaches for self-administration of Baclofen. The MDS coordinator will conduct a random chart audit on a monthly basis for the next 4 months and quarterly thereafter x 4 to ensure compliance.</p> <p>3(c) The interdisciplinary team was instructed to put together an individualized care plan for each incontinent resident as well as documenting interventions. The MDS coordinator will conduct a random chart audit on a monthly basis for the next 4 months and thereafter quarterly to ensure compliance.</p> <p>4. The care plans for skin tears, self-medication and incontinence care will randomly be audited every month and the results of the audit will be presented to the Quality Assurance Committee until the Committee determines that compliance has been achieved.</p>	<p>7/21/09</p> <p>7/21/09</p>

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD02-0022	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/21/2009
--	--	--	--

NAME OF PROVIDER OR SUPPLIER KNOLLWOOD HSC	STREET ADDRESS, CITY, STATE, ZIP CODE 6200 OREGON AVE NW WASHINGTON, DC 20015
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	<p>Continued From page 3</p> <p>3. The charge nurse failed to develop a care plan for incontinence for Resident #12.</p> <p>A review of the resident's annual Minimum Data Set assessment completed May 14, 2009, coded the resident in Section H (Continence in last 14 days) as being usually incontinent of bowel and bladder function.</p> <p>A review of the resident's care plan, last updated May 14, 2009, revealed a care plan entitled "Unable to perform self-care secondary to cognitive loss." Under approaches was an entry that directed to toilet the resident every two hours.</p> <p>There was no evidence in the record that a care plan with appropriate goals and approaches to restore or improve normal bowel and bladder function was initiated by the facility.</p> <p>A face-to-face interview was conducted with Employee #8 was conducted on May 21, 2009 at 10:30 AM. He/she acknowledged that there was no care plan for bowel and bladder incontinence. The record was reviewed May 21, 2009.</p> <p>B. Based on observations, staff interview and record review for one (1) of 15 sampled residents and one (1) of 10 supplemental residents reviewed, it was determined that The charge nurse failed to review and revise care plans for: one (1) resident for incontinence, anticoagulant therapy and long term memory loss and one (1) resident after a behavioral episode. Residents #9 and S1.</p> <p>The findings include:</p>	L 051		

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD02-0022	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/21/2009
--	--	--	--

NAME OF PROVIDER OR SUPPLIER KNOLLWOOD HSC	STREET ADDRESS, CITY, STATE, ZIP CODE 6200 OREGON AVE NW WASHINGTON, DC 20015
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	<p>Continued From page 4</p> <p>1. The charge nurse had developed two (2) care plans related to incontinence for Resident #9, who was assessed as continent, one (1) related to bleeding from anticoagulant therapy, who was not receiving anticoagulant therapy medication and one (1) for long term memory loss who was assessed with no long term memory problems.</p> <p>A. Review of Resident #9's record revealed an admission Minimum Data Set (MDS) assessment completed December 31, 2007 that coded the resident as frequently incontinent of bladder in Section H (Continence in the last 14 days). The quarterly MDS assessments completed March 27 and June 19, 2008 coded the resident as occasionally incontinent in Section H.</p> <p>The quarterly MDS assessments completed September 11 and December 4, 2008 and March 10, 2009, and a significant change MDS completed April 30, 2009, coded the resident in Section H as continent of bowel and bladder function.</p> <p>A review of the resident's care plan last updated April 30, 2009, revealed the following: " Risk for UTI (urinary tract infection) related to incontinent bladder. Risk for skin breakdown related to incontinence of bladder and impaired mobility." The above cited care plans failed to reflect the resident's continent status.</p> <p>B. A review of the resident's care plans revealed the following: " Risk for bleeding related to Lovenox and ASA (aspirin)."</p> <p>The resident was hospitalized on April 14, 2009 and returned to the facility on April 24, 2009.</p>	L 051	<p>It is ADF/Knollwood's policy and practice to review and revise care plans after a change in the resident's status occurs.</p> <p>1(a) Resident # 9 care plan was reviewed and revised to mirror the residents' current condition and long-term memory loss and to reflect changes in medication. Resident #9 has only 1 care plan related to incontinence status.</p> <p>1(b) Resident S1's care plan was updated to reflect the behavior documented in the social worker's notes and to plan approaches to change or avoid such behaviors.</p> <p>2(a) The Interdisciplinary team has reviewed care plans for residents' condition changes and revised as needed.</p> <p>2(b) The interdisciplinary team has care planned for unusual behaviors documented in the clinical records of all residents.</p> <p>3. The Director of Nursing or designee will conduct an audit of the care plans every week X 4 then monthly thereafter to ensure that the care plans reflect the resident's current condition.</p> <p>4. The results of the audit will be presented to the Quality Assurance Committee until it is determined that compliance has been achieved.</p>	<p>7/21/09</p> <p>7/21/09</p> <p>7/21/09</p> <p>7/21/09</p> <p>7/21/09</p>

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD02-0022	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/21/2009
--	--	--	--

NAME OF PROVIDER OR SUPPLIER KNOLLWOOD HSC	STREET ADDRESS, CITY, STATE, ZIP CODE 6200 OREGON AVE NW WASHINGTON, DC 20015
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	<p>Continued From page 5</p> <p>physician prior to the hospitalization but not included in the list of medications after being discharged with from the hospital. According to the plan of care signed by the physician on April 28, 2008, the resident was not prescribed Aspirin or Lovenox post hospitalization. The care plan was not revised to reflect the change in the resident's medication.</p> <p>C. A review of the resident's care plans revealed the following: "Compromised long term and short term memory loss and impaired judgment."</p> <p>According to the admission MDS assessment completed December 31, 2007 and the quarterly MDS assessments completed March 27, June 9, September 11 and December 4, 2008 and March 10, 2009 and the significant change MDS completed April 30, 2009, the resident was coded in Section B (Cognitive Patterns) for short term memory problems. However, the resident was not coded for long term memory problems.</p> <p>A face-to-face interview with Employee #4 was conducted on May 21, 2009 at 7:00 AM. He/she confirmed that the resident was continent of bowel and bladder function, was not currently receiving anticoagulant therapy and did not have long term memory problems. He/she acknowledged that the above cited care plans did not reflect the resident's current status. The record was reviewed May 20, 2009.</p> <p>2. The charge nurse failed to revised and review Resident S1's care plan after a behavioral episode.</p> <p>A review of Resident S1's record revealed the following social medical notes dated November</p>	L 051		

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD02-0022	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/21/2009
--	--	--	--

NAME OF PROVIDER OR SUPPLIER KNOLLWOOD HSC	STREET ADDRESS, CITY, STATE, ZIP CODE 6200 OREGON AVE NW WASHINGTON, DC 20015
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

L 051 Continued From page 6

24, 2008, "Resident found in bed with male resident without top on but in depends, resident appeared to only be cuddling ..."

There was no evidence that additional goals and approaches were initiated after the above cited episode. There was no evidence in the resident's record that any similar episodes had occurred after November 24, 2008.

A face-to-face interview was conducted with Employee #4 on May 20, 2009 at 9:00 AM. He/she acknowledged that no approaches were initiated after the above cited episode. The record was reviewed May 20, 2009.

C. Based on record review and staff interviews for three (3) of 15 sampled residents and one (1) of 10 supplemental residents, it was determined that The charge nurse failed to provide care in accordance with each resident's plan of care: for two (2) residents observed in bed without a floor mat, one (1) resident observed unattended in his/her room, and one (1) resident whose wheelchair was not locked at the bedside. Residents #1, 3, 11 and JH3.

The findings include:

1. The charge nurse failed to implement place a mat at the resident's bedside for Resident #1.

During the environment tour conducted on May 19, 2009 at 12:00 PM, Resident #1 was observed sleeping in a low bed with out a fall/floor mat adjacent to his/her bed.

A review of the resident's record revealed a care plan entitled, "...History of falls" that was last reviewed May 6, 2009. Included in the

L 051

It is ADF/Knollwood's policy and practice to provide care in accordance with each resident's plan of care.

1(a) The floor mat was placed at resident #1's beside. 5/21/09

1(b) The wording in resident # 3's care plan was changed to: " Do not leave resident #3 in her room alone sitting in her wheelchair." 7/21/09

1(c) Resident #11 approaches for fall prevention are being followed and the wheelchair is locked at his bedside when he is in bed. 7/21/09

1(d) The floor mat was placed at resident JH3's bedside. 7/21/09

2. Interventions have been put in place for residents who are at risk for falls. These will be shared with the line staff during report. 7/21/09

The nursing staff will be re- educated to follow the interventions put in place for the residents who are at risk for falls. 7/21/09

3. An audit will be conducted weekly X 4, then monthly X 4, then quarterly thereafter by the Director of Nursing or designee to ensure that the interventions for the residents at risk for falls are followed. 7/21/09

4. The results of the audit will be reported to the Quality Assurance Committee until the Committee determines that compliance has been achieved.

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD02-0022	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/21/2009
--	--	--	--

NAME OF PROVIDER OR SUPPLIER KNOLLWOOD HSC	STREET ADDRESS, CITY, STATE, ZIP CODE 6200 OREGON AVE NW WASHINGTON, DC 20015
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

L 051	<p>Continued From page 7</p> <p>approaches was, "Low bed with mat on the floor."</p> <p>The observation was made in the presence of Employees #13 and 14 at the time of the observation.</p> <p>A face-to-face interview was conducted on May 20, 2009 at 2:00 PM with Employee #3. He/she acknowledged that the mat was not placed at the resident's bedside. The record was reviewed on May 20, 2009.</p> <p>2. The charge nurse failed to follow identified approaches for Resident #3 after a fall with injury.</p> <p>A review of the resident's clinical record revealed that the resident fell without injury on the following days: November 26, 2008, December 4, 3008, December 9, 2008, March 26, 2009, and March 27, 2009. On February 13, 2009, the resident fell and sustained a hematoma and laceration to the forehead.</p> <p>A review of the resident's clinical record revealed a " H/O [History of] fall with injury" care plan started on November 13, 2008 with several entries corresponding to the aforementioned fall dates. Under " Approach frequency" , for February 13, 2009 that corresponded to the date the resident fell with injury, the entry stated: " Do not leave resident in Rm [Room] unattended"</p> <p>The resident was observed on May 20, 2009 at approximately 3:30 PM asleep in a low bed with the side rails up and floor mats on both sides of the bed. He/ she was alone in the room, unattended.</p>	L 051		
-------	--	-------	--	--

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD02-0022	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/21/2009
--	--	--	--

NAME OF PROVIDER OR SUPPLIER KNOLLWOOD HSC	STREET ADDRESS, CITY, STATE, ZIP CODE 6200 OREGON AVE NW WASHINGTON, DC 20015
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

L 051

Continued From page 8

the side rails up and floor mats on the floor on both sides of the bed. He/ she was alone in the room unattended. According to Employee # 9, the resident is very active when awake and staff avoid interrupting his/her sleep.

A face-to-face interview was conducted with Employees #7 and 8 on May 21, 2009 at approximately 8:30 AM. After reviewing the resident's clinical record including the aforementioned care plan, they both acknowledged the above cited care plan approach was not followed. The record was reviewed May 21, 2009

3. The charge nurse failed to follow identified approaches for Resident #11 who had multiple falls.

A review of Resident #11's nurses' notes revealed the following:
 January 12, 2009 at 2:45 PM: "Resident found on floor of room ..."
 February 18, 2009 at 9:00 AM: "Found on floor at bedside ...MD notified ..."
 March 14, 2009 at 5:00 PM: "On floor between the bathroom door in room ...MD notified ..."
 March 19, 2009 at 9:00 PM: "Tried to walk- couldn't ...fell-getting back into the chair ... [Physician] notified ..."
 March 31, 2009 at 8:30 PM: "Slid off side of bed ...MD notified ..."
 April 3, 2009 at 3:30 PM: "Found sitting on floor by bedside ...MD notified ..."
 April 24, 2009 at 7:30 PM: "Got out of chair, alarm went off ...sitting on floor ...MD notified ..."
 May 5, 2009 at 7:00 PM: "Sitting at bedside with staff present. Slid off side of bed ...MD notified ..."

Interventions had been put into place after each

L 051

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD02-0022	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/21/2009
--	--	--	--

NAME OF PROVIDER OR SUPPLIER KNOLLWOOD HSC	STREET ADDRESS, CITY, STATE, ZIP CODE 6200 OREGON AVE NW WASHINGTON, DC 20015
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	<p>Continued From page 9</p> <p>fall. The resident's care plan entitled, "Resident with history of multiple falls, gait unsteady, unassisted transfers, mobility impairment, disease process of Parkinson's and Dementia" was reviewed. The intervention put into place after the fall that occurred on March 31, 2009 was, "Keep wheelchair locked and close to the bed while the resident is in bed. Keep the bed raised slightly below the level of the wheelchair to facilitate transfer if resident needs to do so."</p> <p>An observation of Resident #11 was conducted on May 21, 2009 at 6:40 AM. The resident was sleeping in bed which was slightly elevated, with the wheelchair stored in the resident's bathroom.</p> <p>A face-to-face interview was conducted with Employees #23 and 24 on May 21, 2009 at 6:30 AM. Both employees acknowledged that Resident #11 always called for assistance and that the wheelchair was kept in the bathroom, not at the bedside.</p> <p>A face-to-face interview was conducted with Employee #4 on May 21, 2009 at 7:00 AM. He/she acknowledged that the care plan approach was not implemented.. The record was reviewed May 21, 2009.</p> <p>4. The charge nurse failed to implement place a floor mat at the resident's bedside for Resident JH3.</p> <p>During the environmental tour conducted on May 19, 2009 at 2:00 PM, Resident JH3 was observed awake and lying in a low bed. The bedside floor mat was observed stored in the closet.</p>	L 051		

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD02-0022	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/21/2009
--	--	--	--

NAME OF PROVIDER OR SUPPLIER KNOLLWOOD HSC	STREET ADDRESS, CITY, STATE, ZIP CODE 6200 OREGON AVE NW WASHINGTON, DC 20015
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	<p>Continued From page 10</p> <p>reviewed March 26, 2009. Included in the approaches was, "Low bed with mat on the floor."</p> <p>A physician's order signed April 6 and May 6, 2009, directed, "Floor mat to left side of bed."</p> <p>A face-to-face interview was conducted with Employee #25 at the time of the observation. When queried about why the floor mat was in the closet, the employee stated that he/she had only left a few minutes to get the nurse to give</p>	L 051		
L 052	<p>3211.1 Nursing Facilities</p> <p>Sufficient nursing time shall be given to each resident to ensure that the resident receives the following:</p> <p>(a) Treatment, medications, diet and nutritional supplements and fluids as prescribed, and rehabilitative nursing care as needed;</p> <p>(b) Proper care to minimize pressure ulcers and contractures and to promote the healing of ulcers:</p> <p>(c) Assistants in daily personal grooming so that the resident is comfortable, clean, and neat as evidenced by freedom from body odor, cleaned and trimmed nails, and clean, neat and well-groomed hair;</p> <p>(d) Protection from accident, injury, and infection;</p> <p>(e) Encouragement, assistance, and training in self-care and group activities;</p>	L 052		

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD02-0022	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/21/2009
--	---	--	---

NAME OF PROVIDER OR SUPPLIER KNOLLWOOD HSC	STREET ADDRESS, CITY, STATE, ZIP CODE 6200 OREGON AVE NW WASHINGTON, DC 20015
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

L 052 Continued From page 11

his or her own clothing; and shoes or slippers, which shall be clean and in good repair;

(2)Use the dining room if he or she is able; and

(3)Participate in meaningful social and recreational activities; with eating;

(g)Prompt, unhurried assistance if he or she requires or request help with eating;

(h)Prescribed adaptive self-help devices to assist him or her in eating independently;

(i)Assistance, if needed, with daily hygiene, including oral care; and

j)Prompt response to an activated call bell or call for help.

Based on observations, staff interview and record review for four (4) of 15 sampled residents and two (2) of 10 supplemental residents, it was determined that sufficient nursing time was not given to each resident as evidenced by failing to: follow the physician's orders for medication administration for three (3) residents, follow physician orders for placement of a floor mat and bed alarm for one (1) resident, crush medications identified as non-crushable for one (1) resident and clarify physician's orders for blood pressure parameters and blood pressure medications for one (1) resident. Residents #2, 3, 5, 8, JH1 and JH2.

The findings include:

L 052

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD02-0022	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/21/2009
--	--	--	--

NAME OF PROVIDER OR SUPPLIER KNOLLWOOD HSC	STREET ADDRESS, CITY, STATE, ZIP CODE 6200 OREGON AVE NW WASHINGTON, DC 20015
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

L 052

Continued From page 12

revealed facility staff failed to administer cardiac medications in accordance with physician's orders.

According to the history and physical examination completed by the physician on April 14, 2009, Resident #2's diagnoses included: Failure to Thrive; Percutaneous Endoscopic Gastrostomy (PEG); Cardiac Dysrhythmias; Dementia, Colitis and Hypothyroidism.

Physician's orders signed May 7, 2009 directed: Amiodarone 200 mg 1 tablet daily via PEG for arrhythmia (original date 1/23/09) and Digoxin 0.125 mg 1 tablet daily via PEG for arrhythmia (original date 1/23/09) - hold for heart rate less than 60 beats per minute (bpm).

The Medication Administration Record (MAR) for the month of March 2009 revealed Amiodarone and Digoxin were held on March 21, 2009 as evidenced by annotations on the reverse side of the MAR for each of the medications, "9 AM ...hold for low pulse." The MAR revealed the resident's 9AM pulse was assessed at 74 and 76 beats per minute.

A face-to-face interview was conducted with Employee #3 on May 20, 2009 at approximately 3:15 PM. In response to a query regarding the omission of the cardiac medications, he/she agreed that the resident's heart rate on the morning of March 21, 2009 was within acceptable parameters for administration of the medication. He/she wasn't sure why the MAR revealed the medications were omitted. He/she stated that it would be investigated. No further evidence relative to the omission of the medications was provided.

L 052

It is ADF/Knollwood's policy and practice to provide each resident with 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.

1(a) Resident #2 is receiving her cardiac medication according to the physician's order.

1(b) Resident #3 is receiving her medications per physician's order.

1(c) Resident #5's floor mat and bed alarm are in place. The bed alarm is being checked for proper functioning and positioning on every shift.

1(d) The Solutab ordered for resident # 8 is being administered as directed per physician's order.

1(e) Resident JH1's patch is administered and replaced per physician's order.

1(f) Resident #JH2's order and parameter for blood pressure medications were clarified.

5/21/09

5/21/09

5/21/09

5/22/09

5/25/09

5/21/09

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD02-0022	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/21/2009
--	--	--	--

NAME OF PROVIDER OR SUPPLIER KNOLLWOOD HSC	STREET ADDRESS, CITY, STATE, ZIP CODE 6200 OREGON AVE NW WASHINGTON, DC 20015
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

L 052 Continued From page 13

There was no evidence of any untoward affect sustained by the resident secondary to the omission of the medications in the clinical record. The record was reviewed May 19, 2009.

2. Facility staff failed to ensure that the residents were free medication errors. Resident #3.

A review of the physician's order signed and dated on May 6, 2009 directed " Tylenol (Acetaminophen) 500mg tab [1] tab [po] [tid] for back pain" and Artificial tears solution " Instill [2] drops both eyes three times daily for dry eyes"

On May 19, 2009, at approximately 10:00 AM, during the medication pass, Employee #9 was observed administering two (2) tablets of Acetaminophen 500mg orally and instilling one (1) drop of Liqui Tears (Artificial tears) into each eye to Resident #3.

A face-to-face interview was conducted on May 20, 2009 at approximately 1:30 PM with Employee #9. He/she acknowledged that the resident received two (2) tablets of Acetaminophen instead of one (1) tablet. Additionally, Employee #9 acknowledged that he/she administered one (1) drop of Artificial Tears solution in each eye to the resident.

3. Facility staff failed to follow physician's orders for the placement of a floor mat and bed alarm for Resident #5.

A review of Resident #5's record revealed a physician's order initiated March 9, 2009 and most recently renewed May 1, 2009, that directed, "Bed alarm - check for proper.

L 052

2. The licensed nurses were re-educated to follow physician's instructions when completing a medication administration, the importance of following the ordered dosage of medication, to keep the mats on the floor and the bed alarms on the beds as directed by the plan of care, the importance of administering resident's medication according to the instructions for medications that should not be crushed, to ensure that the resident's patch is applied per physician's order and checked to ensure that the patch is present on the resident's body after placement, and to clarify orders required to administer the medications that can affect the blood pressure when the blood pressure is low.

3. A random audit of the residents receiving cardiac medication, medication administration, floor mats and bed alarms, medications that should not be crushed, residents with a patch, and residents on blood pressure medications will be completed to ensure compliance. The audits will be completed by the Director of Nursing or designee every week X 4 then every month X 4, then every quarter x 3.

4. The result of these audits will be presented to the Quality Assurance Committee until the Committee determines compliance.

7/21/09

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD02-0022	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/21/2009
--	--	--	--

NAME OF PROVIDER OR SUPPLIER KNOLLWOOD HSC	STREET ADDRESS, CITY, STATE, ZIP CODE 6200 OREGON AVE NW WASHINGTON, DC 20015
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

L 052

Continued From page 14

A physician's order initiated March 19, 2009 and most recently renewed May 1, 2009 directed, "Floor mats to both sides of bed q shift."

An observation of Resident #5's room was conducted on May 19, 2009 at 2:45 PM and May 20, 2009 at 7:30 AM. A floor mat and bed alarm were not observed on either date.

A face-to-face interview view was conducted on May 20, 2009 at 7:40 AM with Employee #4. He/she checked the resident's room and acknowledged that a bed alarm and a floor mat were not present. The record was reviewed May 20, 2009.

4. Facility staff failed to follow "Nursing 2008 Handbook", Lippincott, 28th Ed. pg 724, under "Nursing Considerations" for the administration of Prevacid SoluTab for Resident #8.

The facility's "Nursing 2008 Handbook", Lippincott, 28th Ed. pg 724, under Nursing Considerations for Prevacid, stipulated, " ... dissolve a 15 mg tablet in 4 ml water and give with in 15 minutes ..." Medication label states " Do not crush or chew"

On May 19, 2009, at approximately 10:00 AM, during the medication pass, Employee #9 was observed crushing Lisinopril 40 mg tablet, Levothyroxine 112mg tablet and the Prevacid 15 mg solutab together to administer to Resident #8. Employee #9 was interrupted by the surveyor before the medication was given to the resident.

A face-to-face interview was conducted at that same time with Employee #9. He/she stated that

L 052

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD02-0022	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/21/2009
--	--	--	--

NAME OF PROVIDER OR SUPPLIER KNOLLWOOD HSC	STREET ADDRESS, CITY, STATE, ZIP CODE 6200 OREGON AVE NW WASHINGTON, DC 20015
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	<p>Continued From page 15</p> <p>Employee #2 to find out how to give the medication.</p> <p>5. Facility staff failed to follow physician order for administering the Exelon patch for Resident JH1.</p> <p>A review of the physician's order signed and dated April 8, 2009 directed, " Exelon Patch 4.6 mg/24 hr, Apply [1] one patch to rotating sites daily."</p> <p>The manufacture's package insert stipulates, " Bathing does not affect the patch. If the patch falls off, a new patch should be applied for the rest of the day, then replace the patch the next day at the same time as usual."</p> <p>On May 20, 2009 at approximately 9:40 AM during the medication pass Employee #19 was observed placing the Exelon patch on to Resident JH1's upper right chest. At this time, no Exelon patch was observed on the resident.</p> <p>A face-to-face interview was conducted on May 20, 2009 at 2:00 PM, Person #1 stated that he/she did not see the patch when they a wash-up the resident this morning at approximately 9:00 AM.</p> <p>A face-to-face interview was conduct at that same time with Employee #19. He/she stated that he/she did not see a patch on the resident before he/she placed the new patch on the resident.</p> <p>6. Facility staff failed to clarify the physician's order and parameters for blood pressure (BP) for Resident JH2.</p>	L 052		

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD02-0022	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/21/2009
--	--	--	--

NAME OF PROVIDER OR SUPPLIER KNOLLWOOD HSC	STREET ADDRESS, CITY, STATE, ZIP CODE 6200 OREGON AVE NW WASHINGTON, DC 20015
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

L 052 Continued From page 16
hold BP Rx, If BP >180/100 call MD"

On May 19, 2009 at approximately 10:15 AM during the medication pass, Employee #10 took Resident JH2' s blood pressure (BP). The BP measure was 95/47. Employee #10 did not administer the Lisinopril 10 mg tablet. Employee #10 administered the following oral medications: Carvedilol 6.25 mg tablet, Calcium w/D 600-400 tablet, Aricept 5 mg tablet, Citalopram 19 mg , Evista 60 mg, KCl 10 mEq tablet, Furosemide 40 mg tablet, Docusate 100 mg Capsule and one (1) Metamucil packet. The Carvedilol 6.25 mg tablet was not held as per physician order.

A face-to-face interview was conducted on May 19, 2009 at approximately 2:00 PM with Employee #10. He/she stated that the physician wanted to hold the Lisinopril 10 mg tablet only. Employee #10 clarified the order for the Lisinopril 10 mg tablet with the physician that

L 052

L 083 3216.4 Nursing Facilities

Physical restraints shall not be applied unless:

(a)The facility has explored or tried less restrictive alternatives to meet the resident's needs and such trails have bene documented in the resident's medical record as unsuccessful;

(b)The restraint has been ordered by a physician for a specified period of time;

(c)The resident is released, exercised and toileted at least every two (2) hours,except when a resident's rest would be unnecessary disturbed.

L 083

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD02-0022	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/21/2009
--	--	--	--

NAME OF PROVIDER OR SUPPLIER KNOLLWOOD HSC	STREET ADDRESS, CITY, STATE, ZIP CODE 6200 OREGON AVE NW WASHINGTON, DC 20015
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 083	<p>Continued From page 17</p> <p>decline in the resident's physical, mental psychological or functional status; and</p> <p>(e)The use of the restraint is assessed and re-evaluated when there is a significant change in the resident's condition.</p> <p>This Statute is not met as evidenced by: Based on observations, staff and resident interviews and record review for two (2) of 15 sampled residents, it was determined that the facility failed to engage in a systematic and on-going assessment for the use of the least restrictive restraints. Residents #3 and 12.</p> <p>The findings include:</p> <p>1. Facility staff failed to perform on-going assessments for a least restrictive device for Resident #3's seat belt.</p> <p>The resident was observed on May 19, 2009 at approximately 10:00 AM through 12:00 PM in the day room across from the nursing station participating in various activities. The resident was observed with a fastened seat belt in place.</p> <p>Resident #3 was observed on May 19, 2009 at approximately 12:15 PM at lunch with three (3) other residents in a private room away from the dining room to provide decreased distraction. The resident talked non-stop through out the dining period. The seat belt was observed in place.</p> <p>The resident was coded on the annual Minimum Data Set assessment completed on October 7, 2008, and the quarterly MDS assessments completed December 31 2008 and March 26, 2009 for the use of side rails and a trunk restraint (seat belt) in Section P4 (Devices and</p>	L 083	<p>It is ADF/Knollwood's policy and practice to regularly perform ongoing assessments for the use of the least restrictive restraints for residents with a physical restraint.</p> <p>Resident # 3 was coded in the Minimum Data Set on October 7, 2008, and the quarterly MDS assessments for December 31, 2008 and March 26, 2009 for the use of 1/2 side rails and a trunk restraint in Section P4.</p> <p>The care plan entitled "History of Multiple Falls/ Seat Belt when out of bed to Wheelchair" was reviewed.</p> <p>1(a) Resident #3's physical restraint elimination assessment was completed.</p> <p>1(b) Resident #12's physical restraint elimination assessment was completed.</p> <p>2. Physical restraint elimination assessments have been completed for all other residents with restraints. The interdisciplinary team has been re-educated to complete a Physical Restraint Elimination Assessment at least quarterly for all the residents who use a physical restraint to ensure that the least restrictive device is used for the resident.</p>	<p>7/21/09</p> <p>7/21/09</p> <p>7/21/09</p>

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD02-0022	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/21/2009
--	--	--	--

NAME OF PROVIDER OR SUPPLIER KNOLLWOOD HSC	STREET ADDRESS, CITY, STATE, ZIP CODE 6200 OREGON AVE NW WASHINGTON, DC 20015
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 083	<p>Continued From page 18</p> <p>Restraints).</p> <p>A review of the care plan entitled "Physical Restraint - Seat belt in the wheelchair and full side rails in bed " revealed that the care plan had been reviewed and revised on March 27, 2009.</p> <p>However, the resident's clinical record lacked evidence that an assessment was completed by facility staff to ensure that the seat belt and the side rails were the least restrictive devices for Resident #3.</p> <p>A face-to-face interview was conducted with Employees #7 and 8 on May 20, 2009 at approximately 2:45 PM. They both acknowledged that the resident ' s clinical record lacked evidence that an on-going assessment for the use of the least restrictive device was conducted. The record was reviewed May 20, 2009.</p> <p>2. Facility staff failed to perform on-going assessments for Resident #12's seat belt and side rails.</p> <p>Resident #12 was observed on May 19, 2009 at 2:00 PM in his/her room, lying in bed with full side rails raised on both sides of the bed.</p> <p>Resident #12 was observed on May 20, 2009 at 11:00 AM participating in an activity with a fastened soft Velcro seat belt. When asked, the resident was unable to open the seat belt.</p> <p>A review of the annual Minimum Data Set (MDS) completed May 14, 2009, coded the resident for long and short term memory problems in Section B (Cognitive Patterns). Resident #12 was coded as requiring extensive assistance for</p>	L 083	<p>3. An audit of residents with restraints will be conducted by the Director of Nursing or designee to ensure that the residents with restraints are assessed for the use of the least restrictive device on a quarterly basis or with a change in status. The audit will be completed every month X 6.</p> <p>4. The result of the audit will be presented to the Quality Assurance Committee until the Committee determines that compliance has been achieved.</p>	<p>7/21/09</p> <p>7/21/09</p>

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD02-0022	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/21/2009
--	---	--	---

NAME OF PROVIDER OR SUPPLIER KNOLLWOOD HSC	STREET ADDRESS, CITY, STATE, ZIP CODE 6200 OREGON AVE NW WASHINGTON, DC 20015
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

L 083 Continued From page 19

movement on both sides of the body in Section G (Physical Functioning and Structural Problems). The resident was coded in Section P4 (Devices and Restraints) for the use of side rails and a trunk restraint (seat belt) daily. Disease diagnoses listed in Section I included: Dementia, Arthritis, Parkinson's Disease, and Behavioral Problems.

The resident was coded on the quarterly MDS assessments completed September 14 and November 26, 2008 for the use of side rails and a trunk restraint (seat belt) in Section P4.

A review of the care plan entitled "Physical Restraint - Seat belt in the wheelchair and full side rails in bed..." revealed that the care plan had been reviewed and revised on May 14, 2009.

There was no evidence in the record that an assessment had been completed by facility staff to ensure the seat belt and the full side rails were the least restrictive devices for Resident #12.

A face-to-face interview was conducted with Employee #7 on May 21, 2009 at 8:30 AM. He/she acknowledged that an on-going assessment for use of the least restrictive device had not been conducted. The record

L 083

L 091 3217.6 Nursing Facilities

The Infection Control Committee shall ensure that infection control policies and procedures are implemented and shall ensure that environmental services, including housekeeping, pest control, laundry, and linen supply are in accordance with the requirements of this chapter.

L 091

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD02-0022	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/21/2009
--	--	--	--

NAME OF PROVIDER OR SUPPLIER KNOLLWOOD HSC	STREET ADDRESS, CITY, STATE, ZIP CODE 6200 OREGON AVE NW WASHINGTON, DC 20015
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

L 091	<p>Continued From page 20</p> <p>Based on observation, record review and staff interview for one (1) of 15 sampled residents, it was determined that facility staff failed to maintain appropriate practices to prevent spread of infection during a wound care treatment, failed to ensure that the filter was clean for one (1) of three (3) oxygen concentrators and failed to ensure that facility staff washed hands between resident care.</p> <p>The findings include:</p> <p>1. Facility staff failed to maintain appropriate practices to prevent the spread of infection during a wound care treatment.</p> <p>Employee #9 was observed during a wound care treatment to Resident # 3's left heel on May 19, 2009 at approximately 1:30 PM.</p> <p>Employee #9 failed to maintain appropriate practices to prevent spread of infection. when he/she failed to wash his/her hands immediately after discarding dirty linens in the dirty utility room.</p> <p>A face-to-face interview was conducted with Employee #9 on May 21, 2009 at approximately 11:20 AM. He/she acknowledged the aforementioned findings. He/she said, "I thought I washed my hands in the medication room. May be I did not." The record was reviewed May 21, 2009.</p> <p>2. Facility staff failed to ensure that one (1) of three (3) oxygen filters was clean.</p> <p>The environmental tour was conducted on May 19, 2009 from 1:30 PM until 4:00 PM in the presence of Employees #13 and 14 who</p>	L 091	<p>It is ADF/Knollwood's policy and practice to maintain an infection control program to include the prevention of infection during wound treatments and to ensure that oxygen concentrator filters are clean.</p> <p>1(a) Employee #9 was re-educated on the importance of infection control to include handwashing immediately after discarding dirty linen.</p> <p>1(b) The oxygen concentrator filter for Room# 15 (typo #25) was immediately removed, cleaned and replaced.</p> <p>2. Staff will be inserviced on Infection Control to include handwashing after discarding dirty linen and the cleaning of oxygen concentrator filters. In addition, all oxygen concentrator filters were checked for cleanliness and observed to be in compliance. Licensed staff will initial the resident TAR (Treatment Administration Record) weekly after cleaning the filters.</p> <p>3. The ADON or designee will conduct an audit of handwashing by staff and the cleanliness of oxygen concentrator filters to assure that they are cleaned on a weekly basis, weekly x 4, then monthly x 4, then quarterly x 3 to ensure compliance by staff.</p> <p>4. The result of the audit will be presented to the Quality Assurance Committee until the Committee determines compliance.</p>	<p>5/30/09</p> <p>5/21/09</p> <p>7/21/09</p> <p>7/21/09</p>
-------	--	-------	--	---

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD02-0022	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/21/2009
--	--	--	--

NAME OF PROVIDER OR SUPPLIER KNOLLWOOD HSC	STREET ADDRESS, CITY, STATE, ZIP CODE 6200 OREGON AVE NW WASHINGTON, DC 20015
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 091	<p>Continued From page 21</p> <p>acknowledged the findings at the time of the observations.</p> <p>During the environmental tour of the facility, the oxygen concentrator in room 25 was observed soiled with dust. The filter was immediately removed, cleaned and replaced by Employee #3. He/she stated at the time of the observation that the oxygen concentrator filters should be cleaned weekly and as needed.</p> <p>3. Facility staff failed to wash hands between resident care.</p> <p>Employee #9 was observed during a wound care treatment to Resident #3's left heel on May 19, 2009 at approximately 1:30 PM. Employee #9 loosened the resident's old dressing and discarded it in the wastebasket. He/she placed a towel between the resident's left heel and the bed, cleansed the wound, applied cream on a 4x4 gauze, and secured the wound with tape.</p> <p>Employee #9 gathered the towel used as a wound barrier and the towel used as a barrier on the table and carried them unbagged against his/her chest to the soiled utility room and disposed of the linen in the appropriate container.</p> <p>Employee #9 went into the medication room, after discarding the dirty linens, left the medication room and walked towards the hallway across from the medication room, and went in and out of four (4) residents' rooms. Employee #9 did not wash his/her hands during any of the above cited activities.</p> <p>A face-to-face interview was conducted with Employee #9 on May 21, 2009 at approximately</p>	L 091		

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD02-0022	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/21/2009
--	--	--	--

NAME OF PROVIDER OR SUPPLIER KNOLLWOOD HSC	STREET ADDRESS, CITY, STATE, ZIP CODE 6200 OREGON AVE NW WASHINGTON, DC 20015
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 091	Continued From page 22 aforementioned findings. He/she said, "I thought I washed my hands."	L 091		
L 099	<p>3219.1 Nursing Facilities</p> <p>Food and drink shall be clean, wholesome, free from spoilage, safe for human consumption, and served in accordance with the requirements set forth in Title 23, Subtitle B, D. C. Municipal Regulations (DCMR), Chapter 24 through 40. This Statute is not met as evidenced by:</p> <p>Based on observations during the tour of the main kitchen, it was determined that facility staff failed to maintain a clean and sanitary kitchen as evidenced by soiled: two (2) of three (3) deep fryers and electrical equipment under the fryers, one (1) of one (1) tilt grill, one (1) of one (1) set of pipes behind the appliances, the lip of two (2) of two (2) convection ovens and their exterior surfaces, two (2) of two (2) standing racks, one (1) of one (1) vent above the clean pot and pan storage area, three (3) of six (6) back flow drains, two (2) of six (6) floor drains and two (2) of four (4) drain pipes from the ice machine.</p> <p>Additional findings included: chicken stored above crab meat in the walk-in refrigerator; no thermometer in the ice cream freezer, three (3) of three (3) perforated pans stored wet and ready for re-use, three (3) of six (6) back flow pipes with insufficient air gaps, and two (2) of two (2) buckets filled with sanitizer solution in the food preparation area.</p> <p>In the Special Care Center serving kitchen the following was observed: eight (8) of eight (8) dish racks stored on the floor, three (3) of three (3) dusty light covers, one (1) of one (1) marred wall, one (1) of two (2) ice scoops stored on top of the ice machine, two (2) of two (2) containers</p>	L 099	<p>It is ADF/Knollwood's policy and practice to maintain a clean and sanitary kitchen.</p> <p>1. The two (2) deep fryers and electrical equipment under the fryers, one (1) tilt grill, one (1) set of pipes behind the appliances, the lip of two (2) convection ovens and their exterior surfaces, two (2) standing racks, one (1) vent above the clean pot and pan storage area, three (3) back flow drains, two (2) floor drains and two (2) drain pipes from the ice machine have been cleaned.</p> <p>The crabmeat was immediately discarded. A thermometer was placed in the ice cream freezer, three (3) perforated pans were rewashed and stacked separately to dry, three (3) back flow pipes were repaired, and two (2) buckets filled with sanitizer solution in the food preparation area were removed.</p> <p>In the Special Care Center serving kitchen, eight (8) dish racks were removed from the floor, three (3) light covers were cleaned, one (1) marred wall was repaired, one (1) ice scoop was removed from the top of the ice machine</p>	<p>5/22/09</p> <p>5/22/09</p> <p>5/25/09</p>

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD02-0022	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/21/2009
--	--	--	--

NAME OF PROVIDER OR SUPPLIER KNOLLWOOD HSC	STREET ADDRESS, CITY, STATE, ZIP CODE 6200 OREGON AVE NW WASHINGTON, DC 20015
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 099	<p>Continued From page 23</p> <p>undated when opened of pink lemonade, and one (1) of one (1) bottle of chocolate syrup undated when opened in the refrigerator.</p> <p>The following was observed in the freezer in the kitchen located on the Special Care Center unit: one (1) of one (1) five-gallon container of vanilla ice cream undated when opened; 11 individual servings of ice cream undated and unlabeled and one (1) dish of tapioca pudding, uncovered, undated and unlabeled.</p> <p>These observations were made in the presence of Employees #13 and 26, who acknowledged the findings at the time of the observations.</p> <p>The tour of the main kitchen was conducted from 8:30 AM through 12:30 PM on May 19, 2009.</p> <p>The findings include:</p> <p>1. The following items were observed soiled with grease and accumulated debris in the main kitchen: The interior and exterior surfaces of two (2) of three (3) deep fryers. The gas and electrical wiring located below two (2) of three (3) deep fryers. The interior and exterior hinges of one (1) of one (1) tilt grill. One (1) of one (1) set of pipes located between the appliances. The lip and exterior surfaces of two (2) of two (2) convection ovens. The shelf surfaces of two (2) of two (2) standing racks. One (1) of one (1) exhaust vent located above the clean storage rack for pots and pans. Three (3) of six (6) back flow drains located throughout the main kitchen.</p>	L 099	<p>and inserted in the ice scoop holder, two (2) containers of pink lemonade was dated, and one (1) bottle of chocolate syrup was dated.</p> <p>In the Special Care Center freezer, one (1) five-gallon container of vanilla ice cream was discarded, eleven (11) individual servings of ice cream were discarded and one (1) dish of tapioca pudding was discarded.</p> <p>The interior and exterior surfaces of two (2) deep fryers were cleaned. The gas and electrical wiring located below two (2) deep fryers were cleaned. The interior and exterior hinges of one (1) tilt grill were cleaned. One (1) set of pipes located between the appliances were cleaned. The lip and exterior surfaces of two (2) convection ovens were cleaned. The shelf surfaces of two (2) standing racks were cleaned. One (1) exhaust vent located above the clean storage rack for pots and pans was cleaned. Three (3) back flow drains located throughout the main kitchen were cleaned. Two (2) floor drains located throughout the main kitchen were cleaned. Two (2) ice machine drainpipes were cleaned.</p> <p>The crabmeat in the walk-in refrigerator was immediately discarded.</p> <p>Three (3) perforated pans were rewashed and stacked separately to dry.</p>	<p>5/21/09</p> <p>5/25/09</p> <p>5/21/09</p> <p>5/21/09</p>

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD02-0022	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/21/2009
--	--	--	--

NAME OF PROVIDER OR SUPPLIER KNOLLWOOD HSC	STREET ADDRESS, CITY, STATE, ZIP CODE 6200 OREGON AVE NW WASHINGTON, DC 20015
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 099	<p>Continued From page 24</p> <p>Two (2) of six (6) floor drains located throughout the main kitchen.</p> <p>Two (2) of four (4) ice machine drain pipes with approximately 1/2 inch of a white substance on the end of each pipe.</p> <p>2. Chicken pieces were observed stored on the middle shelf of a storage rack above crab meat in the walk-in refrigerator.</p> <p>3. Three (3) of three (3) perforated pans were observed stored wet and ready for re-use in the pot and pan wash area.</p> <p>4. Three (3) of six (6) back flow pipes were observed with insufficient air gaps to prevent the back flow of contaminated water into the potable water system.</p> <p>5. Two (2) of two (2) buckets of sanitizer were observed near cantaloupe, celery and onions being chopped in the food preparation area.</p> <p>The following was observed in the Special Care Center kitchen:</p> <ol style="list-style-type: none"> Eight (8) of eight (8) dish racks stored on the floor. Three (3) of three (3) dusty light covers near the ice machine. One (1) of one (1) marred and scarred wall. One (1) of two (2) ice scoops stored uncovered on top of the ice machine. Two (2) of two (2) containers of concentrated pink lemonade undated when opened. One (1) of one (1) 32 ounce container of chocolate syrup undated when opened. <p>The following was observed in the freezer in the kitchen located on the Special Care Center:</p> <ol style="list-style-type: none"> One (1) of one (1) five-gallon container 	L 099	<p>Three (3) back flow pipes were repaired.</p> <p>Two (2) buckets filled with sanitizer solution in the food preparation area were removed.</p> <p>In the Special Care Center serving kitchen, eight (8) dish racks were removed from the floor, three (3) light covers were cleaned, one (1) marred wall was repaired, one (1) ice scoop was removed from the top of the ice machine two (2) containers of pink lemonade was dated, and one (1) bottle of chocolate syrup was dated.</p> <p>In the Special Care Center freezer, one (1) five-gallon container of vanilla ice cream was discarded, eleven (11) individual servings of ice cream were discarded and one (1) dish of tapioca pudding was discarded.</p> <p>2. Each piece of equipment has been thoroughly cleaned by kitchen staff. In addition, kitchen staff have been re-educated on sanitation, specifically addressing every issue cited.</p> <p>3. The Director of Dining or designee will make weekly sanitation inspections x4, then every month x 3, then quarterly x 3.</p> <p>4. The results of the monitoring will be presented to the Quality Assurance Committee until the Committee determines that compliance has been achieved.</p>	<p>7/3/09</p> <p>5/21/09</p> <p>5/25/09</p> <p>5/21/09</p> <p>6/1/09</p> <p>6/1/09</p>

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD02-0022	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/21/2009
--	--	--	--

NAME OF PROVIDER OR SUPPLIER KNOLLWOOD HSC	STREET ADDRESS, CITY, STATE, ZIP CODE 6200 OREGON AVE NW WASHINGTON, DC 20015
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

L 099 Continued From page 25
undated when opened.
2. 11 of 11 individual dishes of ice cream undated when prepared.
3. One (1) of one (1) container of tapioca uncovered, undated and unlabeled.

L 099

L 145 3226.5 Nursing Facilities

The medication for self-administration shall be securely stored and accessible only to the appropriate resident and staff. This Statute is not met as evidenced by: Based on observations during the medication storage area inspection, it was determined that facility staff failed to keep bedside medication stored in a locked drawer for Resident #7.

The findings include:

On May 21, 2009 during the inspection of the medication storage areas Lamisil ointment was observed on Resident #7 bedside tray.

A review of the resident's clinical record revealed the following physician's orders dated May 6, 2009: "Please observe resident self administration of Baclofen weekly on Tuesday at 4:00 PM ...Baclofen 20 mg 1 tab (Tablet) PO 3 times a day ...for muscle spasms ...Lamisil AT Cream 1% apply to temporal area on scalp for fungus 2 times a day as needed (May keep at bedside)."

The facility staff failed to keep the Lamisil ointment in a locked drawer.

A face-to-face interview was conducted with Employee #19 at the same time of the inspection. He/she stated that they were unaware of the ointment on the bedside tray. it

L 145

It is ADF/Knollwood's policy and practice to keep bedside medication for residents who self-medicate stored in a locked drawer.

1 Lamisil ointment for Resident #7 was immediately secured in a locked drawer on 5/21/09. Lamisil ointment was subsequently discontinued on 6/19/09.

5/21/09

2 An audit was conducted on 5/23/09 to ensure that all medications kept at the bedside were secured in locked drawers. The audit revealed that there was no other resident with orders to leave medication at the bedside.

5/23/09

3. The medication nurses will be inserviced on assuring the drawers are locked. The ADON or designee will randomly audit weekly x 4, then monthly x 4 then quarterly x 3 to ensure compliance.

7/21/09

4. The result of the audit will be presented to the Quality Assurance Committee until the Committee determines that compliance has been achieved.

7/21/09

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD02-0022	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/21/2009
--	--	--	--

NAME OF PROVIDER OR SUPPLIER KNOLLWOOD HSC	STREET ADDRESS, CITY, STATE, ZIP CODE 6200 OREGON AVE NW WASHINGTON, DC 20015
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 145	Continued From page 26 stored in the resident ' s locked bedside drawer.	L 145	It is ADF/Knollwood's policy and practice to maintain proper temperature control for medication refrigerators.	
L 157	<p>3227.8 Nursing Facilities</p> <p>Each refrigerator that is used for storage of medication shall operate at a temperature between thirty-six degrees (36°F) and forty-six (46°F) Fahrenheit; each refrigerator shall be equipped with a thermometer that is easily readable, accurate and in proper working condition.</p> <p>This Statute is not met as evidenced by: Based on observations during the inspection of the medication refrigerators, it was determined that facility staff failed to maintain proper temperature control of the medication refrigerator on the HSC unit.</p> <p>The findings include:</p> <p>The U.S. Pharmacopeia National Formulary, stipulates, "A refrigerator is a cold place in which the temperature is maintained thermostatically between 2 degrees (°) Fahrenheit (F) and 8 °F (36 ° F and 46 ° F).</p> <p>On May 20, 2009, at approximately 12:00 PM during the inspection of the medication refrigerators, the HSC unit ' s medication refrigerator's thermometer registered 50 ° F.</p> <p>A face-to-face interview was conducted at the time of the observation. Employees #3 and 20 acknowledged that the refrigerator was out of the temperature range and adjusted the refrigerator's thermostat.</p>	L 157	<p>1. The medication refrigerator in the Health Services Center was adjusted to maintain proper temperature control on 5/20/09 and 5/21/09.</p> <p>2. The other refrigerators in the Health Services Center and Special Care Center were audited for proper temperature control on 5/20/09 and 5/21/09 and were observed to be functioning within acceptable range.</p> <p>3. The medication nurses will be inserviced on the proper maintenance of refrigerator temperature between 36 degrees F and 46 degrees F. The ADON or designee will randomly audit weekly x 4, then monthly x 4 then quarterly x 3 to ensure compliance.</p> <p>4. The result of the audit will be presented to the Quality Assurance Committee until the Committee determines that compliance has been achieved.</p>	<p>5/21/09</p> <p>5/21/09</p> <p>7/21/09</p>

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD02-0022	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/21/2009
--	--	--	--

NAME OF PROVIDER OR SUPPLIER KNOLLWOOD HSC	STREET ADDRESS, CITY, STATE, ZIP CODE 6200 OREGON AVE NW WASHINGTON, DC 20015
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 157	<p>Continued From page 27</p> <p>The medication refrigerator was re-inspected on May 21, 2009 at approximately 10:00 AM; the HSC unit's medication refrigerator's thermometer registered 30 ° F.</p> <p>A face-to-face interview was conducted at the time of the observations. Employee #2 acknowledged that the refrigerator was out of temperature range.</p>	L 157		
L 159	<p>3227.10 Nursing Facilities</p> <p>Each medication container that has a soiled, damaged, illegible or otherwise incomplete label on it shall be returned to the pharmacy for relabeling or shall be destroyed.</p> <p>This Statute is not met as evidenced by: Based on observations of medication storage areas, it was determined that facility staff failed to ensure proper labeling was on Resident#7's medication container.</p> <p>The findings include:</p> <p>On May, 21, 2009 during the inspection of medication storage areas, Resident #7 medication for Baclofen was observed stored in a locked bedside drawer. The medication container was not labeled with a dispensing label that denoted the resident's name and the name of the medication.</p> <p>A face-to-face interview was conducted with Employee #19 at the same time of the inspection. He/she stated that he/she did not know that the dispensing label had come off of the medication bottle.</p>	L 159	<p>It is ADF/Knollwood's policy and practice to ensure that medication bottles are labeled correctly.</p> <ol style="list-style-type: none"> 1. Resident #7 medication for Baclofen was discarded and replaced on 5/21/09 with a properly labeled container with the resident's name, name of the medication, and dosage. 2. An audit was conducted on 5/23/09 to ensure that all medications were properly labeled. The audit revealed that all medications were properly labeled. 3. The medication nurses will be inserviced on the proper labeling of medications kept at the bedside. The ADON or designee will randomly audit weekly x 4, then monthly x 4 then quarterly x 3 to ensure compliance. 4. The result of the audit will be presented to the Quality Assurance Committee until the Committee determines that compliance has been achieved. 	<p>5/21/09</p> <p>5/23/09</p> <p>7/21/09</p>

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD02-0022	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/21/2009
--	--	--	--

NAME OF PROVIDER OR SUPPLIER KNOLLWOOD HSC	STREET ADDRESS, CITY, STATE, ZIP CODE 6200 OREGON AVE NW WASHINGTON, DC 20015
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 214	Continued From page 28	L 214		
L 214	<p>3234.1 Nursing Facilities</p> <p>Each facility shall be designed, constructed, located, equipped, and maintained to provide a functional, healthful, safe, comfortable, and supportive environment for each resident, employee and the visiting public. This Statute is not met as evidenced by: Based on observation and staff interview during a tour of the main kitchen, it was determined that facility staff failed to ensure that all dietary staff were aware of the safe lightening of a gas stove burner.</p> <p>The tour of the main kitchen was conducted on May 19, 2009 from 8:30 AM until 12:00 PM in the presence of Employee #26.</p> <p>The findings include:</p> <p>During the tour of the main kitchen, Employee #27 was asked to ignite the four (4) burners on the gas stove. Three (3) burners lit immediately. The fourth burner did not light. Employee #27 was asked how he/she would light the burner that did not ignite. Employee #27 stated, "We use a paper towel or a piece of paper."</p> <p>Employee #26 acknowledged Employee #27's statement at the time of the observation and added, "We have a lighter, like the kind used on candles to light the burner if it doesn't ignite on its own. (Employee #27) knows better."</p>	L 214	<p>It is ADF/Knollwood's policy and practice to ensure that the resident environment remains as free of accident hazards as is possible and that each resident receives adequate supervision and assistance devices to prevent accidents.</p> <ol style="list-style-type: none"> The gas-stove burner has been repaired. Dining staff were educated on the safe lighting of a gas-stove burner, and what measures to take if a burner does not light. Spot checks will be conducted by the Director of Dining or designee and kitchen staff will demonstrate the proper lighting of a gas-stove burner weekly x 4 then quarterly x 3. The result of the spot checks will be submitted to the Quality Assurance Committee until the Committee determines that compliance has been achieved. 	<p>5/22/09</p> <p>5/30/09</p> <p>7/3/09</p>
L 410	<p>3256.1 Nursing Facilities</p> <p>Each facility shall provide housekeeping and maintenance services necessary to maintain the exterior and the interior of the facility in a safe, sanitary, orderly, comfortable and attractive</p>	L 410		

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD02-0022	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/21/2009
--	--	--	--

NAME OF PROVIDER OR SUPPLIER KNOLLWOOD HSC	STREET ADDRESS, CITY, STATE, ZIP CODE 6200 OREGON AVE NW WASHINGTON, DC 20015
---	---

(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)	
L 410	<p>Continued From page 29</p> <p>manner.</p> <p>This Statute is not met as evidenced by:</p> <p>A. Based on observations during the environmental tour, it was determined that facility staff failed to maintain an orderly and comfortable environment as evidence by: dusty blinds in two (2) of 21 rooms observed, foot rests for wheelchairs on the floor in two (2) of 21 rooms observed and cracked/torn arm rests in six (6) of 20 wheel chairs observed.</p> <p>The environmental tour was conducted on May 19, 2009 from 1:30 PM until 4:00 PM in the presence of Employees #13 and 14 who acknowledged the findings at the time of the observations.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Dusty blinds were observed in rooms 2 and 18 in two (2) of 21 resident rooms observed. 2. Foot rests were observed on the floor in rooms 6 and 45 in two (2) of 21 rooms observed. 3. Cracked, worn and/or torn arm rests were observed on wheel chairs in rooms 6, 9, 24 (two wheelchairs) 26, and 49 in six (6) of 20 wheelchairs observed. <p>Employee #2 presented an order confirmation from a supply company dated May 20, 2009 that included 20 padded arm rest replacements. An interview was conducted with Employee #2 on May 21, 2009 at 4:30 PM. When queried about the frequency that resident wheelchair arm rests were assessed for replacement, he/she stated, "Whenever necessary." There was no evidence that a system was in place to reassess the residents' wheelchair arm rests for repair or</p>	L 410	<p>It is ADF/Knollwood's policy and practice to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <ol style="list-style-type: none"> 1(a) Blinds were dusted in rooms 2 and 18. 1(b) Footrests were removed from the floor in rooms 6 and 45. 1(c) Cracked, worn and/or torn armrests were replaced on wheelchairs in rooms 6, 9, 24A, 24B, 26 and 49. <ol style="list-style-type: none"> 2. Staff have been re-educated to keep wheelchair footrests off the floor. All resident rooms were checked for dusty blinds, foot rests on floors, and cracked, worn and/or torn arm rests. All are now in compliance. 3. The Director of Environmental Services or designee will conduct an audit for dusty blinds, foot rests on floors, and cracked, worn and/or torn arm rest and assess wheelchair armrests for repair or replacement every month x 4, then every quarter. 4. The results of the audits will be submitted to the Quality Assurance Committee until the Committee determines that compliance has been achieved. 	<p>5/21/09</p> <p>5/21/09</p> <p>5/28/09</p> <p>7/21/09</p> <p>7/21/09</p>

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD02-0022	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/21/2009
--	--	--	--

NAME OF PROVIDER OR SUPPLIER KNOLLWOOD HSC	STREET ADDRESS, CITY, STATE, ZIP CODE 6200 OREGON AVE NW WASHINGTON, DC 20015
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 410	<p>Continued From page 30</p> <p>replacement on a consistent basis.</p> <p>B. Based on observation and staff interview during a tour of the main kitchen, it was determined that facility staff failed to maintain the following equipment: one (1) of one (1) hose with damaged insulation, one (1) of four (4) burners on the gas stove that failed to light, and one (1) of one (1) sanitizer system for the three (3) compartment sink that failed to dispense the appropriate amount of sanitizer.</p> <p>The tour of the main kitchen was conducted on May 19, 2009 from 8:30 AM until 12:30 PM in the presence of Employee #26 who acknowledged the findings at the time of the observations.</p> <p>The findings include:</p> <ol style="list-style-type: none"> One (1) of one (1) hose attached to the wall was observed with insulation protruding from the insulation wrapping. One (1) of four (4) burners failed to light when tested on the gas oven. The three (3) compartment sink, used to wash, rinse and sanitize cooking and baking utensils, was observed. The observation revealed that the ph test strip failed to change color when the water in the sanitizer sink was tested. This indicated that sanitizer was not added to the water. Employee #28 emptied the water from the sink, re-filled the sanitizer sink and adjusted the amount of sanitizer to be added to the water. When tested, the ph test strip failed to change color revealing that sanitizer had not been added to the water. <p>Employee #26 notified the maintenance</p>	L 410	<ol style="list-style-type: none"> One (1) hose with damaged insulation was repaired, one (1) burner on the gas stove was repaired, and one (1) sanitizer system for the three (3) compartment sink was repaired at time of survey. Rounds were conducted throughout the kitchen and all above items have been addressed. Training has been conducted on the procedures for using the sanitizer system and for testing for the proper amount of sanitizer in the water. No further items of this type were found during the rounds. The Director of Dining or designee will make weekly inspections x4, then every month x 3, then quarterly x 3. The results of the monitoring will be presented to the Quality Assurance Committee until the Committee determines that compliance has been achieved. 	<p>7/2/09</p> <p>7/2/09</p> <p>7/21/09</p>

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD02-0022	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/21/2009
--	--	--	--

NAME OF PROVIDER OR SUPPLIER KNOLLWOOD HSC	STREET ADDRESS, CITY, STATE, ZIP CODE 6200 OREGON AVE NW WASHINGTON, DC 20015
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

L 410	<p>Continued From page 31</p> <p>department that the sanitizer system was not functioning properly and a maintenance employee was promptly dispatched to the kitchen.</p> <p>After approximately 15 minutes, it was observed that the sanitizer sink was filled with water and sanitizer which resulted in soapy type bubbles in the water. The test strip turned very dark green, indicating too much sanitizer had been added. The water was emptied out of the sink.</p> <p>The sanitizer system was again adjusted by the maintenance employee and the sanitizer sink re-filled. There were no bubbles in the sanitizer sink and the test strip turned olive green indicating that the appropriate amount of sanitizer was present in the water.</p> <p>C. Based on observations during the environmental tour, it was determined that facility staff failed to ensure that handrails were securely attached.</p> <p>The environmental tour was conducted on May 19, 2009 from 1:30 PM to 4:30 PM.</p> <p>These observations were made in the presence of Employees #13 and 14 who acknowledged these findings at the time of the observations.</p> <p>The findings include:</p> <p>Loose handrails were observed in the corridors on the Health Service Center near room 2 at 1:40 PM and room 18 at 1:50 PM. Employee #20 repaired the hand rails at the time of the observation.</p> <p>Employees #13 and 14 acknowledged the</p>	L 410	<p>1.The handrails in the corridors in the Health Service Center near room 2 at and room 18 were repaired. Employee #20 repaired the handrails at the time of the observation.</p> <p>2. Rounds were conducted throughout the Health Services Center and Special Care Center and no further items of this type were found.</p> <p>3. The Chief Engineer or designee will make monthly rounds/inspections of all handrails x 4, then quarterly x 3.</p> <p>4. The results of the monitoring will be presented to the Quality Assurance Committee until the Committee determines that compliance has been achieved.</p>	<p>5/19/09</p> <p>5/20/09</p> <p>7/21/09</p>
-------	--	-------	---	--

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD02-0022	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/21/2009
--	--	--	--

NAME OF PROVIDER OR SUPPLIER KNOLLWOOD HSC	STREET ADDRESS, CITY, STATE, ZIP CODE 6200 OREGON AVE NW WASHINGTON, DC 20015
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 410	Continued From page 32 findings at the time of the observation.	L 410		

