	T OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(¥2) •••	ILTIPLE CONSTRUCTION (X3) DATE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILD	ATMT IN AN AND A REAL
		095024	B. WING	Adria 02/22/2007
		ASHINGTON-HADLEY SNF		STREET ADDREAS OFTY, STATE, ZIP CODE 4601WL KING AVE SW
				WASHINGTON, DC 20032
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE CROSS- REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE
F 000	INITIAL COMMEN	rs	F 00	00 F221
F 221 SS=D	February 20 throug deficiencies were b observations, and in and residents. The based on a census of survey and three 483.13(a) PHYSICA The resident has th physical restraints in discipline or conver treat the resident's in This REQUIREMEN Based on observation review for one (1) s determined that fac Resident S1 for the The findings include During the initial tou on February 20, 200 room in a geri chair straight back chair. A face-to-face interview immediately with a 0 regarding the position CNA stated, "I usua Resident S1] gets re geri chair and put his straight back] chair up. It's the only thin	e right to be free from any mposed for purposes of lience, and not required to medical symptoms. IT is not met as evidenced by on, staff interview and record upplemental resident, it was lity staff failed to assess use of a restraint. e: IT, Resident S1 was observed 07 at 9:30 AM, sitting in his/her with his/her feet resting on a	F 22	 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The straight back chair was removed immediately on 2/20/07 and the CNA was instructed by RCC to stop the deficient practice. An assessment of the resident was done. It was determined that restraint is not necessary. How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken? Rounds on all residents' room and day rooms were conducted on 2/20/07 to ensure that no other resident is being prevented from getting up by using straight back chairs. No other resident's were found to be affected by this deficient practice. What measure will be put in place or what systemic changes you will make to ensure the deficient practice does not recur? All nursing staff was in-serviced on 2/28/07, 3/5/07, and 3/7/07 on the facility's restraint policy, which includes the types of restraints recognized by the facility. (Emphasis was placed on the use a straight back chair as a form of restraint as not acceptable practice). See attachment #1.

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.

STATEMEN	T OF DEFICIENCIES DF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN		(X3) DATE SU COMPLE	
		095024	B. WING _		02/2	2/2007
	PROVIDER OR SUPPLIER	ASHINGTON-HADLEY SNF	4	REET ADDRESS, CITY, STATE, ZIP CODE 601 ML KING AVE SW VASHINGTON, DC 20032	· ·	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE	BE CROSS-	(X5) COMPLETION DATE
F 221	The CNA stated, "A A review of the resi	At least since Christmas." dent's record revealed that	F 221	 F-221 4. How the corrective action (monitored to ensure the 		April 5, 2007
F 253 SS=D	straight back chair evidence in the rec back chair was reco restraint. The reco 2007. 483.15(h)(2) HOUS The facility must pr maintenance service	esment for the use of the as a restraint. There was no ord that the use of the straight ognized by facility staff as a rd was reviewed February 22, SEKEEPING/MAINTENANCE ovide housekeeping and ces necessary to maintain a nd comfortable interior.	F 253	practice will not recur (i. Quality Assurance Program put into place? RCC's will conduct daily r monitor, and outcomes reported to DON and Admi	e., what n will be ounds to will be nistrator neetings. to new neetings,	
	During the environr that housekeeping were not adequate safe and sanitary m marred and scarred damaged walls and These observatio	NT is not met as evidenced by nental tour, it was determined and maintenance services to maintain the facility in a nanner, as evidenced by: d straight back chairs, I doors and stained ceiling tiles ns were made in the presence aintenance, Housekeeping sing staff.				
	the 3 East dining ro in seven (7) of seve February 21, 2007 2. Walls were obs scarred in the follow rooms 301, 312, 31	egs of straight back chairs in om were marred and scarred en (7) chairs observed on				

ULINIERS FUR MEDIUARE & MEL	HUMAN SERVICES DICAID SERVICES			PRINTED: 03/06/2007 FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PR	OVIDER/SUPPLIER/CLIA NTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	B. WING		02/22/2007
NAME OF PROVIDER OR SUPPLIER SPECIALTY HOSPITAL OF WASHING	GTON-HADLEY SNF	S	TREET ADDRESS, CITY, STATE, ZIP CODE 4601 ML KING AVE SW WASHINGTON, DC 20032	
(X4) ID SUMMARY STATEMENT PREFIX (EACH DEFICIENCY MUST B TAG REGULATORY OR LSC IDENT	E PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE	D BE CROSS- COMPLETION
 F 221 Continued From page 1 The CNA stated, "At least A review of the resident's r there was no assessment straight back chair as a resevidence in the record that back chair was recognized restraint. The record was 2007. F 253 483.15(h)(2) HOUSEKEEF SS=D The facility must provide he maintenance services nect sanitary, orderly, and comf This REQUIREMENT is n During the environmental t that housekeeping and ma were not adequate to main safe and sanitary manner, marred and scarred straigh damaged walls and doors a These observations were of the Director of Maintena Supervisor and nursing sta The findings include: 1. The arms and legs of s the 3 East dining room wer in seven (7) of seven (7) of February 21, 2007 at 2:00 2. Walls were observed to scarred in the following are rooms 301, 312, 316, 324 	ecord revealed that for the use of the straint. There was no the use of the straight by facility staff as a reviewed February 22, PING/MAINTENANCE ousekeeping and essary to maintain a ortable interior. ot met as evidenced by our, it was determined intenance services tain the facility in a as evidenced by: nt back chairs, and stained ceiling tiles e made in the presence nce, Housekeeping off.	F 22	 were cleaned by housekee 2/22/07. The stained ceiling 3East ding room were rep 3/5/07. 2. How will you identify other who have the potential to be by the same deficient prace what corrective action will be a statement of the s	residents d by the ight back om were jed walls were all rrved in 3 3/6/07. 3 ider mats ping on g tiles on laced on residents affected tice and be taken? ekceping al rounds iles were rred and and walls No other dirty. place or vill make tice does s to be instituted tg and A rounds entify any oms. All to the

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Facility ID: HADLEY

If continuation sheet Page 2 of 39

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE S AND PLAN OF CORRECTION 095024 (X2) MULTIPLE CONSTRUCTION (X3) DATE S OPSO24 095024 B. WING 02/2 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4601 ML KING AVE SW 02/2 SPECIALTY HOSPITAL OF WASHINGTON-HADLEY SNF ID PROVIDER'S PLAN OF CORRECTION 02/2 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION MUST BE PRECEDED BY FULL PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS. F 253 Continued From page 2 February 21, 2007. F 253 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur (i.e., what Quality Assurance Program will be put into place? Starred or soiled in rooms 301, 318, 3 East dayroom and 3 East shower room in four (4) of 18 door observations from 2:00 PM through 3:30 PM on February 21, 2007. F 253 4. Ceiling tiles were observed stained or damaged in rooms 301, 316, 343 and the 3 East dining room in four (4) of 18 ceiling tile observations from 2:00 PM through 3:30 PM on February 21, 2007. F 278 F 278 483.20(q) (-1) (I	
09302402/2NAME OF PROVIDER OR SUPPLIERSPECIALTY HOSPITAL OF WASHINGTON-HADLEY SNFSTREET ADDRESS, CITY, STATE, ZIP CODE4601 ML KING AVE SWWASHINGTON, DC 20032(X4) ID PREFIX TAGSUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)ID PREFIX TAGPROVIDER'S PLAN OF CORRECTION (EACH CORRECT WE ACTION SHOULD BE CROSS- REFERENCED TO THE APPROPRIATE DEFICIENCY)F 253Continued From page 2 February 21, 2007.F 2534. How the corrective action(s) will be monitored to ensure the deficient practice will not recur (i.e., what Quality Assurance Program will be guarity Assurance Program will be put into place? The Maintenance and Housekeeping Supervisor will do weekly rounds to commence 4/3/07; any deficient findings will be reported in monthly Environment of Care Committee, Process Improvement, and QA meeting.4. Ceiling tiles were observed stained or damaged in rooms 301, 316, 343 and the 3 East dining room in four (4) of 18 ceiling tile observations from 2:00 PM through 3:30 PM on February 21, 2007.PROVIDER'S PLAN OF CORRECTION PREFIX The Maintenance and QA meeting.	(X5) COMPLETI DATE
NAME OF PROVIDER OR SUPPLIERSTREET ADDRESS, CITY, STATE, ZIP CODESPECIALTY HOSPITAL OF WASHINGTON-HADLEY SNF(X4) ID PREFIX TAGSUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)ID PREFIX TAGPROVIDER'S PLAN OF CORRECTION 	(X5) COMPLETI DATE
PREFIX TAG(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)PREFIX TAG(EACH CORRECTIVE ACTION SHOULD BE CROSS- REFERENCED TO THE APPROPRIATE DEFICIENCY)F 253Continued From page 2 February 21, 2007.F 2534. How the corrective action(s) will be monitored to ensure the deficient 	COMPLETI DATE April 5,
 February 21, 2007. 3. Doors were observed damaged, marred, scarred or soiled in rooms 301, 318, 3 East dayroom and 3 East shower room in four (4) of 18 door observations from 2:00 PM through 3:30 PM on February 21, 2007. 4. Ceiling tiles were observed stained or damaged in rooms 301, 316, 343 and the 3 East dining room in four (4) of 18 ceiling tile observations from 2:00 PM through 3:30 PM on February 21, 2007. 	
SS=D The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a	

		AND HUMAN SERVICES & MEDICAID SERVICES					FORM	03/06/2007 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI				(X3) DATE SU COMPLE	
		095024	B. WI	NG			02/2	2/2007
NAME OF F				STR		RESS, CITY, STATE, ZIP CODE		
SPECIAL	TY HOSPITAL OF W	ASHINGTON-HADLEY SNF				ING AVE SW GTON, DC 20032		
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F 278	Clinical disagreeme material and false s This REQUIREMEN Based on staff inter one (1) of 15 samp determined that Re coded for behaviors Data Set (MDS) ass The findings include	ant does not constitute a tatement. IT is not met as evidenced by view and record review for ed residents, it was sident #12 was inaccurately on the quarterly Minimum sessment.	F		2.	What corrective action(s) accomplished for those a found to have been affected deficient practice? MDS Coordinator was not survey findings, and re-edu 2/22/07. MDS modification v and transmitted on 2/22/07 attachment #1. How will you identify other a who have the potential to be by the same deficient prace what corrective action will b An audit of all resident M behavior monitoring flow sho	residents I by the diffied of cated on was done . See residents affected tice and e taken? DS with	
F 279	according to the qu February 5, 2007, th Section E4e, "Mood care. The Assessm the MDS was Febru the last date of obse period for Section E According to the "B January and Februa notes for January a no evidence that the A face-to-face intern Certified Nurse Aide at 2:30 PM. He/she to fight us when we couple of months, n she] has given anyt was reviewed Febru 483.20(d), 483.20(k	ehavior Monitoring Sheet" for ary 2007, and the nurses' and February 2007, there was e resident resisted care. view was conducted with the e (CNA) on February 21, 2007 e stated, "[Resident #12] used re tried to give care. But for a ow, I haven't heard that [he/ body any trouble." The record	F2		3.	reviewed to ensure that behavious were within the parameter of the look back from the AR attachment #2. What measure will be put in what systemic changes you with the ensure the deficient prace not recur? At weekly IDT care plan meater the term members will review the resident's scheduled for care compliance to the 7-day looi behaviors are coded in the MI How the corrective action(simonitored to ensure the practice will not recur (i. Quality Assurance Program put into place? Compliance monitoring outcode reported to the Administration in the MDS QA Attachment #3.	place or vill make tice does eting, the MDSs of plan for c back if DS.) will be deficient e., what n will be omes will or by the pommittee	April 5, 2007
SS=D	CARE PLANS							
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Facility ID: HADLEY

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CENTER	S FOR MEDICARE	& MEDICAID SERVICES				APPROV 0938-03
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SI COMPLE	
		095024	B. WING		02/2	2/2007
	ROVIDER OR SUPPLIER	ASHINGTON-HADLEY SNF	4	REET ADDRESS, CITY, STATE, ZIP COD 4601 ML KING AVE SW WASHINGTON, DC 20032	E	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION SHOU REFERENCED TO THE APPROPRIA	JLD BE CROSS-	(X5) COMPLETI DATE
F 279	to develop, review a comprehensive plan The facility must de plan for each reside objectives and time medical, nursing, ar needs that are ident assessment. The care plan must to be furnished to at highest practicable psychosocial well-be 25; and any service required under §483 to the resident's exe including the right to 10(b)(4). This REQUIREMEN Based on observation of the clinical record residents, it was def failed to initiate a ca precautions during to The findings include A review of Residen	he results of the assessment and revise the resident's in of care. velop a comprehensive care and that includes measurable tables to meet a resident's ind mental and psychosocial tified in the comprehensive describe the services that are ttain or maintain the resident's physical, mental, and eing as required under §483. It is not met as evidenced by on staff interview and review of for one (1) of 15 sampled termined that facility staff ire plan for aspiration meal time for Resident #3.	F 279	 What corrective action(s) accomplished for those of found to have been affected deficient practice? The care plan for resident reviewed and additional ap for aspiration precaution added and shared with the during the surveyor on 2/20 attachment #1. How will you identify residents who have the pot be affected by the same practice and what correcti will be taken? Audits of all resident's care are on a purce diet were rev include aspiration precautit tool was done on 2/20/0 attachment #2. No other were found to have this practice. What measure will be put or what systemic changes make to ensure the practice does not recur? The interdisciplinary team 	residents ed by the # #3 was proaches as were surveyor 0/07, See y other tential to deficient ve action plan that viewed to ons. A 07. See residents deficient in place you will deficient was re- on all blan. All ced on a spiration ehensive	
	physician's orders d directed, "4 Gram N nectar thick [nectar precautions require assistance at meal	ated December 12, 2006 that a (sodium) pureed diet with thickened liquids]. Aspiration close supervision and time; elevate HOB (head of at meal time and one (1) hour			a puree	

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	<u>RS FOR MEDICARE</u> OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(Y2) MI H		OMB NO.	0938-0391
	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILD		COMPLE	
		095024	B. WING		02/2	2/2007
	ROVIDER OR SUPPLIER	ASHINGTON-HADLEY SNF		TREET ADDRESS, CITY, STATE, ZIP CODE 4601 ML KING AVE SW WASHINGTON, DC 20032		
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F 279 F 280 SS=D	after meals." The review of the replan dated Februar with goals and appr precautions during A face-to-face inter Resident Care Coo at approximately 9:3 the resident's care of approaches for asp meal time. The rec 20, 2007. 483.20(d)(3), 483.1 CARE PLANS The resident has the incompetent or othe incapacitated under participate in planni changes in care and A comprehensive con- within 7 days after to comprehensive asso- interdisciplinary tea physician, a register for the resident, and disciplines as deternand, to the extent p the resident, the resident and revised by a tea each assessment.	esident's interdisciplinary care y 9, 2007 lacked a problem oaches for aspiration meal time. view was conducted with the rdinator on February 20, 2007 30 AM who acknowledged that olan lacked goals and iration precautions during ord was reviewed on February 0(k)(2) COMPREHENSIVE e right, unless adjudged erwise found to be the laws of the State, to ng care and treatment or	F 28	 F279 4. How the corrective action(s) we monitored to ensure the definition practice will not recure (i.e., Quality Assurance Program we put into place? Monitoring for compliance we conducted by the IDT weekly do care plan meeting. The RCC' report all deficient practices to DON and Administrator weekly the monthly QA meeting monitoring. See new QA 	icient what vill be luring s will to the y and for	April 5, 2007
ORM CMS-25	67(02-99) Previous Versions	Obsolete Event ID: GH2211	F	Facility ID: HADLEY If cont	inuation sheet	Page 6 of 39
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DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 095024 02/22/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4601 ML KING AVE SW SPECIALTY HOSPITAL OF WASHINGTON-HADLEY SNF WASHINGTON DC 20032 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE (X4) ID ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-(EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG TAG . F 280 Continued From page 6 F 280 Based on staff interview and record review for F280 one (1) of 15 sampled residents, it was What corrective action(s) will be determined that facility staff failed to update accomplished for those residents Resident #12's fall care plan with goals and found to have been affected by the approaches after multiple falls with a subsequent deficient practice? iniury. A care plan meeting was held on 2/23/07 for resident #12 by IDT team The findings include: who reviewed additional approaches to prevent future falls such as utilization A review of Resident #12's record revealed the of a chair alarm, a new low bed and following: floor mat for this resident. See March 11, 2006 - found on the floor in room attachment #1. Chair alarms arrived 3/6/07, and in-service conducted for August 10, 2006 - observed kneeling on floor September 17, 2006 - observed climbing out of staff, attachment #2. How will you identify other residents 2 bed who have the potential to be affected October 15, 2006 - attempting to climb out of bed by the same deficient practice and October 28, 2006 -attempting to climb out of bed what corrective action will be taken? November 23, 2006 - found on the floor An audit of the all the remaining November 28, 2006 - found crawling on the floor residents with multiple falls was done November 29, 2006 - attempted to get out of bed on 2/23/07 per facility protocol by the February 3, 2007 - sitting on the floor RCCs to prevent any other resident February 17, 2007 - found on the floor with from being affected by this practice. swelling and complaint of pain to left wrist All residents at risk for falls were evaluated for chair alarms, low beds, An x-ray of the left wrist and arm was taken on and floor mats. See attachment #3. February 18, 2007 and revealed a fracture of the left wrist. What measure will be put in place or what systemic changes you will make A review of the care plan revealed that on March to ensure the deficient practice does not recur? 12, 2006, facility staff initiated the approach of The falls prevention protocol was replacing the resident across from the nurse's visited on 3/5/07 to institute low beds, station when up in the geri chair. There was no floor mats and chair alarms for all evidence that facility staff implemented any residents at risk for frequent falls. additional approaches to prevent the resident Ongoing education for staff and from falling. On February 17, 2007, Resident #12 auditing of the charts of all residents fell out of the geri chair, onto the floor in the day per facility protocol will be done by the room and fractured his/her left wrist. RCC to ensure that deficient practice does not recur. A face-to-face interview was conducted with the

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PRINTED: 03/06/2007 FORM APPROVED

	T OF DEFICIENCIES	KEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1. 1		(X3) DATE SI COMPLE	
				ILDING		
		095024	B. WI	NG	02/2	2/2007
	ROVIDER OR SUPPLIER	ASHINGTON-HADLEY SNF		STREET ADDRESS, CITY, STATE, ZIP COE 4601 ML KING AVE SW WASHINGTON, DC 20032	Ε	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		ULD BE CROSS-	(X5) COMPLETIO DATE
F 280 F 309 SS=G	Resident Care Coo at 8:15 AM. He/sh were no new goals March 12, 2006 to falling. The record 2007. 483.25 QUALITY C Each resident mus provide the necess or maintain the hig mental, and psycho	ordinator on February 22, 2007 e acknowledged that there and approaches initiated after prevent Resident #12 from was reviewed February 22,		 4. How the corrective actio monitored to ensure th practice will not recur Quality Assurance Progr put into place? 309 RCC will use the facility form and audit all charts presently at risk for falls a admissions to ensure that a put in place after any reside deficient practices will be the DON and the monthly 0 	e deficient (i.e., what cam will be chart audit of residents nd any new care plan is nt falls. Any reported to	April 5, 2007
	: Based on staff inter three (3) of 15 sam supplemental resid facility staff failed to for one (1) resident diagnosed with Dila complete order way monitoring and follo to decrease freque of feeling depresse weigh one (1) resid month; and ensure as ordered by the p and H1. The findings includ 1. Facility staff faile	NT is not met as evidenced by rview and record review for pled residents and one (1) ent, it was determined that b: follow up on a Dilantin level who was subsequently antin toxicity; ensure that a s written for blood sugar bw-up on the resident's request ncy of fingersticks and a report d for one (1) resident; re- lent who lost 48 pounds in one that a PT/INR level was drawn ohysician. Residents #14, 1, 6 e: ed to follow up on a Dilantin (sult for Resident #14 who was			· · ·	

DEPAR		AND HUMAN SERVICES					03/06/2007
		& MEDICAID SERVICES					APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI			(X3) DATE SU COMPLE	JRVEY
		095024	B. WI	NG .		02/2	2/2007
NAME OF P	ROVIDER OR SUPPLIER	· ·		s ¹	TREET ADDRESS, CITY, STATE, ZIP CODE		
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F 280 F 309	Resident Care Coo at 8:15 AM. He/she were no new goals March 12, 2006 to p falling. The record 2007.	rdinator on February 22, 2007 e acknowledged that there and approaches initiated after prevent Resident #12 from was reviewed February 22,	• •••	280	interinty i	esidents by the on could t as the nursing	
SS=G	provide the necessa or maintain the high mental, and psycho accordance with the and plan of care.	receive and the facility must ary care and services to attain best practicable physical, social well-being, in e comprehensive assessment			 How will you identify other rewine who have the potential to be a by the same deficient pract what corrective action will be Records of all residents reDilantin level orders were revia 2/24/07 to check if, results were record and if not results were or results were reported to physic orders carried out accord appropriate documentation are reading to the medical records of intermit fame. See ottochem t # 1 	affected ice and taken? ecciving ewed on re in the btained; cian and ordingly; recorded	
	three (3) of 15 sam supplemental reside facility staff failed to for one (1) resident diagnosed with Dila complete order was monitoring and follo to decrease frequer of feeling depressed weigh one (1) reside month; and ensure as ordered by the p and H1. The findings include 1. Facility staff failed Phenytoin) level res	view and record review for oled residents and one (1) ent, it was determined that : follow up on a Dilantin level who was subsequently ntin toxicity; ensure that a written for blood sugar w-up on the resident's request hey of fingersticks and a report d for one (1) resident; re- ent who lost 48 pounds in one that a PT/INR level was drawn hysician. Residents #14, 1, 6 e: d to follow up on a Dilantin (rult for Resident #14 who was ted to the hospital with a		•	 if any. See attachment # 1. 3. What measure will be put in what systemic changes you w to ensure the deficient pract not recur? Medical records of future reside will receive Dilantin with Dilar test order will be reviewed of licensed staff on the night shift. outcomes will be documented lab log sheet, see attachment # 4. How the corrective action(s) monitored to ensure the of practice will not recur (i.e Quality Assurance Program put into place? Monitoring outcomes will be to the Administrator at daily meetings. Monthly cor monitoring outcomes will b rep QA committee by DON. attachment #3. 	ill make ice does ents who ntin level daily by Review d on the 2. will be leficient e., what will be reported standup npliance	April 5, 2007

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If continuation sheet Page 8 of 39

TAG REFERENCED TO THE APPROPRIATE DEFICIENCY) PA F 309 Continued From page 8 diagnosis of Dilantin toxicity. F 309 The physician's order sheet dated December 2006 directed, "Dilantin tevel every 3 months- March/June/Sept/Dec [original order dated September 8, 2006]." F 309 A review of the laboratory (lab) section of the record revealed that a Dilantin level was drawn on December 1, 2006. There was no evidence in the review. F 309 A race-to-face interview was conducted with the Resident Care Coordinator and the Director of Nursing on February 21, 2007 at 12:30 PM. After reviewing the record, they both acknowledged that there were no Dilantin level results. How the corrective action (1) the put into and the have the residents for ompleteness of the orders (completeness of parameters). No other residents were inducted by this deficient practice. According to the following nurses' notes: February 7, 2007 at 2:00 PM. "Speech therapist expressed concern to writer about resident's measure will be at alfacted by this deficient practice. What corrective action (1) the put in place or what systemic change you will make to ensure the deficient practice. February 7, 2007 at 8:00 PM, "Speech therapist expressed concern to writer about resident's monitored to convey concerns of weakness and decline in speech patiern. Doctor [name] ordered that resident by ransferred to ER [emergency room] for evaluation of altered mergency room] of evaluation of altered mergency room [or evaluation of altered mergency room] of evaluation of altered mergency room] of altered to contered to a Call on convey concerns of tweakness and decline in speech pattern. Doctor [name] ordered that resident			AND HUMAN SERVICES				FORM	03/06/2007 APPROVED 0938-0391
MARE OF PROVIDER OR SUPPLIER 02/22/2001 SPECIALTY HOSPITAL OF WASHINGTON-HADLEY SNF STREET ADDRESS. CITY, STATE JP CODE 4601 ML KING AVE SW WASHINGTON, DC 20032 (Y4) D PREFX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG STREET ADDRESS. CITY, STATE JP CODE 4601 ML KING AVE SW WASHINGTON, DC 20032 F 309 Continued From page 8 diagnosis of Dilantin toxicity. In Prefix TAG F 309 F 309 Continued From page 8 diagnosis of Dilantin toxicity. F 309 A review of the laboratory (lab) section of the record that the results for the aforementioned Dilantin level were present at the time of this review. F 309 A face-to-face interview was conducted with the Resident Care Coordinator and the Director of Nursing on February 71, 2007 at 12:30 PM. After reviewing the record, they both acknowledged that there were no Dilantin level results. F 309 A cacording to the following nurses: February 7, 2007 at 2:00 PM. "Physical therapist came up on the unit and stated that the resident was much weaker on the left is die than yesterday in therapy. A call has been made to Doctor [name] 1 to make [him/her] aware." What measure will be put in place or what systemic changes you will make to easure the deficient practice and what corrective action(s) will be monitoring to convey concerns of weakness and decline in speech pattern. Doctor [name] tordered that resident be rensfered to EF [emergency room] for evaluation of altered exercised adout convey concerns of weakness and decline in speech pattern. Doctor [name] endered that resident be rensfered to EF [emergency room] for evaluation of altered exercised concerns of weakness Aprin				l` '				
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 expressed concern to writer about resident's weakness on the right side. This writer contacted Doctor [name] to convey concerns of weakness and decline in speech pattern. Doctor [name] ordered that resident be transferred to ER [emergency room] for evaluation of altered powerlegical status. Follow up coll mode to 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur (i.e., what Quality Assurance Program will be put into place? Monitoring outcomes will be reported to Administrator at daily stand up 		diagnosis of Dilantii The physician's or 2006 directed, "Dila March/June/Sept/D September 8, 2006 A review of the labor record revealed that December 1, 2006. record that the resu Dilantin level were p review. A face-to-face inter Resident Care Coo Nursing on Februar reviewing the record that there were no I According to the fol February 7, 2007 at came up on the uni was much weaker of in therapy. A call hat I to make [him/her]	h toxicity. der sheet dated December intin level every 3 months- ec [original order dated]." pratory (lab) section of the t a Dilantin level was drawn on There was no evidence in the lts for the aforementioned present at the time of this view was conducted with the rdinator and the Director of y 21, 2007 at 12:30 PM. After d, they both acknowledged Dilantin level results. lowing nurses' notes: 2:00 PM "Physical therapist t and stated that the resident on the left side than yesterday is been made to Doctor [name aware."	Г ·		 F-309 (2A) What corrective action(s accomplished for those found to have been affect deficient practice? The physician was notified order for finger stick was re carried out for resident attachment #1. How will you identify othe who have the potential to b by the same deficient pr what corrective action will Medical records of all receiving finger sticks wer for completeness of th (completeness of parameters residents were found to be this deficient practice. What measure will be put what systemic changes you to ensure the deficient pra- not recur? Nursing staff on both unit serviced about receiving ar out complete physician or monitoring tool created 	residents ed by the d and new ceived and #1. See residents be affected actice and be taken? residents e reviewed ne orders). No other affected by in place or will make actice does s were in- ind carrying ders. New	
determine status resident was taken to hospital [name] and admitted for Dilantin toxicity and dehydration."		expressed concern weakness on the rig Doctor [name] to co and decline in spee ordered that resider emergency room] fo neurological status. determine status	to writer about resident's ght side. This writer contacted invey concerns of weakness ch pattern. Doctor [name] at be transferred to ER [or evaluation of altered Follow up call made to resident was taken to hospital			4. How the corrective action monitored to ensure the practice will not recur Quality Assurance Progra put into place? Monitoring outcomes will to Administrator at daily meetings and monthly at QA	e deficient (i.e., what am will be be reported stand up	April 5, 2007

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		AND HUMAN SERVICES		her Blo &	FORM APPRO	
		& MEDICAID SERVICES			<u>MB NO. 0938-</u>	-0391
STATEMENT	OPDEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	(X2) MULTI		3) DATE SURVEY COMPLETED	
AND PLAN O	FOURRECTION	IDENTIFICATION NOWBER.	A, BUILDIN	G	COMPLETED	
			B. WING			
<u>.</u>		095024			02/22/2007	7
NAME OF PI	ROVIDER OR SUPPLIER		STR	REET ADDRESS, CITY, STATE, ZIP CODE		
				601 ML KING AVE SW		
SPECIAL	TY HOSPITAL OF W	ASHINGTON-HADLEY SNF	l v	VASHINGTON, DC 20032		· .
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	<u> </u>	PROVIDER'S PLAN OF CORRECTION		
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TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	REFERENCED TO THE APPROPRIATE DEFI	CIENCY) DA	ATE
				F-309 (2B)		
F 309	Continued From pa	ae 9	F 309		he	
	•	-	1 000	accomplished for those resid		
1 1		07 at 4:15 PM the facility staff		found to have been affected by		
4		n level results at the request		deficient practice?		
1		e lab report revealed a Dilantin		Physician was notified on 2/22/07	of	•
	result of 29.6 H [hig	h], [normal range 10.0-20.0].		resident #1s request. The physicia		
	These			did not change the order. The med		
and File An Article	I nere was no evide	nce that facility staff followed		Director was notified and changed	the	
\$.X		evel drawn on December 1,		order from daily to finger sticks ev	rery	
	2006. Subsequently			Monday and Friday.	_	
		diagnosis of Dilantin toxicity on		How will you identify other resid		
		he record was reviewed on		who have the potential to be affe		
: MAK	February 21, 2007.		:	by the same deficient practice		
· 				what corrective action will be tal		
		d to ensure that a complete		A chart audit was conducted on 3/		
disguer pauling to to	order was written fo	r blood sugar monitoring and		of all nursing notes to ensure nur		
		ent #1's request to decrease		staff follow-up of all residents req		•
-		gersticks and the resident's		do occur. No other deficient pract were noted.	lices	-
	statement of feeling	depressed timely.		3. What measure will be put in plac		
		·		what systemic changes you will n		
		dent #1's record revealed a		to ensure the deficient practice		
		ited June 6, 2006 and		not recur?		
		red every 30 days, with the		The RCC/designces will rev	view	
		igned February 2, 2007. The		resident's records in the respec		
		cose finger stick every day at		units of evidence of documenta		
	6:00 AM."			addressing follow up of reside		
75				requests from the previous shifts d	aily.	
		ion from the physician	1	Identified deficient practices will		
		facility staff should take for		called to the attention of staff invo		
	the results of the fin	ger stick.		to correct immediately. Failure for		
ekultus maan -				compliance will result in progres	SIVE	
		ose monitoring record and the		disciplinary action. 4. How the corrective action(s) wil	1 ba	
1.8		June 2006 through February	l	monitored to ensure the defic		5,
		finger sticks ranged from 90		practice will not recur (i.e., w	1 2007	
		per 13, 2006, the resident's		Quality Assurance Program wil		
		(Normal range is 60-120).		put into place?		
		nce that facility staff notified		Outcomes will be reported to D	NON	
	the physician of the	elevated finger stick results.		daily and DON will report		
				Administrator daily at stand		
		view was conducted with the		meetings. All deficient practices		
	cnarge nurse on Fe	bruary 20, 2007 at 11:00 AM.		be tracked and monitored at mon QA meetings.	thly	

1.4.4.4.5

STATEMEN	T OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL	LTIPLE CONSTRUCTION	(X3) DATE SU COMPLE	
		095024	B. WING	S	02/2	2/2007
NAME OF F				STREET ADDRESS, CITY, STATE, ZIP CC	_/	
SPECIAI	TY HOSPITAL OF W	ASHINGTON-HADLEY SNF		4601 ML KING AVE SW WASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION SHI REFERENCED TO THE APPROPRI	OUL BE CROSS-	(X5) COMPLETION DATE
F 309	On February 21, 20 obtained the Dilant of the surveyor. The result of 29.6 H [hig There was no evide up on the Dilantin le 2006. Subsequent! hospitalized with a February 7, 2007. T February 21, 2007. 2. Facility staff faile order was written for follow-up on Reside the frequency of fin statement of feeling A. A review of Res physician's order da subsequently renew most recent order s order directed, "Glu 6:00 AM." There was no direct regarding the action the results of the fin A review of the gluo nurses' notes from 2007, revealed that	2007 at 4:15 PM the facility staff in level results at the request e lab report revealed a Dilantin gh], [normal range 10.0-20.0]. ence that facility staff followed evel drawn on December 1, y, the resident was diagnosis of Dilantin toxicity on The record was reviewed on d to ensure that a complete or blood sugar monitoring and ent #1's request to decrease gersticks and the resident's g depressed timely. ident #1's record revealed a ated June 6, 2006 and ved every 30 days, with the signed February 2, 2007. The iccose finger stick every day at tion from the physician in facility staff should take for	F 3	 D9 F-309 (2B) 1. What corrective action accomplished for the found to have been aff deficient practice? Physician was notified of request. 2. How will you identify ot who have the potential t by the same deficient what corrective action w A chart audit was conduct of all nursing notes to error at a staff follow-up of all resis do occur. No other defice were noted. 3. What measure will be p what systemic changes y to ensure the deficient prot recur? The RCC/designees resident's records in th units of evidence of d addressing follow up requests from the previou Identified deficient practicalled to the attention of to correct immediately. F compliance will result in disciplinary action. 4. How the corrective action of put into place? Outcomes will be reported. 	se residents ected by the 'resident #1s her residents to be affected practice and vill be taken? ted on 3/5/07 nsure nursing idents request tient practices ut in place or you will make practice does will review ne respective ocumentation of resident's is shifts daily. tices will be staff involved ailure for staff n progressive toon(s) will be the deficient r (i.e., what gram will be	April 5, 2007
	fingerstick was 252 There was no evide the physician of the A face-to-face inter charge nurse on Fe	(Normal range is 60-120). ence that facility staff notified elevated finger stick results. view was conducted with the bruary 20, 2007 at 11:00 AM.		daily and DON wil Administrator daily a meetings. All deficient be tracked and monitore QA meetings.	t stand up practices will	
DRM CMS-25	67(02-99) Previous Versions	Obsolete Event ID: GH2211		Facility ID: HADLEY If	continuation sheet I	Page 10 of 3
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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	
			A. BUILD	ING		
		095024	B. WING		02/2	2/2007
ame of P	ROVIDER OR SUPPLIER	·	S	TREET ADDRESS, CITY, STATE, ZIP CO	DDE	
SPECIAL	TY HOSPITAL OF W	ASHINGTON-HADLEY SNF		4601 ML KING AVE SW WASHINGTON, DC 20032		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO		(X5)
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F 309	Continued From pa	ae 10	F 30	9 _{F-309} (2C)		
	•	d the nurse what action would		- F-309 (2C) 1. What corrective action	ı(s) will he	
		dent's fingerstick was below 60		accomplished for those res		
		nurse stated, "It is a nursing		have been affected by	the deficient	
	judgement to notify			praetiee?	tified of the]
				The Psychiatrist was ne resident's request. The P		
	There was no evide	ence in the record that the		the resident on March		
	resident experience	ed hypoglycemic or		attachment #1.	, 2007. 300	
	hyperglycemic read	tions. The record was		2. How will you identify other	residents who	
	reviewed February	20, 2007.		have the potential to be a		
				same deficient practice corrective action will be ta		
	B. According to a n	urse's note dated June 9,		A chart audit was condu		
	2006 at 6:00 AM, "F	Resident stated, "I don't want		resident's request to se		
ĺ	my finger stick. I an	n not that bad a diabetic." Will		were followed. No other		
	have AM nurse call	[physician] and see if daily BS		found to have this defic		
ł	[blood sugar] can b	e changed."		All residents with the		
ļ				depression and /or verbal		
	There was no evide	ence that facility staff followed		sadness, anger, or	-	
	up on the resident's	s request. A review of the		documented in record we		
	Medication Adminis	stration Record for June 2006		the clinical social		
	through February 2	007 revealed that the resident		intervention and/or fo		
	had a finger stick de	one every morning at 6:00 AM		Psychiatrist as deemed ap		
				 What measure will be put i systemic changes you will 		
		view with the RCC was		the deficient practice does		
	conducted on Febru	uary 20, 2007 at 11:30 AM.		Nursing staff were in-service		
	He/she stated, "I wa	asn't aware that the resident		expressions of mood		
	didn't want daily fing	ger sticks. No one told me."		changes of their reside		
				leaders for intervention		
		urse's note dated June 19,		social worker. A new		A
ſ		Resident MD has been called		created see attachment #2 4. How the corrective acti		April 5, 2007
		sident because resident said [monitored to ensure the de		2007
1		d. MD promised to come and		will not recur (i.e.,	what Quality	
	see resident tonight	t."		Assurance Program will be		
	 .			Outcomes will be repo		
		nce that the physician saw the		daily and DON wil	•	
		, 2006. There was no		Administrator daily a meetings. All deficient		
		y staff followed-up on the		be tracked and monitore		
	resident's statemen	it of depression.		QA meetings.		
						
	I ne psychiatrist sav	w the resident on July 19, 2006				

PRINTED: 03/06/2007

TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REFERENCED TO THE APPROPRIATE DEFICIENCY) DA F 309 Continued From page 11	NAME OF PRO	· ·			ING		1	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CMY, STATE, ZIP CODE SPECIALTY HOSPITAL OF WASHINGTON-HADLEY SNF STREET ADDRESS, CMY, STATE, ZIP CODE MARING AVE SW VASHINGTON, DC 20032 PADE DEFINITION OF LSC IDENTIFYING NIFORMATION) PREVIX F 309 Continued From page 11 F 309 The resident was prescribed Zoloft for depression. F 309 A face-fo-face interview was conducted with the RCC on February 20, 2007 at 11:35 AM. He/she stated, "The resident's record, the RCC stated," The psychiatrist didn't soc the resident for about a month after [he/she] stated, "The psychiatrist didn't soc the resident for about a month after [he/she] state (he/she] was depressed." F 309 A face-ro-face interview was conducted with the RCC on February 20, 2007 at 11:35 AM. He/she state," The resident's record, the RCC stated, "The psychiatrist didn't soc the resident for about a month after [he/she] state finaled to re-weigh Resident ff6 after significant weight loss. How will you identify other residents what storence weights and what storence weights and what storence weight set assessment dated December 28, 2006 included the following diagnose in Section I: Diabetes other cardiovascular Disage, Anthritis, Allergies, Anemia and Renal Failure. What measure will be gate anothy, see attached 42. Extractica deet month, Reweights will be done no later than the Gried weight Poist, Parkit was conducted on all remaining residence of 24 bb from 24. Successive weights and will be done no later than the Gried weight Poist, Parkit and Printips, Allergies, Anemia and Renal Failure.	NAME OF PRO		095024	B. WING		·	02/2	2/2007
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depression.A face-to-face interview was conducted with the RCC on February 20, 2007 at 11:35 AM, He/she stated, "The resident is an antidepressant. The psychiatrist saw [him/her]"After reviewing the Resident's record, the RCC stated, "The resident's record, the RCC stated, "The reschatist didn't see the resident for about a month after [he/she] said [he/she] was depressed." The record was reviewed February 20, 2007.3. Facility staff failed to re-weigh Resident #6 after significant weight loss.The annual Minimum Data Set assessment dated December 28, 2006 include the following diagnoses in Section I: Diabetes Mellitus, Congestive Heart Failure, Hypertension, Peripheral Vascular Disease, other Cardiovascular Disease, atthritis, Allergies, Anernia and Renal Failure.According to the "Yearly Weight Chart' for Resident #6, the resident weight charge to weights to be dugust 2, 2006 2277# (pounds) September 1, 2006 229.2#. October 3, 2006 229.2#. Cotober and November 2006.There was no evidence in the record that facility staff re-weighed the resident after the atorementioned weight loss.There was no evidence in the record that facility staff re-weighed the resident after the atorementioned weight loss.There was no evidence in the record that facility staff re-weighed the resident after the atorementioned weight loss.There was no evidence in the record that facility staff re-weighed the resident after the atorementioned weight loss.There was no evidence in the record that facility staff re-weighed the resident the atorementioned weight loss.There was no evidence in the record that facility staff re-weighed the resident the atorementioned weight loss.There was no evid	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CO	RRECTIVE ACTION SHOULI	D BE CROSS-	(X5) COMPLETI DATE
depression.A face-to-face interview was conducted with the RCC on February 20, 2007 at 11:35 AM. He/she stated, "The resident is an antidepressant. The psychiatrist saw [him/her]"After reviewing the Resident's record, the RCC stated, "The resident said [he/she] was depressed." The record was reviewed February 20, 2007.3. Facility staff failed to re-weigh Resident #6 after significant weight loss.The annual Minimum Data Set assessment dated December 26, 2006 include the following diagnoses in Section I: Diabetes Mellitus, Congestive Heart Failure. Hypertension, Peripheral Vascular Disease, other Cardiovascular Disease, athritis, Allergies, Anernia and Renal Failure.According to the "Yearly Weight Chart' for Resident #6, the resident weighed: August 2, 2006 2277# (pounds) September 1, 2006 223.2#. October al, November 2006.There was an 18% weight change between August 2, 2006 214#.There was an 18% weight change between August and September 2006.August 2, 2006 214#.There was an 18% weight change between August and September 2006.August 2, 2006 214#.There was an 18% weight change between August and September 2006.August 2, 2006 included August 2, 2006 214#.There was an 18% weight change between August and September 2006.August 4, 2006 finclude to rescident after the atoremetioned weight loss.Anewight change between August 2, 2006 214#.There was an oevidence in the record that facility staff re-weighed the resident after the atoremetioned	F 309 C	Continued From pa	ge 11	F 30	9			
depression.A face-to-face interview was conducted with the RCC on February 20, 2007 at 11:35 AM, He/she stated, "The resident is an antidepressant. The psychiatrist saw [him/her]"After reviewing the Resident's record, the RCC stated, "The resident's record, the RCC stated, "The reschatist didn't see the resident for about a month after [he/she] said [he/she] was depressed." The record was reviewed February 20, 2007.3. Facility staff failed to re-weigh Resident #6 after significant weight loss.The annual Minimum Data Set assessment dated December 28, 2006 include the following diagnoses in Section I: Diabetes Mellitus, Congestive Heart Failure, Hypertension, Peripheral Vascular Disease, other Cardiovascular Disease, atthritis, Allergies, Anernia and Renal Failure.According to the "Yearly Weight Chart' for Resident #6, the resident weight charge to weights to be dugust 2, 2006 2277# (pounds) September 1, 2006 229.2#. October 3, 2006 229.2#. Cotober and November 2006.There was no evidence in the record that facility staff re-weighed the resident after the atorementioned weight loss.There was no evidence in the record that facility staff re-weighed the resident after the atorementioned weight loss.There was no evidence in the record that facility staff re-weighed the resident after the atorementioned weight loss.There was no evidence in the record that facility staff re-weighed the resident after the atorementioned weight loss.There was no evidence in the record that facility staff re-weighed the resident the atorementioned weight loss.There was no evidence in the record that facility staff re-weighed the resident the atorementioned weight loss.There was no evid		=	-		F-309 (3)	- 4		
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There was no evidence in the record that facility staff re-weighed the resident after the aforementioned weight loss.to DON and administrator daily at stand up meetings. All deficient practices will be tracked and monitored at monthly QA meetings.			ibel 2000.					
staff re-weighed the resident after the aforementioned weight loss. All deficient practices will be tracked and monitored at monthly QA meetings.	· · · · · · · ·	here was no evide	nce in the record that facility	t	to I	OON and administrator dail	ly at stand	
aforementioned weight loss. with be tracked and monthly QA meetings.				{				
indituity QA incettings.							itored at	
CRM CMS-2567(02-99) Previous Versions Obsolete Event ID: GH2211 Facility ID: HADLEY If continuation sheet Page 1					mo	nthly QA meetings.	<u></u> ·	<u>_</u>
	ORM CMS-2567	(02-99) Previous Versions	Obsciete Event ID; GH221	1 F	Facility ID: HADLE	Y If cont	inuation sheet	Page 12 d
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TATEMEN	OF DEFICIENCIES	& MEDICAID SERVICES	_	SIVE SHO THEY VERUE STOLETION	OMB NO.	URVEY
ND PLAN (IDENTIFICATION NUMBER:	A. BUILD	ING	COMPLE	TED
		095024	B. WING		8212	2/2007
IAME OF F	ROVIDER OR SUPPLIER		s [.]	TREET ADDRESS, CITY, STATE, ZIP CODE 4601 ML KING AVE SW		
SPECIA		ASHINGTON-HADLEY SNF		WASHINGTON, DC 20032	/	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOUL REFERENCED TO THE APPROPRIATI	D BE CROSS-	(X5) COMPLETIC DATE
F 309	Continued From pa	ge 11	F 30	9		
	-	prescribed Zoloft for		F-309 (3) 1. What corrective action(s) accomplished for those		
	RCC on February 2 stated, "The reside	view was conducted with the 20, 2007 at 11:35 AM. He/she nt is on an antidepressant.		found to have been affect deficient practice? The resident was weighed o Employee was counseled	n 2/20/06. on the	-
	stated, "The psychi about a month after depressed." The re 20, 2007. 3. Facility staff faile	Resident's record, the RCC atrist didn't see the resident for r [he/she] said [he/she] was ecord was reviewed February d to re-weigh Resident #6		 importance of weighing resid How will you identify other who have the potential to b by the same deficient pra what corrective action will A chart audit was conduct remaining residents to ensur- were being done and were co- attachment #1. 	residents e affected ctice and be taken? ed on all re weights	
	December 26, 2006 diagnoses in Section Congestive Heart F Peripheral Vascular Cardiovascular Dise Anemia and Renal	m Data Set assessment dated S included the following on I: Diabetes Mellitus, ailure, Hypertension, r Disease, other ease, Arthritis, Allergies, Failure.		3. What measure will be put i what systemic changes you to ensure the deficient pranot recur? A newly created Weight began 3/7/07 to include dinursing to commence morattached #2. Education of conducted on 3/7/07. Weigwas updated to reflect weight done 1st thru the 5th of ea	will make ctice does committee etary and nthly, see staff was ght Policy ghts to be	
	Resident #6, the re August 2, 2006 September 1, 2006 October 3, 2006 November 2, 2006 There was an 18% August and Septem October and Novem	277# (pounds) 229.2#. 230# 214#. weight change between aber 2006 and 7% between aber 2006.		 4. How the corrective action monitored to ensure the practice will not recur (Quality Assurance Progra put into place? Outcomes will be reported daily and DON will Administrator daily at meetings. All deficient pra be tracked and monitored a 	er than the s) will be deficient i.e., what m will be to DON report to stand up ctices will	April 5, 2007
	staff re-weighed the			QA meetings.		

Event ID: GH2211

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	03/06/2007 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU			(X3) DATE SI COMPLE	JRVEY
		095024	B. WI	NG	·	02/2	2/2007
	ROVIDER OR SUPPLIER	ASHINGTON-HADLEY SNF	•		TREET ADDRESS, CITY, STATE, ZIP CODE 4601 ML KING AVE SW WASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	- IX	PROVIDER'S PLAN OF CORREC	BE CROSS-	(X5) COMPLETION DATE
F 309	Continued From pa A face-to-face intern Resident Care Coo at 4:00 PM. He/she loss is greater than weight the resident. wasn't re-weighed a November 2006). A face-to-face intern dietician on Februar she stated, "I did a Resident] at least tw August, September talked about the car she] ate and how in high in sodium beca informed the doctor and that I was coun twice a week. I talke resident to eat only not to eat the carry weight loss is desire medical condition. more edema and th According to the fac Resident 's Weight exists between two weight should be ob licensed nurse or de Charge Nurse and I Significant Weight C	ge 12 view was conducted with the rdinator on February 20, 2007 e stated, "When the weight five pounds we have to re- I don't know why the resident at these times (September and view was conducted with the y 20, 2007 at 3:45 PM. He/ ot of counseling with [wo or three times a week in , October and November. We ry out Chinese food that [he/ portant it was not to eat foods ause of [Resident's] edema. I of the resident's condition seling the resident at least ed at great length with the the food we provided here, out food. [His/her] on-going ed because of the resident's Resident] doesn't have any e breathing is better." sility's policy, SNS. 59 " ": "If a variance of 2-4 lb successive weights a re- tained and verified by the esignee and reported to the DON " and " Addressing Changes" states: "All icant weight changes will be e supervision of a licensed	F		 P9 F-309 (4) 1. What corrective action(s) accomplished for those of found to have been affected deficient practice? Retrospectively corrective actinnot be done. On 2/22/07 bl redrawn and found to be he Blood was redrawn on 2/2. results were shared with physical placed on resident's reconstructure attachment #1. 2. How will you identify other of who have the potential to be by the same deficient practice what corrective action will be A chart audit was conducted residents receiving Coumadi PT/INR ordered were reviewed results and if they were in the same deficient of the same deficient practice of the same de	will be residents I by the on could ood was malized. 3/07 and ician and rd. See residents affected tice and e taken? d on all n with a d for lab the record to other this same nent #2. place or vill make tice does include ordered. nsed staff sis. RCC asis. A b reports	
	The above cited pol as:	icy defines significant change			· · ·		

Facility ID: HADLEY

If continuation sheet Page 13 of 39

	F OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI			(X3) DATE SI COMPLE	
		095024	B. WING		02/22/2007		
	ROVIDER OR SUPPLIER	ASHINGTON-HADLEY SNF		4601 ML I	DRESS, CITY, STATE, ZIP CO KING AVE SW GTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CO H CORRECTIVE ACTION SH RENCED TO THE APPROPR	OULD BE CROSS-	(X5) COMPLET DATE
F 309	5% in one month 7.5% in three month 10% in six months There was no evide staff re-weighed the The record was rev 4. Facility staff faile level was drawn as Resident H1. A review of Reside physician's order d directed, "Increase tube (gastrostomy Do PT/INR in on has been given for	ths and ence in the record that facility e resident after the weight loss. viewed February 20, 2007. ed to ensure that a PT/INR ordered by the physician for nt H1's record revealed a ated February 8, 2007 that Coumadin to 6mg daily via G- tube) for pulmonary embolism e week when 6 mg Coumadin one week."	F 30	9 F-309 (4 4 .	How the corrective actimonitored to ensure a practice will not recu Quality Assurance Proput into place? RCC will report to Administrator at dail meeting. Outcomes mo be reported to the QA monthly.	the deficient r (i.e., what gram will be DON and y stand up nitoring will	April 5, 2007
F 323 SS=D	A face-to-face inter RCC on February 2 acknowledged that drawn on February reviewed February 483.25(h)(1) ACCII The facility must er environment remai as is possible.	view was conducted with the 23, 2007 at 1:45 PM. He/she the PT/INR should have been 15, 2007. The record was 22, 2007.	F 323	3			
	tour, it was determ	ions during the environmental ined that facility staff failed to vironment was free from			·		Page 14 c

		AND HUMAN SERVICES				FORM	03/06/2007 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLE CO	INSTRUCTION	(X3) DATE S COMPLE	URVEY
		095024	B. WIN	IG		02/2	2/2007
	PROVIDER OR SUPPLIER	ASHINGTON-HADLEY SNF		4601 ML	DDRESS, CITY, STATE, ZIP COD . KING AVE SW NGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORF CH CORRECTIVE ACTION SHOL ERENCED TO THE APPROPRIAT	JLD BE CROSS-	(X5) COMPLETION DATE
F 323	accident hazards a resident's bed that closing and one (1) in a resident's room made in the present Maintenance, Hous nursing staff. The findings include 1. During the enviro observation at 2:40 revealed that the por room 333 preventer closing. A face-to-face inter with the surveyor w Staff members indi bed had been a cor resident refused to Resident S3 was in 2007 at 3:00 PM. A surveyor of the con resident agreed to door to close. 2. During the initial 20, 2007, an isolate blanket on the floor in room 324. The the easily moved when A face-to-face inter Resident Care Coo touring with the sur Resident] has had	s evidenced by one (1) prevented the door from blanket observed on the floor a These observations were ce of the Director of sekeeping Supervisor and e: onmental tour, an isolated PM on February 21, 2007, osition of Resident S3's bed in d the resident's door from view with facility staff touring as conducted immediately. cated that the position of the neern for many years. The move the position of the bed. terviewed on February 21, After explanation by the cerns regarding the door, the position the bed to allow the tour, at 9:30 AM on February ed observation revealed a near the bed of Resident S4 planket was not secured and touched. view was conducted with the rdinator (RCC) who was veyor. He/she stated, "[that down on the floor since ent] complains the floor is cold.		 323 F323 (1) F323 (2) /ul>	What corrective action(accomplished for those found to have been affect deficient practice? The resident agreed to position of the bed to allow be closed, and the wheels were locked in place. Maim put a permanent mark on the staff and resident to kni positioning of bed. How will you identify othe who have the potential to by the same deficient pr what corrective action will All other rooms were evalu deficient practice and no ot was found to be affected. What measure will be put what systemic changes you to ensure the deficient pr not recur? All staff was educated as to of accident and the pre 3/7/07. Housekeep Maintenance Department responsible for monitor weekly environmental rour How the corrective action monitored to ensure the practice will not recur Quality Assurance Progr put into place? The Maintenance and He Supervisor will monitor the schedule and report an practices to the Administra and monthly to EOC Patient Safety, Process In and Quality Assurance medition to the correct of the top of the schedule and report an and Quality Assurance medition to the correct of the top of the schedule and report an and Quality Assurance medition top of the schedule and report an and Quality Assurance medition top of the schedule and report an and Quality Assurance medition top of the schedule and report an and Quality Assurance medition top of the schedule and report an and Quality Assurance medition top of the schedule and report an and Quality Assurance medition top of the schedule and report an and Quality Assurance medition top of the schedule and report an and Quality Assurance medition top of the schedule and report an and quality Assurance medition top of the schedule and report an and quality Assurance medition top of the schedule and report an and quality Assurance medition top of the schedule and report an and quality Assurance medition top of the schedule and report an and quality Assurance medition top of the schedule and report an and quality Assurance medition top of the schedule and report an and qua	residents ted by the change the the door to of the bed tenance will he floor for ow correct er residents be affected ractice and Il be taken? ated for this her resident in place or u will make actice does the hazards vention on bing and s will be ing during inds. n(s) will be e deficient (i.e., what ram will be busekeeping te areas on a by deficient ator weekly, Committee, nprovement,	April 5, 2007

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES		<u> </u>	Levised Hurser		APPROVE 0938-039
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLE (LDING		(X3) DATE SI COMPLE	
		095024	B. WIN	IG		02/2	2/2007
IAME OF P	ROVIDER OR SUPPLIER			STREET	ADDRESS, CITY, STATE, ZIP COD		
SPECIAL	TY HOSPITAL OF W	ASHINGTON-HADLEY SNF		4601 I	ML KING AVE SW HINGTON, DC 20032	-	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORF EACH CORRECTIVE ACTION SHOL EFERENCED TO THE APPROPRIA	JLD BE CROSS-	(XS) COMPLETIO DATE
F 323	Continued From pa			323 1.		a) mill ba	
1 020		-	. F.	231.	What corrective action(accomplished for those		
		s evidenced by one (1)			found to have been affect		
	resident's ded that	prevented the door from		{	deficient practice?		
	closing and one (1)	blanket observed on the floor h. These observations were		{	Resident agreed to replace b	lanket with	
					red rug with a non skid b	acking that	l
-		nce of the Director of sekeeping Supervisor and			was completed on 2/21/		
\$1		sekeeping supervisor and		{	discussion with all reside		
¥1 °	nursing staff.				agreed by all residents to		ļ
· ·	The findings includ				rugs from resident's rooms.		
i	The findings includ	e:	•	p .	How will you identify othe		
а.	A D Star B - américa				who have the potential to		
,	1. During the enviro	onmental tour, an isolated		Ì	by the same deficient pr what corrective action wil		
	observation at 2:40	PM on February 21, 2007,		{	All other resident's with ru		
		osition of Resident S3's bed in			floors were evaluated for th		(
•	-	d the resident's door from	•		practice and the resid		
	closing.				informed that the rugs		
		the stitute of the state			removed. All residents agro		ł
	A face-to-face inter	view with facility staff touring		3.	What measure will be put		
	with the surveyor W	as conducted immediately.		ſ	what systemic changes yo		1.
	Staff members indi	cated that the position of the			to ensure the deficient pr		
	bed had been a co	ncern for many years. The			not recur?		
	resident refused to	move the position of the bed.			All staff was educated as to		
		1		1	of accident and the pro-		(
'e'	Resident S3 was in	terviewed on February 21,			injury. Housekeeping and M		
	2007 at 3:00 PM. /	After explanation by the			Departments will be resp	weekly	
ST.	surveyor of the con	cerns regarding the door, the	}	[monitoring during cnvironmental rounds. A c		
444		position the bed to allow the			check list was created for r		Į
· · ·	door to close.	· ·	-	1	also. See attachment #1.	idianing outer	
				4.	How the corrective actio	n(s) will be	} .
• .	2. During the Initial	tour, at 9:30 AM on February		[**•	monitored to ensure th		April 5,
	20, 2007, an isolat	ed observation revealed a		•	practice will not recur		2007
•		r near the bed of Resident S4	ļ		Quality Assurance Prog		· .
		blanket was not secured and			put into place?		
	easily moved when	i loucnea.))		ousckceping	
	A francisco francisco inter	tion was conducted with the	{		Supervisor will monitor th	c areas on a	[
	A race-to-race intel	rview was conducted with the			schedule and report an	y deficient	,
	Resident Care Coo	ordinator (RCC) who was			practices weekly to the Ad	uninistrator,	
	touring with the su	rveyor. He/she stated, "[ļ		and monthly to EOC comm Safety Committee,	Process	
	Residentj nas had	that down on the floor since			Safety Committee, Improvement Committee,		ι ·
	Christmas. [Kesid	ent] complains the floor is cold.	1	1	Assurance meeting.	und Zonny	

	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SI COMPLE	TED
		095024	B. WING		02/2	2/2007
	PROVIDER OR SUPPLIER	ASHINGTON-HADLEY SNF	4	REET ADDRESS, CITY, STATE, ZIP COD 601 ML KING AVE SW WASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION SHOU REFERENCED TO THE APPROPRIA	JLD BE CROSS-	(X5) COMPLETIO DATE
F 323	accident hazards as resident's bed that closing and one (1) in a resident's room made in the presen Maintenance, Hous nursing staff. The findings include 1. During the enviro observation at 2:40 revealed that the por room 333 prevented closing. A face-to-face inter with the surveyor w Staff members indi- bed had been a cor resident refused to Resident S3 was in 2007 at 3:00 PM. A surveyor of the con resident agreed to p door to close. 2. During the initial 20, 2007, an isolate blanket on the floor	s evidenced by one (1) prevented the door from blanket observed on the floor . These observations were ce of the Director of ekeeping Supervisor and e: 	F 323	 F323 (2) What corrective action(accomplished for those found to have been affect deficient practice? Resident agreed to replace 1 red rug with a non skid to was completed on 2/21/07. How will you identify othe who have the potential to by the same deficient pro- what corrective action with All other resident's with ru floors were evaluated for the practice and the reside informed that the rugs removed. What measure will be put what systemic changes yo to ensure the deficient pro- not recur? All staff was educated as to of accident and the pro- injury. Housekeeping and 1 Departments will be resp monitoring during environmental rounds. A check list was created for also. See attachment #1. How the corrective action monitored to ensure the practice will not recur Quality Assurance Progr put into place? Maintenance and H Supervisor will monitor the schedule and report ar practices weekly to the Action 	e residents cted by the blanket with backing that er residents be affected ractice and ll be taken? igs on room his deficient dents were had to be t in place or u will make ractice does o the hazards evention of Maintenance bonsible for weekly daily rounds nursing staff n(s) will be te deficient (i.e., what ram will be ousekeeping te areas on a by deficient	April 5, 2007
	Resident Care Coo touring with the sur Resident] has bad t	view was conducted with the rdinator (RCC) who was veyor. He/she stated, "[hat down on the floor since ent] complains the floor is cold.		and monthly to EOC comm Safety Committee, Improvement Committee, Assurance meeting.	Process	
ORM CMS-2	567(02-99) Previous Versions	Obsolete Event ID: GH2211	Fa	cility ID: HADLEY If co	ontinuation sheet	Page 15 of

TATEMEN	T OF DEFICIENCIES	E & MEDICAID SERVICES	(X2) MUL		(X3) DATE S COMPLE	
		IDENTIFICATION NONDER.	A. BUILD	A. BUILDING		
		095024	B. WING		02/2	2/2007
AME OF F	PROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP COL	DE	
SPECIAI	LTY HOSPITAL OF W	ASHINGTON-HADLEY SNF		4601 ML KING AVE SW WASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SHO REFERENCED TO THE APPROPRIA	ULD BE CROSS-	(X5) COMPLETIO DATE
F 323		•	F 32	23 F324		
	blanket back dowr why the resident w	ans the floor then put the o on it." The surveyor asked as using a blanket and not a backing. The RCC stated, " with a rug."		 What corrective action accomplished for those found to have been affe deficient practice? 	residents cted by the	
F 324 SS=G	483.25(h)(2) ACCI	DENTS	F 32	staff on the day the incider	insufficient it occurred.	} .
		nsure that each resident supervision and assistance accidents.		2. How will you identify oth who have the potential to by the same deficient p what corrective action wi All residents have the po	be affected ractice and II be taken?	
	:	NT is not met as evidenced by		affected by this deficient p the PPD falls below 3.5. nurse staffing rule was re	The 24 hour	
	one (1) of 15 samp determined that fa	erview and record review for bled residents, it was cility staff failed to provide ion for Resident #12 who had	×	staff to ensure that a minir of 3.5 is achieved on a dai 3. What measure will be pu	num of PPD ly basis. t in place or	
	multiple falls with a	a subsequent injury.		what systemic changes yo to ensure the deficient p not recur?	ractice does	
	The findings includ	le: ent #12's record revealed the		The DON is in the process for PRN staff. A unit clerk weekends on both nursir	position for	
	following:			approved to keep nurses majority of administrativ weekends. On weekends	from doing e duties on	
	August 8, 2006 - c rails	ound on the floor in room observed climbing over the side		inclement weather days w call outs we have in emergency bonus plan for	nen there are stituted an	
	rails	 attempting to climb over side attempting to climb out of bed 		See attached #1.4. How the corrective action	: on(s) will be	April 5,
	November 12, 200 November 28, 200 November 29, 200 February 3, 2007 -	6 - found on the floor 6 - found crawling on the floor 6 - attempted to get out of bed		monitored to ensure t practice will not recur Quality Assurance Prog put into place? All deficient practices will to DON and Administra	(i.e., what ram will be l be reported	2007
		laint of pain to left wrist		RCC for immediate correction.		

Facility ID: HADLEY

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE SUI COMPLET	
		095024	B. WING		02/22	/2007
	SUMMARY STA		4601 WAS	T ADDRESS, CITY, STATE, ZIP CODE I ML KING AVE SW SHINGTON, DC 20032 PROVIDER'S PLAN OF CORRECT		(X5)
PREFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE D		COMPLÉTIC DATE
F 324 F 329 SS=D	during the day of th hours per resident p requirement of 3.5 day. A face-to-face inter Resident Care Coo at 8:15 AM. He/she reviewing the recor- initiated after March resident from falling February 22, 2007. 483.25(I) UNNECE Each resident's dru unnecessary drugs drug when used in duplicate therapy); without adequate m indications for its us adverse consequer should be reduced combinations of the Based on a compre- resident, the facility who have not used given these drugs u therapy is necessar as diagnosed and o record; and residen drugs receive gradu behavioral intervent	e incident was 3.0 nursing per day, below the DC nursing hours per resident per view was conducted with the rdinator on February 22, 2007 e acknowledged that after d, there were no interventions in 12, 2006 to prevent the g. The record was reviewed SSARY DRUGS g regimen must be free from . An unnecessary drug is any excessive dose (including or for excessive duration; or nonitoring; or without adequate se; or in the presence of neces which indicate the dose or discontinued; or any	F 324 F-3 1. F 329 3. 4.	 What corrective action(s) waccomplished for those refound to have been affected deficient practice? The Psychiatrist of resident in notified of the survey findings, re-assessed the resident discontinued the Haldol, see atta #1. How will you identify other rewho have the potential to be a by the same deficient practiwhat corrective action will be The charts of all other residents are affected by this d practice. What measure will be put in pwhat systemic changes you wito ensure the deficient praction for continue Monitoring and outcomes was reported to the MD for adjustments or discontinuation for continue Monitored for presence/abse clinical indication for continue Monitoring and outcomes was reported to the MD for adjustments or discontinuation for continue the corrective action (be monitored to ensure deficient practice will not (i.e., what Quality Ass Program will be put into place Compliance monitoring outcom be reported to monthly Assurance. 	sidents by the #1 was and she and achment sidents iffected ice and taken? ents on o other eficient blace or Il make ce does will be nce of ed use. will be dosage ion by nt #2. s) will e the recur surance ? mes will	April 5, 2007

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