,TMENT OF HEALTH AND HUMAN SERVICES
i ERS FOR MEDICARE & MEDICAID SERVICES

EMENT OF DEFICIENCIES
J PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER

GRANT PARK CARE CENTER

(X4) ID
PREFIX
TAG

095019

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

F 000 1 INITIAL COMMENTS

F 253
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An annual recertification survey was conducted
on April 2 through 5, 2007. The following
deficiencies were based on observations, record reviews and facility staff interviews. The sample included 30 residents based on a census of 281

residents on the first day of the survey and 13 supplemental residents.

483.15(h)(2) HOUSEKEEPING/MAINTENANCE

The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.

This REQUIREMENT is not met as evidenced by:

Based on observations and staff interview during the environmental tour, it was determined that the facility did not provide housekeeping and maintenance services necessary to maintain a safe, clean, and homelike environment for residents as evidenced by: marred and/or damaged doors, floors, baseboards, walls, vertical blinds, and straight back chairs, standing water in the laundry room, graffiti on elevator walls, accumulated cigarette butts on the front sidewalk and cleaning equipment stored on the floor. These observations were made on April 2, 2007 between 2:30 PM and 7:30 PM in the

presence of maintenance, housekeeping and nursing staff.

The findings include:

1, 2S shower room, 301, 324, 4S clean utility

1. The front and edge surfaces of shower, bath and resident room entrance doors were marred

and/or damaged in rooms 201, 203, 210, 220,

PROVIDERJSUPPLIER ENTATNE'S SIGNATURE

(X2) MULTIPLE CONSTRUCTION

A. BUILDING

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B. WING -_vhRjME!T OF A7E

PRINTED: 04/13/2007
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BOMB NO. 0938-0391

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PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

F253(1)
1. The front edges of the shower doors
and resident bathroom doors to rooms
201, 203, 210, 220, 231, 2 South shower,
301, 324, 4 South's clean utility,
basement and laundry doors have been
repaired and painted.
2. The maintenance staff will check all

doors throughout facility to ensure
that no other doors are deficient

3. Housekeeping and maintenance staff were in-serviced on regulations on

I (X5)

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04/30/07

maintaining sanitary, orderly and
comfortable interior to provide residents
with safe, clean and homelike environment 04/30/07
4. Maintenance staff will perform random
weekly inspections of doors
to ensure compliance. Findings from the
weekly audit will be reported to the facility
Quality Improvement Committee monthly. 05/02/07

tatement ending with an asterisk (*) denotes a deficiency which the institution may bd f e excuserom correcting providing it is determined that `tuafds provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days

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
the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued nation.

99) Previous Versions Obsolete Event ID:3ZTP11 Facility ID: GRANTPARK If continuation sheet Page 1 of 44

(X1) PROVIDER/SUPPLIERJCLIA
IDENTIFICATION NUMBER:

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

STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER

GRANT PARK CARE CENTER

(X4) ID
PREFIX
TAG

F 253

(X1) PROVIDER/SUPPLIER/CLIA
IDENTIFICATION NUMBER:

095019

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

Continued From page 1

room, basement and laundry room doors in 11 of 23 doors observed.

2. Floors and baseboards were soiled, marred and/or damaged in rooms 203, 212, 220, 329, 1st floor dining room, 2S pantry, 3S soiled utility room, 4S pantry, basement housekeeping and equipment storage areas in 10 of 28 floors and baseboards observed.

3. Walls were marred, scarred and/or damaged in rooms 201, 203, 231, 234, 2N shower room, 3S dayroom, 4S dayroom, 4S soiled utility room in eight (8) of 24 walls observed.

4. Vertical blinds in dayrooms were damaged with missing slats on 2S, 2N, 3S, 3N, and 4S in 5 of 5 dayroom windows observed.

5. Straight back chairs were damaged and/or marred in dayrooms: 2N nine (9) of 13 chairs observed; 2S eight (8) of 12 chairs observed; 3N six (6) of six (6) chairs observed; 3S five (5) of six
(6) chairs observed; 4S seven (7) of 11 chairs observed.

6. Standing water was observed on the floor in the rear of washers in the laundry room in one (1) of one (1) observation of the laundry room.

7. Elevator door frames were marred and the interior walls of the elevators had graffiti on the
walls in three (3) of three (3) elevators observed.

8. Cigarette butts were accumulated on the
sidewalk near the main entrance on the first day
of the survey in one (1) of one (1) observations of
the front sidewalk.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID:3ZTP11

(X2) MULTIPLE CONSTRUCTION
A. BUILDING

B. WING

STREET ADDRESS, CITY, STATE, ZIP CODE
5000 BURROUGHS AVE. NE

WASHINGTON, DC 20019

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TAG

F 253

PRINTED: 04/13/2007
FORM APPROVED
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(X3) DATE SURVEY
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PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

F253(2)
I I. All floors and baseboards identified
as being damaged in room 203, 212,
220, 329, 1st Floor dining room,
2 South pantry, 3 South soil utility,
4 South pantry, basement
housekeeping and equipment storage
areas have been cleaned and repaired.
2. Maintenance staff will check all

floors and baseboards throughout
building to ensure that no other
floors or baseboards are deficient.
3. Housekeeping and maintenance staff
were in-serviced on regulations on
maintaining sanitary, orderly and
comfortable interior to provide residents
with safe, clean and home-like
environment.

4. Maintenance staff will complete
random weekly inspections of floors
and baseboards to ensure compliance.
Findings from weekly audit will be
reported to facility Quality
Improvement Committee/Risk
Management monthly.

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(X5)
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DATE

04/27/07

04/30/07

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FORM APPROVED

Health Regulation Administration

STATEMENT OF DEFICIENCIES

AND PLAN OF CORRECTION (X1) PROVIDERISUPPLIER/CLIA

IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY
COMPLETED
A. BUILDING

095019 B. WING

04/05/2007
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

GRANT PARK CARE CENTER 5000 BURROUGHS AVE. NE
WASHINGTON, DC 20019

(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE

TAG REGULATORY OR LSC IDENTIFYING INFORMATION)

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TAG CROSS-REFERENCED TO THE APPROPRIATE DATE
DEFICIENCY)

#3

1. Marred, scarred and damaged walls
identified in room 201, 203, 231, 234,
2 North shower room, 3 South day
room, 4 South day room and 4 South
soiled utility room were repaired. 04/27/07
2. Maintenance staff will check all walls
throughout facility to ensure that no
other walls are deficient. 04/30/07
3. Housekeeping and maintenance staff
were in-serviced on regulations on
maintaining sanitary, orderly and
comfortable interior to provide residents
with safe, clean and home-like
environment. 04/30/07
4. Maintenance staff will complete
random weekly inspections of walls
throughout facility to ensure compliance.
Findings from random weekly audit
will be presented to facility Quality
Improvement/Risk Management

meeting. 05/02/07
#4

1. Damaged vertical blinds on 2 South,
2 North, 3 South, 3 North and 4 South
will be replaced. 05/11/07
2. Maintenance staff will check all

vertical blinds in building to ensure
compliance. Damaged blinds will be
replaced. 04/30/07
3. Housekeeping and maintenance staff
were in-serviced on regulations on
maintaining sanitary, orderly and
comfortable interior to provide residents
with safe, clean and home-like

environment. 04/30/07
4. Maintenance staff will complete
weekly audit of all vertical blinds to
ensure compliance. Findings from
weekly audit will be reported to
facility Quality Improvement/Risk
Management Committee monthly. 05/02/07

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Health Regulation Administration

STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER

GRANT PARK CARE CENTER

(X4) ID
PREFIX
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(X1) PROVIDER/SUPPLIER/CLIA
IDENTIFICATION NUMBER:

095019

(X2) MULTIPLE CONSTRUCTION
A. BUILDING
B. WING

STREET ADDRESS, CITY, STATE, ZIP CODE

5000 BURROUGHS AVE. NE
WASHINGTON, DC 20019

SUMMARY STATEMENT OF DEFICIENCIES
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04/05/2007

PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
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45

I I. All straight back chaos on 2 North,
2 South, 3 North, 3 South and 4
South will be repaired.
2. Maintenance will check all chairs
throughout building to ensure that no
other chairs are deficient.

3. Housekeeping and maintenance staff
were in-serviced on regulations on
maintaining sanitary, orderly and
comfortable interior to provide residents
with safe, clean and home-like
environment.
4. Maintenance staff will complete
random weekly audits of all straight
back chairs to ensure compliance.
Findings from weekly audit will be
reported to facility Quality
Improvement/Risk Management
Committee monthly.
#6

1. Leaking hose on back washer was
replaced.
2. All washers were checked to ensure
that no other hoses were leaking.
3. Housekeeping and maintenance staff
were in-serviced on regulations on
maintaining sanitary, orderly and
comfortable interior to provide residents
with safe, clean and home-like
environment.
4. Maintenance staff will complete
weekly audits of all hoses leading
from and to washers. Findings from
weekly audit will be reported to facility
Quality Improvement/Risk Management
Committee.

Health Regulation Administration

STATE FORM 6899 3ZTP11

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(X3) DATE SURVEY
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COMPLETE
DATE

04/30/07

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04/30/07

05/02/07

If continuation sheet 30 of 30

Health Regulation Administration

STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER

GRANT PARK CARE CENTER

(X4) ID
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(X1) PROVIDERISUPPLIER/CLIA
IDENTIFICATION NUMBER:

095019

(X2) MULTIPLE CONSTRUCTION
A. BUILDING
B. WING

STREET ADDRESS, CITY, STATE, ZIP CODE

5000 BURROUGHS AVE. NE
WASHINGTON, DC 20019

SUMMARY STATEMENT OF DEFICIENCIES
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04/05/2007

PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
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#7

1. Elevator door frames have been repaired
and graffiti was cleaned off interior of
elevator while surveyors were in the
building.
2. Maintenance will examine all elevator
door frames to ensure that no other
door frame is deficient.
3. Housekeeping and maintenance staff
were in-serviced on regulations on
maintaining sanitary, orderly and
comfortable interior to provide residents
with safe, clean and home-like
environment.
4. Maintenance staff will complete
random weekly audit of elevators to
ensure compliance. Findings from
weekly audit will be reported to facility
Quality Improvement/Risk Management
Committee monthly.
#8

1. Facility cleaned cigarette butts
immediately after surveyors
identified them

2. Front entrance of building is
routinely cleaned by 7 AM each day.
3. Housekeeping staff educated on
cleaning front of building by 6 AM
daily.
4. Housekeeping supervisor, administrator
or designee will complete weekly
rounds of front entrance. Findings from
weekly audit will be reported to
facility Quality Improvement/Risk
Management Committee monthly.

Health Regulation Administration

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DATE

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If continuation sheet 30 of 30

Health Regulation Administration

STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER

GRANT PARK CARE CENTER

(X4) ID
PREFIX
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(X1) PROVIDER/SUPPLIER/CLIA
IDENTIFICATION NUMBER:

095019

(X2) MULTIPLE CONSTRUCTION
A. BUILDING
B. WING

STREET ADDRESS, CITY, STATE, ZIP CODE

5000 BURROUGHS AVE. NE
WASHINGTON, DC 20019

SUMMARY STATEMENT OF DEFICIENCIES
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PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
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#9

1. All cleaning equipment stored on
floor were removed immediately
from janitor's closet and hallway
on 2 North, 2 South, 3 North and 4
South.
2. Facility housekeeping staff will
complete audit of all janitor's closets
and hallways to ensure that no cleaning
equipment is left sitting on floor to
ensure compliance.
3. Housekeeping staff was re-educated
on importance of storing equipment in
proper location and correctly.
4. Housekeeping supervisor or designee
will complete random weekly audits
to ensure continued compliance.
Findings from weekly audits by
Housekeeping Supervisor will be
reported to facility Quality
Improvement/Risk Management
Committee monthly.

Health Regulation Administration

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(X3) DATE SURVEY
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DATE

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If continuation sheet 30 of 30

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

STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA
IDENTIFICATION NUMBER:

095019

NAME OF PROVIDER OR SUPPLIER

GRANT PARK CARE CENTER

(X4) ID
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F 253

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SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

Continued From page 2

9. Cleaning equipment such as mops, brooms
and dust pans were stored on the floor of the janitorial closets and in the hallway on 2N, 2S, 3N hallway and 4S in four (4) of eight (8) observations of cleaning equipment.

Maintenance, housekeeping and nursing staff acknowledged the above cited items.
483.20(g) - 0) RESIDENT ASSESSMENT

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 resident assessment is subject to a civil money penalty of not more than $5,000 for each
assessment.

Clinical disagreement does not constitute a material and false statement.

(X2) MULTIPLE CONSTRUCTION

A. BUILDING

B. WING

STREET ADDRESS, CITY, STATE, ZIP CODE
5000 BURROUGHS AVE. NE

WASHINGTON, DC 20019

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F 253

F 278

OMB NO. 0938-0391

(X3) DATE SURVEY
COMPLETED

04/05/2007

PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
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(x5)
COMPLETION
DATE

04/17/07

04/30/07

04/30/07

Improvement Committee monthly. 05/02/07

F278 (1)
I. Using the MDS Correction Policy,
an MDS modification for resident #2
was completed to correct falls coding
on April 17, 2007.
2. The MDS Correction policy will be
used to correct other findings based
on review. Residents with falls have
been identified and reviewed from
January, 2007 to present to review
for correct coding on MDS and
correct coding on MDS and appropriate
modifications made.
3. MDS nurses and Unit Managers will be
reeducated on properly coding MDS's
for falls.
4. Administrator/DON or
designee will perform weekly audits
X 4 weeks then monthly audits of
MDS's to ensure that resident
falls are captured and coded
appropriately. Findings from audits
will be reported to facility Quality

F 278 483.20 (g) - 0) Resident Assessment

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

PRINTED: 04/13/2007
FORM APPROVED
OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ()(2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING

COMPLETED

095019 B. WING

04/05/2007
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

GRANT PARK CARE CENTER 5000 BURROUGHS AVE. NE
WASHINGTON, DC 20019

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

F 278 Continued From page 3 F 278 F278 (2)
This REQUIREMENT is not met as evidenced 1. The MDS for resident #23 was corrected. 04/03/07

2. Facility will complete an audit of all new by: admissions from January 2007 to present Based on record review and staff interview for two to ensure that MDS coding reflects (2) of 30 sampled residents, it was determined resident's current conditionstdiseases. 04/30/07

that facility staff failed to accurately code one (1) 3. MDS Coordinator will be reeducated on
resident for falls and include diagnoses on the appropriate coding of MDS sections I, 12, 13,
admission Minimum Data Set (MDS) assessment J4 and J5. 04/30/07
for one (1) resident. Residents #2 and 23. 4. Administrator/DON or designee will
complete weekly audits X 4 weeks then

The findings include: monthly audits of MDS's to ensure correct
coding. Findings from the MDS audits will

1. The facility staff failed to code Resident #2 for be presented to facility Quality
Improvement committee monthly. 05/02/07 falls on the MDS.

A review of Resident #2 ' s record revealed that a
quarterly MDS completed February 6, 2007 did
not code the resident for falls under Section J4
Accidents " .

A review of the nursing progress notes dated
December 10, 2006 revealed, "...Observed resident standing then attempted to sit in motorized chair and missed chair and slid to... [floor]"

A face-to-face interview was conducted with Assistant Unit Manager #1 on April 5, 2007 at 10:50 AM. He/she acknowledged that the resident slid to the floor and the quarterly MDS was not coded for falls. The record was reviewed on April 2, 2007.

2. Facility staff failed to include Resident #23 ' s diagnoses on the admission MDS.

A review of Resident #23 ' s record revealed that the admission MDS was completed October 27, 2006. Section J5, "Stability of Condition" for, "Conditions/diseases make resident's cognitive,

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT

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NAME OF P

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F 278

F 280
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OF DEFICIENCIES
F CORRECTION

ROVIDER OR SUPPLIER

PARK CARE CENTER

(XI) PROVIDERISUPPLIER/CLIA
IDENTIFICATION NUMBER:

095019

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

Continued From page 4

ADL (Activities of Daily Living), mood or behavior

patterns unstable -(fluctuating, precarious, or deteriorating." Section 11, " Disease Diagnoses " was coded as " None of the Above. " Section 12, " Infections " was coded as " None of the Above
Section 13, " Other current or more detailed diagnoses and ICD-9 codes " was blank. In Section P, "Special Treatments and Procedures," the resident was coded as being monitored for an acute medical condition and receiving occupational therapy.

The physician completed the admission history and physical assessment on October 15, 2006.

Working diagnoses included, " S/P (status post) cervical laminectomy, cervical spinal break, C3-C7 spinal cord syndrome. "
A face-to-face interview with Assistant Unit

Manager #1 was conducted on April 4, 2007 at 4:00 PM. He/she acknowledged that diagnoses

were not coded on the MDS. The record was reviewed April 4, 2007.

483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS

The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.

A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility
for the resident, and other appropriate staff in
disciplines as determined by the resident's needs,

-ORM CMS-2567(02-99) Previous Versions Obsolete Event ID:3ZTP11

(X2) MULTIPLE CONSTRUCTION
A. BUILDING

B. WING

STREET ADDRESS, CITY, STATE, ZIP CODE
5000 BURROUGHS AVE. NE

WASHINGTON, DC 20019
ID
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F 278

F 280

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FORM APPROVED
OMB NO. 0938-0391
(X3) DATE SURVEY
COMPLETED

04/05/2007

PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

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(X5)
COMPLETION
DATE

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

STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER

GRANT PARK CARE CENTER

(X4) ID
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F 280

(X1) PROVIDER/SUPPLIER/CLIA
IDENTIFICATION NUMBER:

095019

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

Continued From page 5

and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.

This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview for one (1) of 30 sampled residents, it was determined that facility staff failed to update Resident #20's care plan for falls and alcohol consumption.

The findings include:

A review of the nurses' notes for Resident #20's record revealed the following:

August 22, 2006 at 2:00 PM "...observed floor..." [No injury, MD (medical doctor) not notified.]

September 13, 2006 at 10:50 AM - "...observed on the bathroom floor by the rail..." [No injury, MD notified.]

September 13, 2006 at 2:15 PM- " Resident has been drinking beer. Resident was removed from his/her w/c [wheelchair] and placed in bed ... " [No injury, MD not notified.]

September 18, 2006 at 12:15 AM - " Resident
returned to the unit at 12:15 ... has a very strong
smell of alcohol on his/her breath. " [No injury,
MD not notified.]

September 19, 2006 at 11:00 PM - "...Resident's
breath also smell of alcohol." [No injury, MD not

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 3ZTP11

(X2) MULTIPLE CONSTRUCTION
A. BUILDING

B. WING

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5000 BURROUGHS AVE. NE

WASHINGTON, DC 20019

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F 280

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04/05/2007

PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

F 280 483.20 (d) (3), 483.10 (k)(2) Comprehensiivq
1. Resident #20 was offered an alcoholic
treatment program but refused.
2. Facility will review all residents with ETOH abuse to ensure that they have been properly
care planned and that appropriate treatment
programs have been offered.
3. All licensed staff will be reeducated on identification of residents with alcohol abuse, documentation and notification of physician
and social services.
4. Facility Administrator/DON or designee will perform weekly audits X 4 and then
monthly audits of all residents who display
signs of alcohol abuse to ensure that
appropriate treatment is offered and that
care plans are updated to ensure compliance. Findings from the monthly audit will be
presented to facility Quality Improvement
Committee monthly.

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COMPLETION
DATE

Care Plans

04/30/07

04/30/07

04/30/07

05/02/07

aa dy D. GRANTPARK If continuation sheet Page 6 of 44

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

STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER

GRANT PARK CARE CENTER

(X4) ID
PREFIX
TAG

(X1) PROVIDER/SUPPLIER/CLIA
IDENTIFICATION NUMBER:

095019

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

(X2) MULTIPLE CONSTRUCTION
A. BUILDING

B. WING

STREET ADDRESS, CITY, STATE, ZIP CODE
5000 BURROUGHS AVE. NE
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F 280 Continued From page 6 F 280 notified.]

November 5, 2006 at 12:00 AM- "...Resident was observed with strong smell of alcohol.
Responsible party stated: " He/she had a couple
of beers at the party ..." [No injury, MD not
notified.]

November 18, 2006 at 5:15 PM - "... Resident observed with hematoma on frontal aspect of forehead, sustained from fall on floor in his/her room..." [Injury, MD notified.]

January 10, 2007 at 11:30 PM - "...Resident was observed on the floor lying by CNA while making rounds on his/her back by the side of the [his/her] bed.. .Observed alcohol smell on his/her breath ..." [No injury, MD notified .]

January 11, 2007 at 11:00 PM " Resident was observed sitting out in pitch darkness on front patio. He/she appears to be intoxicated with alcohol (He/she smelled of alcohol). He/she appeared helpless and almost falling out of the chair. He/she appeared so intoxicated he/she could not answer any questions." [No injury, MD not notified.]

February 1, 2007 at 8:00 AM - "Resident was observed on the unit very drunk. He/she was brought up by a staff from downstairs where he/she was drinking. All his/her clothes and pants were saturated with urine. He/she refuse to be undressed and be assisted. He/she was combative and scratched one of the CNA [Certified Nurse Aide] while attempting to wash him/her and keep clean clothes on him/her." [No injury, MD not notified.]

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PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
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(X5)
COMPLETION
DATE

-ORM CMS-2567(02-99) Previous Versions Obsolete Event ID:3ZTP11 acihty ID. GRANTPARK If continuation sheet Page 7 of 44

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

STATEMENT OF DEFICIENCIES
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F 280 Continued From page 7 F 280 February 28, 2007 at 1: 15 AM - "...Observed on

the floor... He/she is smelling very strong of alcohol." [No injury, MD notified.]

April 4, 2007 at 9: 50 PM- "Called stat to parking lot by security. Resident found lying on ground

with wheelchair on side. Nose bruised and
bleeding. Rt (right) wrist scraped... Resident was
asked what he/she had been drinking and response was " Beer" [Injury, MD notified.]

The review of Resident #20's care plan revealed the following problem initiated July 6, 2006, "Resident is consuming alcoholic beverages regardless of prescribed medication interactions

and medical conditions." An approach included, "Notify MD of alcohol consumption / follow orders

as given."

There was no evidence that new approaches were implemented when the care plan was reviewed on August 10 and November 2, 2006 and January 25, 2007. Additionally, there was no evidence that the MD was consistently notified when the resident was observed to be intoxicated.

A review of the "Potential for injury, risk for falls..." care plan revealed that the above cited falls with the exception of the fall on September 13, 2006 were documented. However, facility staff failed to initiate additional approaches after the resident fell on September 13, 2006. Subsequently, the resident fell on November 18, 2006 and on April 4, 2007 and sustained injury from both falls.

A face-to-face interview was conducted with the Unit Manager #2 and the Director of Nursing on April 5, 2007 at approximately 3:00 PM. They

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STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER

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F 280

F 309
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SUMMARY STATEMENT OF DEFICIENCIES
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Continued From page 8

acknowledged that after reviewing the record, the physician was not contacted as per the plan of care after each alcoholic incident. Additionally, no new interventions were initiated after September 13, 2006 to prevent the resident from falling and subsequently sustaining injuries. The record was reviewed April 5, 2007.
483.25 QUALITY OF CARE

Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview and record review for six (6) of 30 sampled residents, it was determined that facility staff failed to provide the necessary care and services as evidenced by failing to: perform an assessment on one (1) resident after returning from the hospital who was subsequently diagnosed with a fracture, perform weekly weights as per physician's orders for two
(2) residents, ensure that one (1) resident received fluids as ordered, assess one (1) resident for a chair alarm, administer medication as ordered by the physician for one (1) resident, and ensure that there was a physician's order prior to withholding medication for one (1) resident. Residents #6, 7, 8, 15, 23 and 29.

The findings include:

1. Facility staff failed to re-assess Resident #6's

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F 280

F 309

04/05/2007

PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
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F 309 483.25 Quality of Care
F309(1)
1. When Resident # 6 returned from
post fall hospitalization, facility
assessed the resident and monitored

resident over a 72 hour period.
Resident #6 was sent out after
nursing assessed that resident
needed further X-ray of knee.
2. Review all resident post falls-April 1,
2007 to present with a
hospitalization (trips to the emergency
room), to ensure no fractures have
been misdiagnosed by 4/30/07.
3. Re-educate all licensed staff on

assessments of post falls, and post
hospitalizations, will review all falls
in daily stand-up meeting to assure
proper assessment and documentation
has occurred.

4. Adlninistrator/DON or designee will
conduct weekly audits X 4 then monthly
audits. Findings will be reported to
the facility quality improvement/risk
management committee monthly by
5/02/07.

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11/14/07

04/30/07

04/30/07

05/02/07

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STATEMENT OF DEFICIENCIES
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SUMMARY STATEMENT OF DEFICIENCIES
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F 309 Continued From page 9

right knee after returning from a hospitalization
post fall. The resident was subsequently
diagnosed with a fractured tibia.

According to the facility's policy, " Fall Risk
Reduction & Management " , number 3.5, revised
date July 2006, " Procedure (after a resident has fallen): 1. Provide immediate care and services to the resident to treat any injuries ... 2. Evaluate resident for any additional injury which would require medical intervention. Evaluation includes but is not limit to: vital signs, assessment of visible head trauma, condition of skin ...condition of trunk and extremities to assess joints for change in normal range of motion ... "

According to a nurse's note dated November 10, 2006 at 9:00 PM, "At 1600 (4:00 PM) writer called and informed resident fell in front of elevator on side. Writer went to assess resident sitting in wheelchair. Upon assessment noted swelling to R (right) knee. Resident complained of pain to right knee ...order to transfer resident to nearest ER in

evaluation of R knee swelling with pain ..."

There was no evidence in the record that facility staff assessed the resident when the resident fell at 4:00 PM. The initial assessment documented in the record was completed by the supervisor at 9:00 PM, five (5) hours after the fall.

A nurse practitioner's order dated November 10, 2006 at 6:00 PM directed, "Transfer resident to ER for stat x-ray and evaluation of R knee injury s/p [status post] fall with pain and swelling ... "

On November 11, 2006 at 4:40 AM, a nurse's note documented, "Resident back to unit from [hospital] via stretcher ....Upon assessment

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PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
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2. Review of all records of residents with
physician's orders for hydration to ensure
that all fluids are given as ordered by the
physician.
3. Re-educate all licensed staff on the

importance of accurately transcribing
orders from month to month.
4. Units Managers or designee will complete random weekly audits to ensure
compliance. Findings from weekly audit
will be presented to the facility quality
improvement/risk management
committee monthly.

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104/30/07

5/02/07

output X 2 weeks on resident # 8. ,14/30/07

F309(2)
1. Facility immediately obtained weights
for resident # 7 and weekly weights x
4 weeks.

2. On all admissions, all records will be
reviewed to ensure that all weekly
weights X 4 weeks have been
completed.
3. Facility educator will re-educate all
licensed nursing staff on obtaining
weekly weights X 4 weeks as ordered
by the physician.
4. DON/Designee will report findings
from weekly audit will be
presented to the facility quality
improvement/risk management
committee monthly..
F309(3)
1. The facility staff obtained a
physician's order to perform intake and

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

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION

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(X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING
095019 B. WING
04/05/2007

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE
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SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL

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PROVIDER'S PLAN OF CORRECTION

(EACH CORRECTIVE ACTION SHOULD BE (X5)
COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE
DEFICIENCY)

F 309 Continued From page 10 F 309
resident alert, verbally responsive. Skin warm and F309(4)
1. Resident #15 was assessed for bed/ dry to touch. No sign of distress noted. Denies chair alarm. Bed/chair alarm was

any pain at this time. No new order. Resident to implemented immediately. 04/03/07 follow up with primary care physician within 1-2 2. 100010 audit of all residents with bed/
days. Supervisor notified. Resident made .

chair alarms to ensure appropriate use. 04/23/07
comfortable in bed. Vital signs 98.6 (temperature 3. Facility educator will re-educate all
in degrees Fahrenheit), 18 (respirations), 70 facility staff on the importance of fall
(pulse), 120/80 (blood pressure)." prevention devices such as bed/chair
alarms. 04/30/07

Discharge instructions from the hospital dated 4. Unit manager/designee will
November 11, 2006 at 12:00 AM that complete random weekly audit on,
accompanied the resident back to the facility residents with bed/chair alarms to

ensure compliance. Findings of weekly included the following: ' Follow up by your audit will be presented to the facility primary care physician. Your diagnosis: DJD quality improvement/risk management

(Degenerative Joint Disease). " There was no committee monthly. 04/30/07
evidence that an evaluation of the right knee was F309(5A)
done or x-rays taken. 1. The 2567 lists resident #23, however
it is resident 25. Resident was not

There was no evidence that the right knee was harmed by this deficient practice. 04/03/07
re-assessed after the resident returned to the 2. Facility Unit Manager or designee
facility or that the physician was notified of the will complete 100% audit of pharmacy
resident's return consult recommendations/orders. beginning March 1, 2007 to ensure no
other pharmacy recommendations or
There was no evidence in the record that facility physician orders have been missed. 0480/07
staff attempted to contact the hospital at the time 3. All licensed nurses will be re-educated
the resident returned to the facility to request on ensuring pharmacy consult/
information regarding the evaluation of the right recommendations are carried out in a
knee and the x-ray results, as directed by the finely manner. 04/30/07
nurse practitioner's order. 4. Unit manager or designee will report
findings from the weekly audits to the

Nurses' notes were dated November 11 2006 at facility quality improvement/risk,
6:00 AM, 3:00 PM and 10:45 PM and November management committee monthly. 05/02/07
12, 2006 at 6:00 AM and 12:30 PM and included
no assessment of the resident's right knee. The
resident was described as having no pain or
distress in the above cited notes.

A nurse's note dated November 12, 2006 at 2:45

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PM documented, " Resident's right knee was

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

STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER

GRANT PARK CARE CENTER

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F 309

(X1) PROVIDER/SUPPLIER/CLIA
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SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

Continued From page 11

checked by supervisor and charge (nurse). Found color normal but still swollen. [Physician] was paged." There was no evidence that the physician contacted the facility or that nursing staff attempted to contact the physician/medical director after this initial attempt.

A nurse's note dated November 13, 2006 at 1:40 PM documented, "...Rt knee still swollen. [Physician] notified and x-ray ordered ... "

A nurse's note dated November 13, 2006 at 3:00 PM documented, "Fall Action Team: Resident alert ...admits to remembering falling but when describing it somewhat different from what happened ...Did not hit head or suffered any body trauma..."

The Fall Action Team member #1, who wrote the above entry, stated in a telephone interview on

April 4, 2007 at 12:10 PM that he/she interviewed the resident but did not do a physical assessment of the resident.

An x-ray was done on November 14, 2006 with the following results, "Osteoporosis. Acute fracture of the proximal tibial metaphysic ..." The resident was sent to the emergency room for evaluation and treatment of the fracture on November 14, 2006 at 11:00 AM.

The resident has a history of DJD (Degenerative Joint Disease) and fracture of the femur documented in the physician's progress note
dated April 29, 2006.

A face-to-face interview was conducted with the
Director of Nursing on April 4, 2006 at 11:00 AM.
He/she acknowledged that there was no

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(X2) MULTIPLE CONSTRUCTION
A. BUILDING

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ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

F 309 F309(5B)
I I. The 2567 lists resident #23, however
it is resident 25. The physician order has
been corrected to reflect the correct
administration of Aspirin.
2. Facility Unit Manager or designee
will complete 100% audit of pharmacy
consult recommendations/orders
beginning March 1, 2007 to ensure no
other pharmacy recommendations or
physician orders have been missed.
3. All licensed nurses will be re-educated

on ensuring pharmacy consult/
recommendations are carried out in a
timely manner.
4. Unit manager or designee will complete weekly audits on pharmacy consultant
recommendations. Findings from the
weekly audit will be submitted to the
facility quality improvement/risk
management committee monthly.
F309(6)
I. Resident #29 is no longer a resident at
this facility.
2. 100% audit of all residents on blood
pressure medication to ensure that
appropriate parameters for administering
and holding medication is in place.
3. Facility educator will re-educate all
licensed nursing staff on appropriate
protocol for withholding blood
medication.

4. Unit manager will complete
weekly random audits on all residents on
blood pressure medication to ensure
appropriate administration of blood
pressure medication. Findings from
the weekly audit will be
submitted to the facility quality
improvement/risk management
committee monthly.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:

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095019

SUMMARY STATEMENT OF DEFICIENCIES
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Continued From page 12

assessment conducted of the right knee after the resident returned from the hospital and that the physician had not been notified of the resident's continued right swollen knee after the resident returned from the hospital. The record was reviewed April 3, 2007.

2. Facility staff failed to follow physician's orders to obtain weekly weights for Resident #7.

A review of the "Physician's Order Sheet" dated January 25, 2007 and signed by the physician (undated), revealed " ...WT [weight] Q [every] week times 4 ... "

A review of the weight record dated January 25, 2007 lacked evidence that weekly weights were completed as ordered by the physician.

According to the resident's record, the resident's weight in January 2007 was 86.2 pounds and March 2007 95.6 pounds. There was no evidence that the resident was weighed in February 2007.

A face-to-face interview was conducted with Unit Manager #1 on April 3, 2007 at 3:30 PM. He/she acknowledged that the weekly weights were not done. The record was reviewed on April 3, 2007.

3. Facility staff failed to weigh Resident #8 and ensure that the resident received fluid as per physician's orders.

A. A review of the "Physician's Admission Orders and Plan of Care" dated and signed January 31, 2007 at 11:05 PM revealed the following order, Wt. Q week x 4 week; wt 0 month. [weigh every week for four weeks then every month] "

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PROVIDER'S PLAN OF CORRECTION
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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES I (X1) PROVIDERISUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:

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095019

SUMMARY STATEMENT OF DEFICIENCIES
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Continued From page 13

A review of Resident #8's record lacked evidence that the resident was weighed every week for four
(4) weeks as ordered.

B. Facility staff failed to ensure that Resident #8 received fluid as ordered.

A review of the "Physician's Admission Orders and Plan of Care" dated and signed January 31, 2007 at 11:05 PM revealed the following order, Drink at least 400 mis Q shift. "

A review of Resident #8's February 2007 Treatment Record (TR) revealed that the resident received 400 mis every shift as ordered, as evidenced by facility staff initials entered into the allotted areas. A review of the March and April 2007 TR lacked evidence that the order for fluid was continued. A review of the physician's orders for March and April 2007 lacked evidence that the order of January 31, 2007 to give fluid had been discontinued.

A face-to-face interview was conducted with the Director of Nursing, Unit Manager #1 and Nutritionist on April 3, 2007, at 1:20 PM. They acknowledged that the resident was not weighed as ordered and did not receive fluid as ordered. This record was reviewed April 2, 2007.

4. Facility staff failed to assess Resident #15 for a chair alarm as per physician's orders.

A review of Resident #15's record revealed that the resident fell on December 26, 2006, February 10 and 19, 2007. The resident sustained no injuries from these falls. The intervention for February 10, 2007 was to have the resident

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PROVIDER'S PLAN OF CORRECTION (X5)
(EACH CORRECTIVE ACTION SHOULD BE ^ COMPLETION CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY)

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

STATEMENT OF DEFICIENCIES
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F 309 I Continued From page 14 F 309 assessed for a chair alarm.

Physician' s orders included:
February 12, 2007, " Please assess resident for
chair alarm".

March 26, 2007, "Please evaluate resident for
bed/chair alarm." There was no evidence in the resident ' s record that the resident had been assessed for a chair alarm.

Resident #15 was observed on April 2, 2007 at 2:30 PM without a chair alarm. On April 3, at 10:30 AM the chair alarm was present. On April 3, 2007 at 3:50 PM, there was no chair alarm.

A review of the Treatment Administration Records (TARS) for February, March and April 2007 revealed that an order to assess/evaluate the resident had been transcribed onto the above

mentioned TARS. The March and April 2007 TARS had "FYI (for your information)" next to the order. There was no evidence that the resident had been assessed for the chair alarm.

A face-to-face interview was conducted on April 3, 2007 at 8:30 AM with Unit Manager #3. He/she was asked when the chair alarm had been initiated. After reviewing the record, the Unit Manager stated, " I really don't know when the alarm was placed. No one signed that the alarm had been in place for February, March or April (2007). I know [Resident #15] has an alarm. It wasn't added to the care plan either. " The record was reviewed April 3, 2007.

5. Facility staff failed to discontinue the use of Ativan and administer Aspirin to Resident #23 as per the nurse practitioner's orders.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 3ZTP1 1 F Ii ID' acit GR

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES 'STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER

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TAG

F 309 Continued From page 15 F 309 A. The review of Resident #23's record revealed a nurse practitioner's order dated March 12, 2007
that directed, " Discontinue Ativan. "

According to the March and April 2007 Medication
Administration Record (MAR), the Ativan was
administered to the resident from March 13 through April 2, 2007. The resident received 19 doses after the order to discontinue Ativan was written.

A face-to-face interview was conducted with

Assistant Unit Manager #1 on April 4, 2007 at
11:30 AM. He/she stated that the Ativan should have been discontinued on March 12, 2007. The record was reviewed April 4, 2007.

B. Facility staff failed to administer Aspirin for Resident #23 as ordered by the nurse practitioner.

A pharmacy "Consultation Report" recommended, "Please consider initiating Aspirin 81 mg daily as a means of primary prevention." The report was signed by the nurse practitioner and included the order, "Aspirin 81 mg po q day." The order was written and signed on March 12, 2007.

A review of the March and April 2007 Medication Administration Records revealed that the order was not initiated and the resident had not received Aspirin as directed by the nurse practitioner.

A face-to-face interview was conducted with Assistant Unit Manager #1 on April 4, 2007 at 8:30 AM. He/she acknowledged that Aspirin was never administered to Resident #23. The record was reviewed April 4, 2007.

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PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
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(x5)
COMPLETION
DATE

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STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER

GRANT PARK CARE CENTER

(X4) ID
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SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

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6. Facility staff failed to ensure that there was a physician's order prior to withholding a blood pressure medication for Resident #29.

During the review of the resident's clinical record, nurses' progress notes revealed the following: November 30, 2006 at 1545 (3:45 PM), "Resident

is not responding well, his pulse (P) is 56, respirations (R) 18, blood pressure (B/P) 134/68. Called the doctor. MD ordered to hold the B/P

medications till further notice... Pass it on to 3-11 shift to keep monitoring."

December 1, 2006 3: 15 PM, "VS 97 (T), 55 (P), 20 ®, 148/60 (B/P). Resident alert and oriented
responds to verbal stimulus. Consumed 75-100% of both meals this shift. MD aware of abnormal B/P and pulse, stated to continue to hold B/P meds..."

The Medication Administration Record (MAR) was reviewed for December 2006. Documented on the MAR and dated November 30, 2006 was FYI (for your information) "Hold B/P Meds until

pulse ox rate is WNL (within normal limits) and Pulse ox Q (every) shift until pulse ox rate is WNL."
The review of the MAR revealed that Avapro and Lasix for blood pressure and a Nitrek patch was circled (to indicate not administered) on December 1, 2 and 3, 2007. It was also documented on the area of the MAR for Medication Exception and Hold Notes that the
medications were not administered on December
1,2 and 3,2007.

There were no physician's orders in the record

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(X1) PROVIDER/SUPPLIER/CLIA
IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION
A. BUILDING

B. WING

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with parameters directed to withhold the
resident's blood pressure medication.

On April 5, 2006 at approximately 11:00AM a face-to-face interview was conducted with the

Assistant Nurse Manager #2 who acknowledged
that there was not a physician's order to withhold
the blood pressure medication. The record was reviewed on April 3, 2007
F 315 483.25(d) URINARY INCONTINENCE
SS=D

Based on the resident's comprehensive
assessment, the facility must ensure that a
resident who enters the facility without an
indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that

catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

This REQUIREMENT is not met as evidenced by:
Based on staff interview and record review for three (3) of 30 sampled residents, it was determined that facility staff failed to completely assess residents for bladder incontinence. Residents #2, 9, and 13.

The findings include:

According to the facility ' s policy, " Restorative
Nursing, Bowel and Bladder Continence Program
revised September 2005, revealed, " ...8.
Complete and review with the interdisciplinary
team, the Bladder Incontinence Evaluation within
the first 21 days after initial identification of

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(X2) MULTIPLE CONSTRUCTION
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PROVIDER'S PLAN OF CORRECTION

(EACH CORRECTIVE ACTION SHOULD BE
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F 315 483.25 (d) Urinary Incontinence
F315(l)
1. Resident #2's record was updated with
bladder incontinence assessment on
April 5, 2007
2. Facility will complete a 100% audit of
all new and re-admits beginning
January 1, 2007 to ensure that all
initial bladder assessments and
ongoing assessments were done.
3. Licensed nursing staff will be re-
educated on appropriate completeness
of bladder assessment process.
4. Unit manager or designee will complete weekly audits X 4 weeks then monthly
audits of bladder assessments of new/
re-admits to ensure compliance. Findings
from audit will be submitted to facility
quality improvement/risk management
committee.

(X5)
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STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER

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F 315

(X1) PROVIDER/SUPPLIER/CLIA
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bladder incontinence. This comprehensive review that includes the following: Completed MDS (Minimum Data Set) & RAP (Resident Assessment Protocol), Completed Elimination Pattern, Physician evaluation, therapy screen (as indicated), psychosocial impact of incontinence, identification of the most likely types of incontinence based on a review of data collection ..., identification of risk factors and underlying causes of incontinence ... " .

1. Facility staff failed to complete Resident #2 's bladder continence assessment.

the resident was determined to be incontinent].

The record revealed an admission MDS, completed November 9, 2006, included an assessment of the resident having bladder incontinence [Section H-Continence] .

Upon further review, the record lacked evidence that additional assessments and/or screens were completed to further assess the resident's bladder status per the facility's policy.

A face-to-face interview was conducted with

Assistant Unit Manager#1, on April 5, 2007. He/she acknowledged that there were no additional assessments completed to determine the resident' s incontinent status. The record was reviewed on April 2, 2007.

The "Nursing Data Collection" form dated October 25, 2006 revealed that bladder incontinence was checked " yes " [indicating that

2. Facility staff failed to complete Resident #9 ' s bladder continence assessment.

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B. WING

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PROVIDER'S PLAN OF CORRECTION
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F315(2)
1. Resident #9's record was updated
with bladder incontinence
assessment on April 5, 2007
2. Facility will complete a 100% audit of
all new and re-admits beginning
January 1, 2007 to ensure that all
initial bladder assessments and
ongoing assessments were done.
3. Licensed nursing staff will be re-
educated on appropriate completeness
of bladder assessment process.
4. Unit manager or designee will complete
weekly audits X 4 then monthly audits of
bladder assessments of new/re-admits to
ensure compliance. Findings from audit
will be submitted to facility quality
improvement/risk management committee.
F315(3)
1. Resident # 13's record was updated with
bladder incontinence assessment on
April 5, 2007
2. Facility will complete a 100% audit of
all new and re-admits beginning
January 1, 2007 to ensure that all
initial bladder assessments and

ongoing assessments were done.
3. Licensed nursing staff ,%ill be re-
educated on appropriate completeness
of bladder assessments and process. Unit
manager or designee will complete
monthly audits of bladder assessments
of new/re-admits to ensure compliance.
4. Findings from audit will be submitted
to facility Quality Improvement
Committee monthly.

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The "Nursing Data Collection" form dated November 3, 2006 revealed that bladder incontinence was checked "yes" [indicating that the resident was determined to be incontinent].

The record revealed a quarterly MDS, completed November 10, 2006, included an assessment of the resident having bladder incontinence [Section H-Continence].

Upon further review, the record lacked evidence that additional assessments and/or screens were completed to further assess the resident's bladder per the facility' s policy.

A face-to-face interview was conducted with Assistant Unit Manager #1, on April 4, 2007 at 11:05 AM. He/she acknowledged that there were no additional assessments completed to determine the resident' s incontinent status. The record was reviewed on April 3, 2007.

3. Facility staff failed to complete Resident #13' s bladder continence assessment.

The "Nursing Data Collection" form dated August 23, 2006 revealed that bladder incontinence was checked [indicating that the resident was determined to be incontinent).

The record revealed an quarterly MDS,completed October 24, 2006,included an assessment of the resident having bladder incontinence [Section H-Continence] .

Upon further review, the record lacked evidence that additional assessments and/or screens were completed to further assess the resident' s bladder incontinent status per the facility's policy.

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F 324
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A face-to-face interview was conducted with

Assistant Unit Manager #2 on April 5, 2007 at
10:50 AM. He/she acknowledged that there were
no additional assessments completed to
determine the resident ' s incontinent status. The record was reviewed on April 3, 2007. 483.25(h)(2) ACCIDENTS

The facility must ensure that each resident receives adequate supervision and assistance devices to prevent accidents.

This REQUIREMENT is not met as evidenced by:
Based on staff interview and record review for one (1) of 30 sampled residents, it was determined that facility staff failed to provide adequate supervision for Resident #20 who had multiple falls with subsequent injuries.

The findings include:

The annual MDS (Minimum Data Set) dated January 25, 2007 coded the resident as having a short and long term memory problems and was moderately impaired for cognitive skills for daily decision making (Section B); required limited assistance with walking on the unit and required limited assistance with transfers (Section G). The resident was coded as above for the quarterly MDS assessments completed August 5, 2006 and November 1, 2006.

A review of Resident #20's nurses' progress notes revealed the following:

August 22, 2006 at 2:00 PM "... observed floor..."

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F 324 483.25 (h) (2) Accidents
1. Resident #20 was offered an alcohol
treatment program but resident refused.
Resident's fall was alcohol abuse related
2. All residents with ETOH abuse as a

problem /diagnosis will be offered treatment.
3. All licensed staff will reeducated on
proper documentation, notification of
physician and family when resident is
observed to be intoxicated. All residents
identified as intoxicated will be placed on
facility 24-hour report for appropriate
follow-up. Facility Administrator/DON or
designee will review 24-hour report as part
of facility morning meeting to ensure that
appropriate treatment options are offered
residents who have been identified as alcohol abusers.

4. DON/Administrator will report findings
from morning review to facility Quality
Improvement committee monthly.

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[No injury, MD (medical doctor) not notified.]

September 13, 2006 at 10:50 AM - "-..observed on the bathroom floor by the rail..." [No injury, MD notified.]

September 13, 2006 at 2:15 PM- " Resident has been drinking beer. Resident was removed from his/her w/c [wheelchair] and placed in bed ... " [No injury, MD not notified.]

September 18, 2006 at 12:15 AM - " Resident returned to the unit at 12:15 ... has a very strong smell of alcohol on his/her breath. " [No injury, MD not notified.]

September 19, 2006 at 11:00 PM - "...Resident's breath also smell of alcohol." [No injury, MD not notified.]

November 5, 2006 at 12:00 AM- "... Resident was observed with strong smell of alcohol. Responsible party stated: " He/she had a couple of beers at the party ..." [No injury, MD not notified.]

November 18, 2006 at 5:15 PM - "... Resident observed with hematoma on frontal aspect of forehead, sustained from fall on floor in his/her room..." [Injury, MD notified.]

January 10, 2007 at 11:30 PM - "...Resident was observed on the floor lying by CNA while making
rounds on his/her back by the side of the [his/her]
bed... Observed alcohol smell on his/her breath
..." [No injury, MD notified .]

January 11, 2007 at 11:00 PM -" Resident was
observed sitting out in pitch darkness on front

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patio. He/she appears to be intoxicated with
alcohol (He/she smelled of alcohol). He/she appeared helpless and almost falling out of the
chair. He/she appeared so intoxicated he/she
could not answer any questions." [No injury, MD
not notified.]

February 1, 2007 at 8:00 AM - "Resident was observed on the unit very drunk. He/she was brought up by a staff from downstairs where he/she was drinking. All his/her clothes and pants were saturated with urine. He/she refuse to be undressed and be assisted. He/she was combative and starched one of the CNA [Certified Nurse Aide] while attempting to wash him/her and keep clean clothes on him/her." [No injury, MD not notified.]

February 28, 2007 at 1:15 AM - "... Observed on the floor... He/she is smelling very strong of alcohol." [No injury, MD notified.]

April 4, 2007 at 9: 50 PM- "Called stat to parking lot by security. Resident found lying on ground

with wheelchair on side. Nose bruised and bleeding. Rt (right) wrist scraped... Resident was asked what he/she had been drinking and response was " Beer" [Injury, MD notified.]

A review of the " Potential for injury/risk for falls ... " care plan revealed that the resident had multiple falls with subsequent injury on November 18, 2006 and April 4, 2007. The care plan lacked
evidence that facility staff implemented any
additional approaches to prevent the resident
from falling.

A review of the social service progress note dated January 25, 2007 at 12:50 PM revealed, " Social

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worker met with resident to discuss several

issues.... educated resident on the mixing of
alcohol and medication. The resident was offered outside service and support with regards to
alcoholism. SW (social worker) will make referral ASAP ...The resident agreed to continue with day

care program. The goal is to attend at least two times per week. In addition, a second goal was to

encourage resident to continue with weekly talk sessions. Social worker will f/u (follow up) as needed once services are in place. "

A face-to-face interview was conducted with the

social worker on April 5, 2007 at approximately 2:15 PM. He/she stated " The resident refused

to attend the outside services. "

The record lacked evidence that the outside services, talk sessions and/or addiction support programs were refused by the resident.

The social worker acknowledged after reviewing the record, that there was no follow up with outside services and/or programs after January 25, 2007 to assist the resident with alcohol addiction.

A face-to-face interview was conducted with the Recreational Therapy Director on April 5, 2007 at approximately 2:15 PM. He/she stated, " The resident is on the list to attend a talk therapy program for drug and alcohol addicted residents,
however the last time he/she attended was November 29, 2006."

A face-to-face interview was conducted with Unit

Manager #2 and the Director of Nursing on April 5, 2007 at approximately 3:00 PM. They

acknowledged after reviewing the record, that

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F 329
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there were no interventions to prevent the resident from falling or to assist the resident with

alcohol addiction. The record was reviewed April 5, 2007.
483.25(1) UNNECESSARY DRUGS

Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.

Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.

This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview for two
(2) of 30 sampled residents, it was determined that facility staff failed to consistently monitor and document an adequate indication for the use of antipsychotic medications. Residents #15 and 25.

(X2) MULTIPLE CONSTRUCTION
A. BUILDING

B. WING

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F 329 483.25 (I) Unnecessary Drugs
329(1)
1. Resident # 15 had a physician's order
written on 4/3/07 PRN Haldol and
Ativan discontinued on 4/3/07.
Psychological evaluation order.
2. All residents receiving psychotropic
medications will be reviewed from
March 1, 2007 to assure a reason for
medication is noted, proper MAR
documentation is noted when a PRN
medication is ordered and a behavior
monitoring record is present and complete.
3. Unit managers/designee will complete
random weekly audits of all residents on
psychotropic medications to assure the
appropriateness and use of the medication.
Re-education of all licensed nurse on
facility protocol on continued use of
psychotropic medications and behavioral
monitoring records.
4. Findings from audit will be reported
to the Quality Improvement Committee
monthly.

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The findings include:

1. Facility staff failed to consistently monitor and document an indication for the continued use of Haldol and Ativan for Resident #15.

A review of Resident #15's record revealed a physician's order dated January 13, 2007, renewed March 2, 2007, directed, "Ativan 0.5 mg po (orally) daily at bedtime PRN (as needed) for agitation" and "Haldol 2 mg 1 tab po every 8 hours PRN (as needed) for agitation."

According to the history and physical examination completed by the physician on December 21, 2006, the resident had a history of agitation and periods of confusion.

The Medication Administration Records (MARS) for January, February and March 2007 were reviewed. Resident #15 received no Haldol and three (3) doses of Ativan in January, no Ativan and 23 doses of Haldol in February and 15 doses of Ativan and 16 doses of Haldol in March 2007.

There was no explanation on the reverse side of the above referenced MARS as to the date, time, reason medication was given or effectiveness of the medication with the exception of one (1) entry for February 24, 2007.

The "Behavior Monitoring Record" for January and March 2007 were reviewed. Ativan was administered on January 14, 18 and 19, 2007. There was no indication on the " Behavior

Monitoring Record " or in the nurses ' notes that the resident exhibited agitated behavior.

(X1) PROVIDER/SUPPLIER/CLIA
IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION
A. BUILDING

B. WING

STREET ADDRESS, CITY, STATE, ZIP CODE
5000 BURROUGHS AVE. NE

WASHINGTON, DC 20019

ID
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F 329

PRINTED: 04/13/2007
FORM APPROVED
OMB NO. 0938-0391

(X3) DATE SURVEY
COMPLETED

04/05/2007

PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

329(2)
1. Resident # 25 continues to receive Ambien for insomnia. A psychological consult
has been ordered.

2. Facility will review all residents receiving Ambien to ensure that there is appropriate
documentation for continued use and that

a behavioral monitoring record is present
and complete.
3. All licensed nurses will be reeducated
on appropriate documentation for residents
receiving psycho-tropic medications and its continued use.

4. The DON, Unit Managers or designee will complete weekly audits X 4 audits then
monthly audits to ensure that behavior
monitoring records are present
and complete and that there is documentation in record to demonstrate need for continued

use. Findings from monthly audits will be
presented to facility Quality Improvement
committee monthly.

(X5)
COMPLETION
DATE

04/30/07

04/30/07

04/30/07

05/02/07

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 3ZTP1 1 Facility ID: GRANTPARK If continuation sheet Page 26 of 44

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

STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER

GRANT PARK CARE CENTER

(X4) ID
PREFIX
TAG

(X1) PROVIDER/SUPPLIER/CLIA
IDENTIFICATION NUMBER:

095019

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

F 329 Continued From page 26

The February 2007 " Behavior Monitoring Record
" for February 2007 was requested but could not
be located by facility staff during the survey
period. The nurse's note dated February 18,
2007 described the resident having an altercation
with another resident. There was no evidence in the nurses ' notes that additional episodes of agitated behavior occurred in February 2007.

The March 2007 " Behavior Monitoring Record " had documentation for 13 days in which the resident exhibited agitated behavior. Ativan was administered 15 times and Haldol was

administered 16 times during March 2007. There was no consistency between the administration of Haldol and the days the resident was identified as exhibiting agitated behaviors. There were no episodes of agitated behaviors documented on the " Behavior Monitoring Record " for the evening shift (3:00 PM to 11:30 PM) to explain why Ativan was administered 15 times at bedtime.

A face-to-face interview was conducted with Assistant Unit Manager #2 on April 3, 2007 at 8:30 AM. After reviewing the record, he/she acknowledged that the reason, time and effectiveness of PRN medications should have been charted on the back of the MARS. Additionally, he/she acknowledged that behavior monitoring was required for residents using Ativan and Haldol and that there was inconsistent documentation to support the administration of those medications. The record was reviewed April 3, 2007.

2. Facility staff failed to consistently monitor and document an adequate indication for the use of Ativan and Ambien for Resident #25.

(X2) MULTIPLE CONSTRUCTION
A. BUILDING

B. WING

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5000 BURROUGHS AVE. NE

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04/05/2007

PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
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(X5)
COMPLETION
DATE

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

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.')MR Nr) nQiR-n,^Q1

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED
095019 B. WING
04/05/2007

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

GRANT PARK CARE CENTER 5000 BURROUGHS AVE. NE
WASHINGTON, DC 20019

(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) 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

COMPLETION
DATE

DEFICIENCY)

F 329 Continued From page 27 F 329

A. Resident #25 was admitted to the facility on
February 1, 2007. According to the admission
Minimum Data Set assessment completed
February 6, 2007, the resident was coded for no
behavior or mood problems in Section E.

The history and physical examination completed by the physician on February 5, 2007, does not include reference to the resident having behavior problems.

The admission orders signed by the physician on February 5, 2007 included, " Ativan 1 mg po at bedtime for agitation. "

According to the February and March 2007 MARs, the resident received Ativan every night at 11:00 PM for both months.

The " Behavior Monitoring Record " was requested for February 2007. Facility staff was unable to locate the monitoring record during the survey. There was no evidence in the nurses' notes that the resident exhibited agitated behaviors during February 2007.

The "Behavior Monitoring Record" for March 2007 indicated that the resident exhibited agitated behaviors during the evening shift (3:00 PM to 11:30 PM - bedtime) on March 31, 2007.

The resident exhibited agitated behaviors during the night shift (11:00 PM to 7:30 AM) March 1 through 7, 2007. There were no other documented episodes of agitated behaviors exhibited by the resident during the month of March 2007 on the " Behavior Monitoring Record " and the nurses' notes.

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

STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER

GRANT PARK CARE CENTER

(X4) ID
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TAG

(X1) PROVIDER/SUPPLIER/CLIA
IDENTIFICATION NUMBER:

095019

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

(X2) MULTIPLE CONSTRUCTION
A. BUILDING

B. WING

STREET ADDRESS, CITY, STATE, ZIP CODE
5000 BURROUGHS AVE. NE

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(X3) DATE SURVEY
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04/05/2007

ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY)

F 329 Continued From page 28 F 329

The physician saw the resident on February 5 and
12 and March 12, 2007. There was no evidence
that the physician reviewed the resident's need
for Ativan.

B. Facility staff failed to consistently identify an
adequate indication for the use of Ambien for Resident #25.

A physician ' s telephone order dated February 5, 2007 and signed by the physician on February 9, 2007, directed, " Ambien CR 6. 25 mg , 1 tab po q HS (bedtime) for insomnia. " The order was
renewed April 4, 2007.

The nurses' notes were reviewed from February 1 through February 9, 2007. There was no evidence that the resident experienced episodes of insomnia.

The physician saw the resident on February 5 and 12 and March 12, 2007. There was no evidence that the physician reviewed the resident's need for Ambien.

A face-to-face interview was conducted with Unit Manager #3 on April 4, 2007 at 11:30 AM.
He/she acknowledged that there was insufficient
documentation for the administration of Ativan and Ambien for Resident #25. The record was reviewed April 3, 2007.
F 363 483.35(c) MENUS AND NUTRITIONAL F 363
SS=DI ADEQUACY

Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition
Board of the National Research Council, National

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

STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER

GRANT PARK CARE CENTER

(X4) ID
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(X1) PROVIDER/SUPPLIER/CLIA
IDENTIFICATION NUMBER

095019

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

F 363 Continued From page 29

Academy of Sciences; be prepared in advance;
and be followed.

This REQUIREMENT is not met as evidenced
by:

Based on observations during the survey period,
it was determined that the spreadsheet for residents on renal diets dated April 1, 2007 included dairy products that exceeded the recommended amount. This observation was made in the presence of the Food Service
Director and dietitian.

The findings include:

F 371
SS=E

According to the spreadsheet dated April 1, 2007, residents on renal diets received

one (1) cup of low fat milk, one (1) cup of whole
milk and an omelette [with cheese]. This
exceeded the daily nutritional requirements for phosphorous and protein for renal diets per Diet Manual for Long Term Care Residents 2000, Revision Office of Health Care Quality, page 32 [1 cup of milk per day and cheese should be limited].

A face-to-face interview was conducted with the

dietician on April 2, 2007 at 11:00 AM. He/she acknowledged that the above cited dairy products exceeded the recommended amount in one (1)
of one (1) observation on April 2, 2007. 483.35(i)(2) SANITARY CONDITIONS - FOOD
PREP & SERVICE

The facility must store, prepare, distribute, and
serve food under sanitary conditions.

=ORM CMS-2567(02-99) Previous Versions Obsolete Event ID:3ZTP11

(X2) MULTIPLE CONSTRUCTION
A. BUILDING

B. WING

STREET ADDRESS, CITY, STATE, ZIP CODE
5000 BURROUGHS AVE. NE

WASHINGTON, DC 20019

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F 363

F 371

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OMB NO. 0938-0391
(X3) DATE SURVEY
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04/05/2007

PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

F 363 483.35 (c) Menus and Nutritional Adequa
1. Cheese was taken off the spreadsheet for
renal diets. Low fat milk was taken off the
Dinner spread sheet and tray cards for renal diets.

2. Menu spreadsheets were changed to provide only 8onces of milk for renal diets and no
cheese.

3. Facility will reeducate dietitian/nutritionist on appropriate menu planning.
4. Food service manager or designee will
perform random weekly audits of menu
spreadsheets to ensure compliance with
DC Dietary guidelines. Findings from the
weekly audit will be presented to facility
Quality Improvement Committee
monthly.

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(X5)
COMPLETION
DATE

04/02/07

04/02/07

04/30/07

05/02/07

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

PRINTED: 04/13/2007
FORM APPROVED

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION

- . - - . UJJV-JJQ I

(X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER:
A. BUILDING COMPLETED

095019 B. WING
04/05/2007

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE
GRANT PARK CARE CENTER 5000 BURROUGHS AVE. NE
WASHINGTON, DC 20019

(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION

TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE
DEFICIENCY)

F 371 Continued From page 30 F 371 F371483.35 (1) (2) Sanitary Conditions-Food rep & Servi F371(l)
1. Walls, floor and baseboard surfaces near

This REQUIREMENT is not met as evidenced the entrance to dietary and floor and
by:

door surfaces on outside back loading

Based on observations during the survey period, dock area were cleaned immediately.

2. Food service staff/housekeeping staff is

04/03/07

it was determined that dietary services were not now monitoring these areas daily to adequate to ensure that foods were prepared and ensure that they remain clean. 04/03/07

served in a safe and sanitary manner as 3. Food service and housekeeping staff
evidenced by: soiled walls, baseboards, doors, were reeducated on importance of
floors, plate warmer, air compressor fan covers, keeping these areas clean. 04/30/07
convection and gas oven panels, a can opener, a 4- Food service manager/housekeeping
deflector plate on the ice machine, coffee cups manager will complete daily rounds,
knives, and hotel pans, drain pipes not installed dough these areas to ensure that they
to prevent water overflow and hot food served remain clean. Findings from the daily

rounds will be reported to facility below 140 degrees Fahrenheit (F) and cold foods Quality Improvement Committee served above 41 degrees F. These observations monthly. 05/02/07 were made on April 4, 2007 between 7:15 AM F371(2)

and 2:30 PM in the presence of the Director of 1. Plate warmer was dismantled and
Food Service. cleaned immediately. 04/02/07
2. Cleaning plate warmer assured that no
The findings include: other resident was affected by this
deficient practice. 04/02/07
1. Wall floor and baseboard surfaces near the 3. Food service staff was reeducated on,
entrance to dietary and floor and door surfaces on the importance of keeping plate warmer

clean

the outside back loading dock area were soiled .

4. Food service manager or designee

04/23/07

with accumulated debris in two (2) of two (2) will complete daily audit of plate warmer
entrance areas observed in the main kitchen. to ensure its cleanliness. Findings from
this daily audit will be presented to facility
2. The interior surfaces near the heating elements Quality Improvement Committee monthly. 05/02/07
of the plate warmer were soiled with accumulated
debris in one (1) of one (1) plate warmer
observed.

3. The air compressor fan covers in the walk-in
refrigerator were soiled with dust in one (1) of one
(1) walk-in refrigerator observed.

4. The front and side panels of the convection

I.A

and gas ovens were soiled with debris in two (2)

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

STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER

GRANT PARK CARE CENTER

(X4) ID
PREFIX
TAG

F 371

095019

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

Continued From page 31

of two (2) ovens observed.

5. The manual crank can opener in the cook's area was soiled with metal shavings on the gear and cutting surfaces and the holder was soiled with food debris in one (1) of one (1) can opener observed.

6. The plastic deflector plate on the interior of the ice machine was soiled with debris in one (1) of one (1) ice machine observed.

7. Coffee cups were stained on the interior with coffee residue after being washed and ready for reuse in 10 of 48 coffee cups observed.

8. Knives were soiled with food after washing and ready for reuse in 16 of 47 knives observed.

9. Hotel pans (12" x 24" x 10") were soiled with food residue after being washed and ready for reuse in five (5) of six (6) hotel pans observed.

10. The ice machine drain pipes in the cook's and serving areas were not installed to prevent water from draining onto floor surfaces. Drain pipes were making contact with a plastic sleeve

surrounding the pipes in two (2) of two (2) drain pipes observed-
11 - Hot foods were served below 140 degrees Fahrenheit (F) and cold foods were served above
41 degrees F.

A test tray for breakfast was observed on April 5,
at 8:50 AM on 3 North. Food temperatures were
as follows:

Corn beef hash: 120 degrees Fahrenheit (F)

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(X1) PROVIDER/SUPPLIER/CLIA
IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION
A. BUILDING

B. WING

STREET ADDRESS, CITY, STATE, ZIP CODE
5000 BURROUGHS AVE. NE .

WASHINGTON, DC 20019
I
ID
PREFIX
TAG

F 371

04/05/2007

PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY)

F371(5)
1. Can opener was dismantled and cleaned
immediately. 04/02/07
2. Facility food service staff cleaned can
opener to ensure that no other residents
were affected. 04/02/07
3. Food service staff was reeducated on
importance of cleaning can opener after
each use. 04/23/07
4. Food service manager or designee
will complete daily audits of can opener to
ensure its cleanliness. Findings from
weekly audits will be reported to facility
Quality Improvement committee monthly. 05/02/07

(X5)
COMPLETION
DATE

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04/20/07

05/02/07

04/02/07

affected by this deficient practice. 04/02/07
3. Food service staff was reeducated on

importance of keeping convection oven
clean at all times. 04/23/07
4. Dietary manager will complete daily audits
of convection oven to ensure continued
cleanliness. Findings from weekly audits
will be reported to facility Quality
Improvement committee monthly. 05/02/07

3. Food service staff was reeducated on
importance of monitoring and keeping fan
covers clean.

4. Food service director or designee will
perform weekly audits of fan covers to
ensure continued cleanliness. Findings
from weekly audits will be reported to
facility Quality Improvement committee
monthly.
F371(4)
1. The convection oven was dismantled

and cleaned immediately.
2. Convection oven was cleaned immediately
to ensure that no other residents were

were affected by deficient practice. 104/03/07

F371(3)
1. The air compressor fan cover was cleaned
immediately.
2. After cleaning fan cover, no other residents

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(X3) DATE SURVEY
COMPLETED

Health Regulation Administration

STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER

GRANT PARK CARE CENTER

(X4) ID
PREFIX
TAG

(X1) PROVIDER/SUPPLIER/CLIA
IDENTIFICATION NUMBER:

095019

(X2) MULTIPLE CONSTRUCTION
A. BUILDING
B. WING

STREET ADDRESS, CITY, STATE, ZIP CODE

5000 BURROUGHS AVE. NE
WASHINGTON, DC 20019

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

ID
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TAG

04/05/2007

PROVIDER'S PLAN OF CORRECTION
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F371(6)
1. Plastic deflector plate was cleaned
immediately.
2. Food service staff cleaned deflector cover
to ensure that no other resident was affected
3. Food service staff was reeducated on
cleaning assignments and importance of
keeping plastic deflector cover clean at all
times.

4. Food service director will complete
daily audit of plastic deflector to ensure
continued cleanliness. Findings from daily audit will be presented to facility Quality
Improvement Committee monthly.
F371(7)
1. Coffee cups were immediately removed
and de-stained.

2. Food service completed 100 percent
audit all coffee cups to ensure that no
others were stained.
3. Food service staff was reeducated on
importance of checking coffee cups
prior to use and what to do when stained
cups are found.

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4. Food service manager or designee will
complete daily audit of coffee cups to
ensure compliance. Findings from daily
audit will be presented to facility Quality
Improvement Committee monthly.
F371(8)
1. All knives with dry debris on them
were removed and cleaned immediately.
2. Food service staff completed immediate audit of all tableware to ensure that they
were clean.
3. Food service staff was reeducated on

importance of thoroughly cleaning and
checking tableware after cleaning to
ensure compliance.
4. Food service manager or designee will
conduct random daily audit of tableware
to ensure that knives, forks and spoons
are clean at all times. Findings from daily
audit will be presented to facility Quality
Improvement Committee monthly.

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(X3) DATE SURVEY
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04/02/07

04/02/07

04/23/07

05/02/07

04/02/07

04/19/07

04/23/07

05/02/07

04/02/07

04/02/07

04/23/07

05/02/07

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Health Regulation Administration

STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER

GRANT PARK CARE CENTER

(X4) 10
PREFIX
TAG

(X1) PROVIDER/SUPPLIER/CLIA
IDENTIFICATION NUMBER:

095019

(X2) MULTIPLE CONSTRUCTION
A. BUILDING
B. WING

STREET ADDRESS, CITY, STATE, ZIP CODE

5000 BURROUGHS AVE. NE
WASHINGTON, DC 20019

SUMMARY STATEMENT OF DEFICIENCIES
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04/05/2007

PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
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F1371(9)

1. All hotel pans were removed, washed,
rinsed, sanitized and air-dried.
2. All hotel pans were check after thorough cleaning that no other residents were
affected.
3. Food service staff was reeducated on
importance of ensuring that hotel pans
are cleaned thoroughly and checked after
cleaning to ensure compliance.
4. Food service manager will conduct daily audit of hotel pans to ensure continued
compliance Findings from daily audit will
be presented to facility Quality
Improvement Committee monthly.
F371(10)
1. Facility maintenance staff repaired
drains immediately to prevent any
drainage on floor and prevent contact
with side of drain.

2. All other drains were examined by
maintenance to ensure that no others
were deficient.

3. Maintenance staff will complete
weekly review of dietary drains to
ensure continued compliance.
4. Findings from weekly audit will be
presented to facility Quality Improvement
Committee monthly.
F371(l 1)
1. No residents were banned by deficient
practice.

Health Regulation Administration
STATE FORM

2. Tray line temps were checked at beginning,
middle and end of meal service to ensure
safe temperatures.
3. Reeducated food service staff and nursing staff on importance of maintaining safe
food temperatures and serving residents
immediately to ensure safe temperatures.
4. Food service manager or designees will
be performing random weekly audits of
food temps in food service department and
on nursing units to ensure acceptable
temperatures. Findings from weekly audits
will be presented to facility Quality
Improvement Committee monthly.

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04/02/07

04/02/07

04/23/07

05/02/07

04/04/07

04/04/07

04/30/07

05/02/07

04/05/07

04/05/07

04/23/07

05/02/07

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

STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER

GRANT PARK CARE CENTER

(X4) ID
PREFIX
TAG

F 371

F 386
SS=D

(X1) PROVIDER/SUPPLIER/CLIA
IDENTIFICATION NUMBER:

095019

(X2) MULTIPLE CONSTRUCTION
A. BUILDING

B. WING

STREET ADDRESS, CITY, STATE, ZIP CODE
5000 BURROUGHS AVE. NE

WASHINGTON, DC 20019

SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG

Continued From page 32

Scrambled Eggs - 112 degrees F
Grits - 128 degrees F
French toast - 108 degrees F
2% Reduced fat mild - 48 degrees F

A test tray for lunch was observed on April 5, 2007 at 1:05 PM on 5 North. Food temperatures were as follows:

Green Beans - 129.2 degrees F
Hot Water (for tea) - 95.5 degrees F
Milk - 53.2 degrees F

The Director of Food Service acknowledged issues identified in items one (1) through 10. The food service supervisors acknowledged the above cited temperatures for the test trays.
483.40(b) PHYSICIAN VISITS

The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications.

This REQUIREMENT is not met as evidenced by:

Based on the review of one (1) of 30 records, it
was determined that the physician failed to
document a complete assessment of Resident
#28's skin on admission.

The findings include:

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F 371

F 386

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PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
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F 386 483.40 (b) Physician Visits
1. Resident #28 is no longer here at facility.
2. Facility Unit Managers will complete
100 percent of all new admissions and
hospital returns beginning January 2007
to ensure that physician documentation
includes assessment of wounds when
warranted.

3. Resident #28's primary care physician
was reeducated on importance of assessing
and documenting patients with wounds.
4. DON or designee will complete random
monthly audits of new admission
and hospital returns to ensure that
physician documentation includes
skin assessment. Findings from
monthly audit will be presented to
facility Quality Improvement
Committee monthly.

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COMPLETION
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04/05/07

04/30/07

04/19/07

05/02/07

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

1STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:

NAME OF PROVIDER OR SUPPLIER

GRANT PARK CARE CENTER

(X4) ID
PREFIX
TAG

F 386

F 431
SS=D

095019

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

Continued From page 33

The resident's admission history and physical examination dated September 27, 2007 was reviewed. For the review of systems that include skin, the physician documented, " open area rt. (right) lower leg. "

The physician's note dated September 29, 2006 failed to include reference to the resident's skin.

The admission Minimum Data Set (MDS) at Section M "Skin Condition/Ulcers" signed and dated October 10, 2006 was coded for Stage 2, five (5) ulcers and Stage 4, four (4) ulcers.

On April 3, at approximately 10:00 AM, a face-to-face interview was conducted with the facility's wound care nurse who indicated, " I saw the resident a couple of days after she was admitted to the facility. She did have multiple open areas. "

The physician failed to document a complete assessment of the resident's skin. The record was reviewed on April 3, 2007.
483.60(b), (d), (e) PHARMACY SERVICES

The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically
reconciled.

Drugs and biologicals used in the facility must be
labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary

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(X2) MULTIPLE CONSTRUCTION
A. BUILDING

B. WING

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5000 BURROUGHS AVE. NE

WASHINGTON, DC 20019

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PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
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F 431483.60 (b), (d), (e) Pharmacy Services
1. Residents Si and S3's insulin was

discarded and immediately and replaced
with new insulin. Resident S2 is no longer
in this facility.

2. An audit of all insulin in the facility
will be completed to ensure that there
are no other expired vials.
3. All licensed nurses will be reeducated
on the monitoring expiration dates on
medication.

4. Director of Nursing or her/
his designee will complete weekly audits
of all insulin vials to ensure that all dates

are current. Findings from the weekly
audits will be reported to facility
Quality Improvement Committee monthly.

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04/30/07

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STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

1 NAME OF PROVIDER OR SUPPLIER

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(X4) ID
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F 4311

(X1) PROVIDER/SUPPLIER/CLIA
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SUMMARY STATEMENT OF DEFICIENCIES
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instructions, and the expiration date when applicable.

In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

This REQUIREMENT is not met as evidenced by:
Based on observation and staff interview, it was determined that facility staff failed to dispose of four (4) vials of medications that were opened for more than 30 days.

The findings include:

An inspection of the medication refrigerator on unit 4S was conducted on April 2, 2007 at 7:50 AM and revealed the following:

Resident S1 's Regular Novolin and Lantus

insulins were dated as being opened on February 22, 2007.

Resident S2's Regular Novolin insulin was dated

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(X5)
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STATEMENT OF DEFICIENCIES
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NAME OF PROVIDER OR SUPPLIER

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F 431

F 441
SS=E

(X1) PROVIDER/SUPPLIER/CLIA
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SUMMARY STATEMENT OF DEFICIENCIES

(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

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as being opened on February 28, 2007.

Resident S3's Regular Novolin insulin was dated as being opened on February 26, 2007.

A face-to-face interview was conducted with Unit Manager #2 at the time of the inspection. He/she reviewed the opened insulin vials and stated, "We discard insulin after it has been open for 30 days. I don't know why these vials are still here." The unit manager immediately disposed of the above four (4) insulin vials.
483.65(a) INFECTION CONTROL

The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections.

This REQUIREMENT is not met as evidenced by:

Based on observations during the environmental tour, it was determined that proper procedures were not followed to control the spread of communicable diseases as evidenced by soiled water/ice machines, toilet seats, a geri chair, an oxygen concentrator and a shower stretcher. These observations were made on April 2, 2007 between 2:30 PM and 7:30 PM in the presence of maintenance, housekeeping and nursing staff.

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F 441483.65 (a) Infection Control
F441(l)
1. Water and ice chutes were in the 2 North

F 441 pantry were cleaned immediately.
2. Housekeeping completed 100 percent audit of all ice machines to ensure that no others
were deficient.

3. Housekeeping staff will be reeducated on importance of keeping water and ice
machines clean.

4. Housekeeping supervisor
will complete random weekly audits of
water and ice machines to ensure compliance. Findings from weekly audits will be
reported to facility Quality Improvement
Committee monthly.
F441(2)
1. The two portable shower toilets on 2N
were cleaned immediately. The toilet seat
on 4S was cleaned immediately.
2. Housekeeping department completed 100 percent audit of all portable toilet seats and training toilet seats to ensure that no other
toilet seats were soiled.

3. Housekeeping supervisor will reeducate
housekeeping and nursing staff on importance of cleaning toilet seats after each use.
4. Housekeeping supervisor or designee will perform random weekly audits to ensure
compliance. Findings from the weekly audit will be reported to facility Quality
Improvement Committee monthly.

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STATEMENT OF DEFICIENCIES
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095019

(X2) MULTIPLE CONSTRUCTION
A. BUILDING
B. WING

STREET ADDRESS, CITY, STATE, ZIP CODE

5000 BURROUGHS AVE. NE
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SUMMARY STATEMENT OF DEFICIENCIES
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F441 (3)
1. Geri-chair in shower room on 2S was
cleaned immediately.
2. Housekeeping supervisor completed 100 percent audit of all geri-chairs to ensure no
others were soiled.

3. Housekeeping supervisor will reeducate
housekeeping/nursing staff on importance of cleaning geri-chairs.
4. Housekeeping supervisor
or designee will complete random weekly
audits of all geri-chairs to ensure compliance. Findings from weekly audits will be reported to facility Quality Improvement Committee monthly.
F441 (4)
1. The oxygen concentrator in room 307
was replaced immediately.
2. Facility nursing supervisors completed 100 percent audit of all oxygen concentrators to ensure that all other concentrators were
compliant.
3. Nursing Director or designee will reeducate staff on importance of ensuring that all
concentrators are kept clean and filters are
present
4. Facility Unit Managers will complete
random weekly audits of all oxygen
concentrators to ensure compliance.
Findings from weekly audits will be
reported to facility Quality Improvement
Committee monthly.
F441(5)
1. Shower stretcher on 3 South was cleaned immediately.
2. Facility completed 100 percent audit of all shower stretchers to ensure that no others
were soiled.

3. Facility housekeeping and nursing staff was reeducated on importance of cleaning shower stretchers after each use.

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4. Housekeeping manager will complete ran dom daily audits of shower stretchers to ensure
continued compliance. Findings from daily
audits will be reported to facility Quality
Improvement Committee monthly.

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DATE

04/02/07

04/03/07

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NAME OF PROVIDER OR SUPPLIER

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SUMMARY STATEMENT OF DEFICIENCIES .
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

F 441 Continued From page 36

The findings include:

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1. The water and ice chutes in the 2N pantry were
soiled with mineral deposits and accumulated
debris in one (1) of seven (7) water/ice machines observed.

2. Two (2) portable shower toilets in the 2N
shower room and one (1) toilet seat in the 4S training toilet were soiled on the seat surfaces with a dark substance in three (3) of four (4)
toilets observed.

3. A geri chair in the shower room of 2S was soiled on the seat surface with a dark brown substance in one (1) of one (1) geri chair observed.

4. An oxygen concentrator in room 307 lacked a filter and the internal parts were soiled with accumulated dust in one (1) of four (4) oxygen concentrators observed.

5. A shower stretcher pad was soiled with dust and debris in the 3S shower room in one (1) of four (4) shower stretchers observed.

Maintenance, housekeeping and nursing staff acknowledged the above cited items.
483.75 ADMINISTRATION

A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

This REQUIREMENT is not met as evidenced

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

STATEMENT OF DEFICIENCIES
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NAME OF PROVIDER OR SUPPLIER

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F 492
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IDENTIFICATION NUMBER:

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SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

Continued From page 37
by:
Based on staff interviews and record review, it was determined that Administrative staff failed to adequately identify and implement necessary actions to assure the provision of quality care for all residents in the facility.

The findings include:

1. Facility staff failed to re-assess a resident after returning from the hospital post fall and who was subsequently diagnosed with a fractured tibia. Cross Reference 483.25, F 309 - Identified as actual harm.

2. Facility staff failed to provide adequate supervision for the resident who had multiple falls with injuries. Cross Reference 483.25 (h)(2), F324 - Identified as actual harm.

3. Facility staff failed to maintain nurse staffing at 3.5 nursing hours per resident per day for seven
(7) of seven (7) days reviewed. Cross reference 483.75, F492 - Identified as no actual harm with the potential for more than minimal harm.

4. Facility staff failed to initiate an action plan for resident-to-resident altercations. Cross Reference 483.75(o), F520 - Identified as no actual harm with potential for more than minimal harm. 483.75(b) ADMINISTRATION

The facility must operate and provide services in compliance with all applicable Federal, State, and
local laws, regulations, and codes, and with
accepted professional standards and principles
that apply to professionals providing services in
such a facility.

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F 492

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PROVIDER'S PLAN OF CORRECTION
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facility Quality Improvement/Risk
Management committee monthly. 05/02/07

3. Re-educate all licensed staff on assessment
of post falls and post hospitalization, will
review all falls during daily stand-up meeting
to assure proper assessment and
documentation has occurred.

4. Administrator/DON or designee will conduct
random audits monthly. Findings from daily
review of falls will be reported to the

have been misdiagnosed by 4/30/07. j 04/30/07

F 490 483.75 Administration
F490(l)
1. When Resident #6 returned from post fall
hospitalization, facility assessed the
resident and monitored resident over a 72
hour period. Resident #6 was sent out after nursing assessed that resident needed
further X-ray of knee.
2. Review all resident post falls-April 1, 2007
to present with a hospitalization (trips to
the emergency room), to ensure no fractures

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STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER

GRANT PARK CARE CENTER

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IDENTIFICATION NUMBER:

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(X2) MULTIPLE CONSTRUCTION
A BUILDING
B. WING

STREET ADDRESS, CITY, STATE, ZIP CODE

5000 BURROUGHS AVE. NE
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SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

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PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
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F490(2)
1. Resident #20 was offered an alcohol
treatment program but resident refused
Resident's fall was alcohol abuse related
2. All residents with ETOH abuse as a

problem /diagnosis will be offered treatment.
3. All licensed staff will reeducated on
proper documentation, notification of
physician and family when resident is
observed to be intoxicated. All residents
identified as intoxicated will be placed on
facility 24-hour report for appropriate
follow-up.
4. Facility Administrator/DON or
designee will review 24-hour report as part
of facility morning meeting to ensure that
appropriate treatment options are offered
residents who have been identified as alcohol abusers. DON/Administrator will report findings from morning review to facility Quality

Improvement committee monthly. F490(3)
1. Facility has hired additional staff and
continues to actively recruit and retain staff. Facility is currently holding weekly
orientation classes for new hires.

2. Daily review of staffing levels is conducted to monitor staffing and to ensure that staffing levels meets the needs of residents.
3. Staffing coordinator, DON, ADON, Charge Nurses, Nursing Supervisors and Unit
Managers will be reeducated on need to
maintain staffing at 3.5 hours per patient day. Daily review of staffing by Administrator/
DON or designee will be completed to ensure compliance. Facility will continue to offer
bonuses and overtime to staff to ensure
compliance.
4. Findings from daily staffing review will
be reported to facility Quality
Improvement Committee monthly.

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04/30/07

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Health Regulation Administration

STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER

GRANT PARK CARE CENTER

(X4) to
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(X1) PROVIDER/SUPPLIER/CLIA
IDENTIFICATION NUMBER:

095019

(X2) MULTIPLE CONSTRUCTION
A. BUILDING
B. WING

STREET ADDRESS, CITY, STATE, ZIP CODE

5000 BURROUGHS AVE. NE

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SUMMARY STATEMENT OF DEFICIENCIES
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PROVIDER'S PLAN OF CORRECTION
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F490(4)
#1
1. Resident QA1 was observed with a steak knife in her hand. Facility staff
immediately confiscated the knife.
2. Resident QAl's room was thoroughly
searched to ensure that he/she had no
other knives in the room. No other
residents were harmed nor threatened

by this incident.
3. Staff was re-educated on importance of
observing their surroundings particularly
when in resident's rooms with focus on

items that could be used as weapons.
4. Unit Manager or designee will conduct
random weekly rounds X 4 weeks then
monthly throughout resident rooms in an
effort to identify potentially dangerous
items that could be used as weapons.

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Health Regulation Administration

STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER

GRANT PARK CARE CENTER

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IDENTIFICATION NUMBER:

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(X2) MULTIPLE CONSTRUCTION
A. BUILDING
B. WING

STREET ADDRESS, CITY, STATE, ZIP CODE

5000 BURROUGHS AVE. NE
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SUMMARY STATEMENT OF DEFICIENCIES
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PROVIDER'S PLAN OF CORRECTION
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F490(4)
#2
1. In all the incidents cited in survey report, the facility took immediate action to
separate residents or temporarily locate
residents. DO, 01G and in some instances
the police was notified. Responsible parties and physicians were notified None of the
resident involved suffered any remarkable
injuries as a result of these personal
confrontations with each other.
2. All resident involved in these resident to

resident altercations will be care planned
as "behavioral" problems, referred to social services and activities for diversional
activities.

3. Facility will re-educate the IDT team
members on integration of care plans that
reflect the residents' behavioral problems,
redirection for aggressive behavior and
diversional activities offered. Administrator

or designee will conduct random monthly
audits of care plans on residents who
display aggressive behavior towards each
other to ensure that facility has made every
attempt to address this behavior.
4. Findings from monthly audit will be
submitted to facility Quality Improvement
Committee monthly.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:

A. BUILDING COMPLETED

095019 B. WING

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

GRANT PARK CARE CENTER 5000 BURROUGHS AVE. NE
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(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY)

F 492 Continued From page 38 F 492 F 492 483.75 (b) Administration
1. Facility has hired additional staff and

This REQUIREMENT is not met as evidenced continues to actively recruit and retain staff.
by: Facility is currently holding weekly
Based on a review of "Nursing Daily Staffing" orientation classes for new hires. 04/30/07
sheets and staff interview for seven (7) of seven 2. Daily review of staffing levels is conducted
(7) days reviewed, it was determined that facility to monitor staffing and to ensure that staffing
staff failed to maintain nurse staffing at 3.5 levels meet the needs of residents. 04/30/07
nursing hours per resident per day. 3. Staffing coordinator, DON, ADON, Charge
Nurses, Nursing Supervisors and Unit

The findings include: Managers will be reeducated on need to

maintain staffing at 3.5 hours per patient day.

Daily review of staffing by Administrator/ According to 22DCMR 3211.3, " Beginning no DON or designee will be completed to ensure
later than January 1, 2005, each facility shall compliance. Facility will continue to offer
employ sufficient nursing staff to provide a bonuses and overtime to staff to ensure
minimum daily average of 3.5 nursing hours per compliance. 04/30/07
resident per day. " 4. Administrator/DON will report findings of
staffing level review to facility Quality

The "Nursing Daily Staffing" sheets for March 29, Improvement Committee monthly. 05/02/07
30, 31, April 1, 2, 3 and 4, 2007 were reviewed
with the Director of Nursing (DON) on April 5,
2007. The staffing sheets revealed the following:
Date Nursing Hours
March 29, 2007 3.4
March 30, 2007 3.2
March 31, 2007 2.9
April 1, 2007 2.7 1
April 2, 2007 2.83
April 3, 2007 3.4
April 4, 2007 3.4

The DON acknowledged that staffing was below
3.5 nursing hours per resident per day. He/she
stated, " Staff is offered overtime and bonuses for working extra. Everybody is trying. We even have half shifts, where someone works four hours extra and the next shift comes in four hours early.

This was a repeat deficiency from the

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STATEMENT OF DEFICIENCIES
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(X1) PROVIDER/SUPPLIER/CLIA
IDENTIFICATION NUMBER:

()(Z) MULTIPLE CONSTRUCTION (X3) DATE SURVEY
A. BUILDING COMPLETED

095019 B. WING
04/05/2007

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE GRANT PARK CARE CENTER 5000 BURROUGHS AVE. NE WASHINGTON, DC 20019
(X4) ID
PREFIX

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL

ID
PREFIX

PROVIDER'S PLAN OF CORRECTION

(EACH CORRECTIVE ACTION SHOULD BE (X5)
COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE
DEFICIENCY)

F 492 Continued From page 39 F 492
re-certification survey completed April 14, 2006
and the follow-up survey completed June 29,
2006.

F 493 483.75(d)(1)-(2) GOVERNING BODY F 493 F 493 483.75 (d) (1)-(2) Governing Body
SS=E F493(l)
The facility must have a governing body, or 1. When Resident #6 returned form post
designated persons functioning as a governing fall ey assessed
body, that is legally responsible for establishing

th
e resident and monitored onsitore

tor
the d resident

and implementing policies regarding the over a 72 hour period. Resident 46
was sent out after nursing assessed management and operation of the facility; and the the resident. 04/30/07
governing body appoints the administrator who is 2. Review all resident post falls-April 1, 2007
licensed by the State where licensing is required, to present with a hospitalization (trips to
and responsible for the management of the the emergency room), to ensure no
facility fractures have been misdiagnosed by)
4/30/07. 04/30/07
3. Governing body has instructed facility

This REQUIREMENT is not met as evidenced administrator to ensure that all licensed
by:

staff is re-educated on assessments of

Based on staff interview and record review, it was post falls and post hospitalizations, will
review all falls in daily stand-up determined that the governing body failed to meeting to assure proper assessment
integrate, coordinate and monitor the facility ' s and documentation has occurre(I 04/30/07
practices related to resident care. 4. Administrator/DON or designee will
conduct random audits monthly by)
The findings include: 4/30/07. Findings will be reported to
the facility Quality Miprovement/Risk

1. Facility staff failed to re-assess a resident after Management Committee monthly. 05/02/07
returning from the hospital post fall and who was
subsequently diagnosed with a fractured tibia.
Cross Reference 483.25, F 309 - Identified as
actual harm.

2. Facility staff failed to provide adequate
supervision for the resident who had multiple falls with injuries. Cross Reference 483.25 (h)(2), F324 - Identified as actual harm.

3. Facility staff failed to maintain nurse staffing at 3.5 nursing hours per resident per day for seven
(7) of seven (7) days reviewed. Cross reference

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Health Regulation Administration

STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER

GRANT PARK CARE CENTER

(X4) ID
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IDENTIFICATION NUMBER:

095019

(X2) MULTIPLE CONSTRUCTION
A. BUILDING
B. WING

STREET ADDRESS, CITY, STATE, ZIP CODE

5000 BURROUGHS AVE. NE
WASHINGTON, DC 20019

SUMMARY STATEMENT OF DEFICIENCIES
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04/05/2007

PROVIDER'S PLAN OF CORRECTION
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F493(2)
I. Resident #20 was offered an alcohol
treatment program but resident refused.
Resident's fall was alcohol abuse related.
2. All residents with ETOH abuse as a
problem /diagnosis will be offered treatment.
3. All licensed staff will reeducated on
proper documentation, notification of
physician and family when resident is
observed to be intoxicated. All residents
identified as intoxicated will be placed on
facility 24-hour report for appropriate
follow-up.
4. Facility Administrator/DON or
designee will review 24-hour report as part
of facility morning meeting to ensure that
appropriate treatment options are offered
residents who have been identified as alcohol abusers. DON/Administrator will report findings from morning review to facility Quality
Improvement committee monthly.
F493(3)
1. Facility has hired additional staff and
continues to actively recruit and retain staff. Facility is currently holding weekly
orientation classes for new hires.
2. Daily review of staffing levels is conducted to monitor staffing and to ensure that staffing levels meet the needs of residents.
3. Staffing coordinator, DON, ADON, Charge Nurses, Nursing Supervisors and Unit
Managers will be reeducated on need to
maintain staffing at 3.5 hours per patient day. Daily review of staffing by Administrator/
DON or designee will be completed to ensure compliance. Facility will continue to offer
bonuses and overtime to staff to ensure
compliance.
4. Findings from daily staffing review will
be reported to facility Quality
Improvement Committee monthly.

Health Regulation Administration

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Health Regulation Administration

STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER

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SUMMARY STATEMENT OF DEFICIENCIES
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04/05/2007

PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

F493(4)
#1

1. Resident QAI was observed with a steak knife in her hand. Facility staff
immediately confiscated the knife.
2. Resident QAI's room was thoroughly
searched to ensure that he/she had no
other knives in the room. No other
residents were harmed nor threatened
by this incident.
3. Staff was re-educated on importance of
observing their surroundings particularly
when in resident's rooms with focus on

items that could be used as weapons.
4. Unit Manager or designee will conduct
random weekly rounds X 4 weeks then
monthly throughout resident rooms in an
effort to identify potentially dangerous
items that could be used as weapons.

Health Regulation Administration
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Health Regulation Administration

STATEMENT OF DEFICIENCIES
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A. BUILDING
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STREET ADDRESS, CITY, STATE, ZIP CODE

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WASHINGTON, DC 20019

SUMMARY STATEMENT OF DEFICIENCIES
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PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
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F493(4)
#2

1. In all the incidents cited in survey report, the facility took immediate action to
separate residents or temporarily locate
residents. DO, OIG and in some instances
the police was notified. Responsible parties and physicians were notified. None of the
resident involved suffered any remarkable
injuries as a result of these personal
confrontations with each other.
2. All resident involved in these resident to resident altercations will be care planned
as "behavioral" problems, referred to social services and activities for diversional
activities.

3. Facility will re-educate the IDT team
members on integration of care plans that
reflect the residents' behavioral problems,
redirection for aggressive behavior and
diversional activities offered. Administrator

or designee will conduct random monthly
audits of care plans on residents who
display aggressive behavior towards each
other to ensure that facility has made every
attempt to address this behavior.
4. Findings from monthly audit will be
submitted to facility Quality Improvement
Committee monthly.

Health Regulation Administration
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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER

GRANT PARK CARE CENTER

(X4) ID
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(X1) PROVIDER/SUPPLIER/CLIA
IDENTIFICATION NUMBER:

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SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

Continued From page 40

483.75, F492 - Identified as no actual harm with the potential for more than minimal harm.

4. Facility staff failed to initiate an action plan for resident-to-resident altercations. Cross Reference 483.75(o), F520 - Identified as no actual harm with potential for more than minimal harm. 483.75(l)(1) CLINICAL RECORDS

The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.

The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.

This REQUIREMENT is not met as evidenced by:
Based on staff interview and record review for two
(2) of 30 sampled residents, it was determined that facility staff failed to consistently document behaviors for one (1) resident and document integration of hospice services for one (1) resident. Residents #2 and 19.

The findings include:

Monitoring Record" and nurses' notes when the
resident was administered medication for agitation.

Resident #2's behavior on the "Behavior

1. Facility staff failed to consistently document

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(X2) MULTIPLE CONSTRUCTION
A. BUILDING

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5000 BURROUGHS AVE. NE

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F 493

F 514

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PROVIDER'S PLAN OF CORRECTION
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F 514 483.75 (1) (1) Clinical Records
F514(1)
1. Resident #2's behavior monitoring record was reviewed and is currently being
monitored for completeness.
2. Facility will conduct a review of all
resident behavior monitoring records to
ensure that they are updated and current.
3. Licensed nurses will be reeducated on
importance of accurately completing
behavior monitoring record when behavior
is present and when medication is
administered. Unit manager will complete
weekly audit of all behavior monitoring
records to ensure that they are being
completed appropriately.
4. Findings from weekly audit will be
presented to facility Quality Improvement
Committee monthly.
F514(2)
1. Resident # 19's care plan was corrected
to fully integrate hospice's care plan.
2. Facility will complete audit of all hospice patients to ensure that their care plans are
fully integrated with hospice services.
3. Hospice and facility IDT team members were reeducated on importance of ensuring that hospice services are fully integrated into the resident's plan care. Facility Unit
Managers will complete monthly audit of
hospice patients' care plans to ensure that
they are fully integrated.
4. Findings from monthly audit will be
presented to facility Quality Improvement
Committee monthly.

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

STATEMENT OF DEFICIENCIES
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NAME OF PROVIDER OR SUPPLIER

GRANT PARK CARE CENTER

(X4) ID
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SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

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According to the Medication Administration Record, Seroquel was administered 31 times in March 2007 and two (2) times in April 2007.

The record lacked evidence that "Behavior Monitoring Records" were implemented for March and April 2007.

A face-to-face interview was conducted with the Assistant Unit Manager #1 on April 5, 2007 at 10:50 AM. He / she acknowledged that "Behavior Monitoring Records" were not implemented for March and April 2007. The record was reviewed April 2, 2007.

2. Facility staff failed to document the integration of hospice services for Resident #19.

A review of Resident #19 physician's order sheet dated October 26, 2006 and signed November 1,

2006 revealed the following telephone order. " Admit to hospice care to evaluate."
A review of Resident #19's record lacked evidence of communication between facility staff and hospice staff.

A face-to-face interview was conducted with the Unit Manager #3 on April 4, 2007, at 1:20 PM. He / she acknowledged that Resident # 19 ' s medical record lacked documented evidence of

integrated hospice services. He / She said, "I
called the hospice nurse just yesterday..." This
record was reviewed April 4, 2007.
483.75(o)(1) QUALITY ASSESSMENT AND
ASSURANCE

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 3ZTP1 1

(X1) PROVIDER/SUPPLIER/CLIA
IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION
A. BUILDING

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

STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER

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(X4) ID
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F 520

(X1) PROVIDER/SUPPLIER/CLIA
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095019

SUMMARY STATEMENT OF DEFICIENCIES
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Continued From page 42

A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.

The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.

A State or the Secretary may not require disclosure of the records of such committee

except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.

Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.

This REQUIREMENT is not met as evidenced by:
Based on a review of incident reports for January, February and March 2007, it was determined that facility staff failed to initiate an action plan for resident-to-resident altercations.

The findings include:

A review of the incident reports for January,
February and March 2007 revealed the following resident-to-resident altercations:

Resident QA1 - January 18, 2007 - Physical fight
with another resident.

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(X2) MULTIPLE CONSTRUCTION
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5000 BURROUGHS AVE. NE

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F 520

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PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
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F 520 438.75 (o) (1) Quality Assessment and Assu
#1
1. Resident QAl was observed with a steak
knife in her hand. Facility staff
immediately confiscated the knife.
2. Resident QA I's room was thoroughly
searched to ensure that he/she had no
other knives in the room. No other
residents were harmed nor threatened

by this incident
3. Staff was re-educated on importance of
observing their surroundings particularly
when in resident's rooms with focus on

items that could be used as weapons.
4. Unit Manager or designee will conduct
random weekly rounds X 4 weeks then
monthly throughout resident rooms in an
effort to identify potentially dangerous
items that could be used as weapons.

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

STATEMENT OF DEFICIENCIES (Xi) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER;

095019

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SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

Continued From page 43

Resident QA2 - February 8, 2007 - Hit another
resident in the dining room,
Resident #10 - February 8, 2007 - Hit two (2) other residents in the dining room.
Resident #15 - February 18, 2007 - Physical fight with another resident.

Resident QA3 - February 20, 2007 - Hit another resident on left side of neck.

Resident 0A4 - February 22, 2007 - Argued with another resident then turned over table and two
(2) chairs.

Resident #10 . March 4, 2007 - Threw a shoe and hit resident on left leg.
Resident QA5 - March 6, 2007 - Scratched by another resident.

Resident QA6 - March 8, 2007 - Loud verbal argument with roommate,
Resident QA7 - March 8, 2007 - Loud verbal argument with another resident.
Resident QA1 - March 11, 2007 - Observed with steak knife and threatening staff.

Resident QA8 - no date - Verbally abusive and hit another resident

Resident QA9 - no date - Screaming at top of voice to roommate

Resident QA10 -no date - Hit by roommate.

A face-to-face interview was conducted with the

QI Compliance Officer on April 5, 2007, at 11:30 AM. He/she acknowledged that there was an increase in resident-to-resident altercations and resident aggressive behaviors and no plan had been developed by the facility to address the issues.

GRANT PARK CARE CENT PAGE 03

(X2) MULTIPLE CONSTRUCTION

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determine if approaches are successful and that
facility has made every attempt to address
resident behavior. Findings from monthly
audit will be submitted to facility Quality
Improvement Committee monthly. 05/02/07

in survey report to help with deescalating
resident's behavior.
4. Administrator or designee will conduct random
monthly audits on residents who display
aggressive behavior towards each other to

alcohol and behavior problems as part of. their pre-admissions screens. Patients who are
identified with these types of problems will not
be admitted. Facility will re.-educate staff on identifying causes that trigger escalating behavior in residents. For existing residents who have displayed inappropriate behavior, facility will assess these resident-, to determine if they are inappropriately placed. Facility will also identify staff members who well with residents identified

to identify more appropriate facility.
3. Facility will re's-educate the Admissions team on their screening process to identify drug,

will work with Residents and family members

F520
#2
1. In all the incidents cited in survey report,
the facility took immediate action to
separate residents or temporarily locate
residents. DO, OIG and in some instances
the police was .notif ed. Responsible parties and physicians were notified. Nora, of the
resident involved suffered any remarkable
injuries as a result of these personal
confrontations with each other.
2. All resident involved in these resident to resident alt,-rc;ations will be cut; planned
as "behavioral" problems, referral to social services and activities for diversional
activities, Residents who the facility deems inappropriately placed, Social Services staff

FORM CMS-25e7(o2-99) Previous Versions Cosolete Event ID, 3ZTPI 1 Facility ID; GRANTPARK If continuation sheet Page 44 of 44