STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095022	A. BUILDING _____ B. WING _____	R 03/14/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON NURSING FACILITY	2425 25TH STREET SE WASHINGTON, DC 20020

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS A follow-up survey to the annual re-certification survey (January 14, 2008) was conducted on March 13 through 14, 2008. The following deficiencies were based on record review, observations and staff interviews. The sample included 18 residents based on a census of 346 residents on the first day of the survey and 24 supplemental residents.	{F 000}	The filing of this Plan of Correction does not constitute that the deficiencies alleged did in fact exist. The Plan of Correction is filed as evidence of the facility's desire to comply with the regulatory requirements of responding to these citations and to continue to provide high quality resident care.	
{F 241} SS=D	483.15(a) DIGNITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview for one (1) of 18 sampled resident, it was determined that facility staff failed to promote care in a manner and in an environment that maintains or enhances dignity as evidenced by one (1) resident having breakfast in room with urine odor and a urinal hanging at the bedside. Resident A3. The findings include: Resident A3 was observed on March 13, 2008 at approximately 9:10 AM in bed. The resident's room emitted a urine odor. A urinal filled with urine, was attached by the handle to the resident's headboard. While the surveyor was conducting tour of the facility with Employee #12, Employee #13 came into Resident A3 ' s room to take away the resident's breakfast tray. The urinal was observed	{F 241}	483.15(a) Dignity 1. The CNA involved in this incident was counseled and disciplined. 3/14/08 2. Inservice was given to nursing staff on all nursing units about the importance of creating providing and maintaining an environment that enhances dignity and respect conducive to the dining experience w/special attention to' emptying urinals immediately after resident use to prevent lingering urine odors in the resident's room. 3/14/08 3. Environmental rounds have been Instituted prior to each meal service to ensure that the resident and his/her environment is one which maintains or enhances dignity. 3/14/08 The Clinical Managers will monitor the findings of the environmental rounds and report their findings to the Director of Nurses. 4. The Director of Nurses will Report on the performance Monitoring and any action plans for Improvement to the Quality Assurance/Quality Improvement Committee which is chaired by the Administrator. 4/4/08	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 4/24/08

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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{F 241}	Continued From page 1 hanging on the headboard. The resident said, "I used the urinal before breakfast tray was set up, I wished it was picked up." At 9:40 AM, after the breakfast tray was removed from the resident's room, the urinal was observed still hanging on the headboard. A face-to-face interview was conducted with Employees # 12, 13 and 14 on March 13, 2008 at approximately 9:40 AM. Employees # 12 and 14 both acknowledged that the resident should not have been served breakfast in a room with urine odor and urinal and a urinal filled with urine hanging on the resident's headboard. Employee # 13 responded, "I do not work on this floor. I am new here. "	{F 241}		
{F 309} SS=D	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 one (1) of 18 sampled residents and one (1) supplemental resident, it was determined that facility staff failed: to obtain a physician's order for Resident F1 that required tracheal suctioning who suctioned himself/herself and follow the physician's order for the use of an alarm for one (1) resident's wheelchair. Residents F1 and P6.	{F 309}		

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{F 309}	Continued From page 2 The findings include: 1. Facility staff failed to obtain a physician's order for Resident F1 who required tracheal suctioning and suctioned himself/herself without the assistance of staff members. On March 13, 2008 at approximately 12:55 PM, Resident F1 was observed suctioning his/her mouth with a catheter. Employee #2 stated that since admission [February 19, 2008] Resident F1 was providing his/her tracheostomy care. The Physician's Order Sheet [POS] dated February 19, 2008 directed, "1. Trach care every shift..." The POS lacked evidence that an order was written for Resident F1 to provide his/her own suctioning and/or tracheostomy care. Additionally, the "Resident/Family Education Form", which includes the resident's current knowledge, readiness to learn, special requirements, teaching method to use - verbal, demonstration... was incomplete. A face-to-face interview was conducted on March 13, 2008 at 1:15 PM with Employee #1 who acknowledged that there was no order from the physician directing self care of the tracheostomy and the "Resident/Family Education Form" was not completed. The record was reviewed on March 13, 2008. 2. The facility staff failed to follow the physician's order for the use of an alarm for Resident #P6's wheelchair. A review of the resident's record revealed a physician's order which was written on November 19, 2007 and signed by the physician on	{F 309}	483.25 Quality of Care 1. Resident #F1 1. A physician order for Resident #F1 to administer his own tracheal care was obtained by the Clinical Manager at the time of the survey. Additionally, the Resident/Family Education form was completed although no further education was needed as the resident had been performing his own tracheal care for some time. 2. No other residents of this facility perform their own tracheal care. 3. Clinical Managers were reminded about the need to obtain a physician order for any resident who performed his/her own tracheal care. The Director of Nurses will monitor this issue to ensure compliance. 4. . The Director of Nurses will Report on the performance Monitoring and any action plans for Improvement to the Quality Assurance/Quality Improvement Committee which is chaired by the Administrator. 2. Resident #P6 1. The alarm was reattached to the resident after new batteries were installed. The resident was near the nursing station at the time and was being monitored for safety by the Unit Clerk. 2. All chair alarm batteries are checked daily to ensure that they are fully operational.	3/14/08 3/14/08 3/14/08 4/4/08 3/14/08 3/14/08

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{F 309}	Continued From page 3 December 12, 2007. The physician's order stated, "Alarm on chair at all times while up in chair for pelvic positioning." The original order for the chair alarm was written on May 29, 2007. During an observation of the resident in the wheel chair on March 14, 2007 at 10:25 AM, it was determined, that the chair alarm was not affixed to the chair. The alarm was observed at 10:30 AM in the presence of Employee #3 on the nurse's station desk. He/she stated that the "batteries were dead." A face-to-face interview was conducted with Employee #3 at approximately 10:35AM on March 14, 2007. He/she acknowledged that the chair alarm was not on the wheel chair during the observation. He/she stated "She always had it on. I saw it on her yesterday." The record was reviewed on March 14, 2008.	{F 309}	3. Clinical Managers will monitor the chair Alarms to ensure they are always operational. 4. The Director of Nurses will Report on the performance Monitoring and any action plans for Improvement to the Quality Assurance/Quality Improvement Committee which is chaired by the Administrator.	3/14/08 4/4/08
{F 425} SS=E	483.60(a), (b) PHARMACY SERVICES The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation	{F 425}		

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{F 425}	Continued From page 4 on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observations during an inspection of the medication carts, it was determined that facility staff failed to follow the plan of correction from the annual licensure survey completed January 14, 2008, to date multiple dose vials when opened. This is a repeat deficiency. The findings include: According to the facility's plan of correction for the annual re-certification survey completed January 14, 2008, "In-services were given to all nursing staff regarding the facility protocol when opening a multi-dose vial ..." According to the attendance record for in-services the program title was, "Multi-dose vials must be dated when open" and "Multi-dose vials must be dated, initialed when opened." Face-to-face interviews were conducted on March 14, 2008 from 1:30 PM through 3:00 PM during the inspection of the medication carts with Employees #4, 5, 6, 7, 8, 9, 10 and 11. The employees individually acknowledged that they had attended an in-service regarding the dating and initialing of multi-dose vials when opened. The aforementioned employees' names appeared on sign-in sheets for the above cited in-services. The following multi-dose vials were observed	{F 425}		

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{F 425}	Continued From page 5 undated when opened: 1S: Xalatan eye drops, 1 vial Heparin injectable solution, 2 vials 1N: Lantus Insulin, 1 vial Xalatan eye drops, 2 vials 3N: Xalatan eye drops, 3 vials Xalatan eye drops, 1 vial The following items were observed unlabeled: 1S: Haldol injectable, 1cc bottle NitroQuick, 1 bottle Cosopt eye drops, 1 vial Systane Lubricant eye drops, 2 vials Xalatan eye drops, 1 vial 3S: One brown and beige capsule and one green pill in a bag used to crush medication. 3 orange pills in an unmarked bottle Albuterol Inhaler Panatol eye drops, 1 vial Flovent Inhaler, 1 inhaler Cosopt eye drops, 1 vial Systane Lubricant eye drops, 1 vial 3N: Vigamox Inhaler, 1 inhaler The following items were not refrigerated as per the	{F 425}	483.60 (a), (b) Pharmacy Services 1. All undated, unlabeled, and expired medications found at the time of the survey were discarded upon discovery. 2. All medication carts and medication rooms were checked for undated, unlabeled, and expired medication. 3. Monitoring rounds have been established to provide documentation on a daily basis that all medication carts have been checked for undated, unlabeled and expired medications. See the attached form. Additionally, inservice was given specially regarding the need to date Xalatan eye drops upon opening and to reinforce the multi-dose vial expiration and storage instructions as per protocol with the facility's pharmacy. 4. The Director of Nurses will report on the performance monitoring rounds for the medication carts and any action plans for improvement to the Quality Assurance/Quality Improvement Committee which is chaired by the Administrator.	3/14/08 3/14/08 3/30/08 4/4/08

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{F 425}	Continued From page 6 1S - Xalatan eye drops, unopened, 2 vials. 2S - Aranesp injectable solution, 1 package The following items were discontinued: 2S: Abreva cream (no order on the March 2008 Medication Administration Record - MAR) Heparin Sodium 10,000 units/cc (no order on the March 2008 MAR) Ciprodex discontinued March 1, 2008 3S: Tobradex Ophthalmic solution, 5 tubes (no order on the March 2008 MAR) Isopto Hyoscine (no order on the March 2008 MAR) Assure Pro, high and low control vials for the glucometer, had the following directions printed on the side of the vial: "Use within 90 days of opening." Vials were observed undated when opened on units 1S, 1N, 2S, 3N and 3S.	{F 425}		