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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	09/22/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON CTR FOR AGING SVCS	2601 18TH STREET NE WASHINGTON, DC 20018

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F 000	INITIAL COMMENTS An annual recertification survey was conducted September 19 through 22, 2006. The following deficiencies were based on observations, record reviews and staff interviews. The sample included 30 residents based on a census of 202 residents on the first day of survey.	F 000	Washington Center for Aging Services makes its best effort to operate in substantial compliance with both Federal and state Law. Submission of this Plan of Correction (POC) does not constitute an admission or agreement by any party, its officers, directors, employees or agents as the truth of the facts alleged or the validity of the conditions set forth on the Statement of Deficiencies. This plan of Correction (POC) is prepared and /or executed solely because it is required by federal and State Law.	
F 253 SS=C	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 during the survey period, it was determined that housekeeping and maintenance services were not adequate to ensure that the facility was maintained in a safe and sanitary manner as evidenced by: soiled exhaust vents in residents ' rooms and common areas and marred and damaged entrance doors. These findings were observed in the presence of Maintenance and Housekeeping Directors. The findings include: 1. The exterior and interior surfaces of exhaust vents in residents' bathrooms and common areas were soiled with accumulated dust and debris. First Floor Rooms 102, 111, 153, 156, 178, 181 and women's toilet room in seven (7) of 19 observations between 11:19 AM and 12:20 PM on September 19, 2006 and between 11:30 AM and 2:00 PM on September 20, 2006.	F 253	F 253 Housekeeping/Maintenance 1. The exterior and interior surfaces of exhaust vents identified on the first, second and third floor and in the common areas have been cleaned. The resident entrance, bathroom and closet doors identified to be marred or damaged have been repaired and/or painted. 2. All exterior and interior vents have been inspected for dust and debris and cleaned if indicated. All entrance, bathroom and closet doors were inspected and repaired or painted as needed. No resident was affected by this practice. 3. The Director of Engineering reviewed the Preventive Maintenance program and re-educated staff on expectations. The exhaust vents and doors are a part of the daily inspection logs. 4. The Director of Engineering and Environmental Services will collaboratively conduct quarterly audits on the exhaust vents. Additionally, audits will be conducted on the doors. Findings will be presented at the Quality Assurance meeting.	10/6/06

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Willistine D. Page	Administrator	10/10/06

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 253	Continued From page 1 Second Floor Rooms 235, 273, 281, toilet room, custodial closet and women's bathroom in six (6) of 24 observations between 9:00 AM and 1:30 PM on September 21, 2006. Third Floor Rooms 359, 382, 388 and men's shower room in four (4) of 19 observations between 2:12 PM and 4:45 PM on September 21, 2006. 2. Residents' entrance, bathroom and closet doors were marred and damaged on the frontal and edge surfaces in the following areas: First Floor Rooms 153, 160, 189 in three (3) of 20 observations between 11:19 AM and 12:20 PM on September 19, 2006 and 11:30 AM and 4:45 PM on September 20, 2006. Second Floor Rooms 239, 235, 272, 273, 282 and 288 in six (6) of 24 observations between 9: 00 AM and 1:30 PM on September 21, 2006. Third Floor Rooms 336, 337, 385, 388 and 380 in five (5) of 19 observations between 2:12 PM and 4:45 PM on September 21, 2006.	F 253		

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F 278 SS=E	483.20(g) - (j) 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. This REQUIREMENT is not met as evidenced by : Based on observation, staff interview and record review for eight (8) of 30 sampled records, it was determined that facility staff failed to sign the MDS at Section R2 for one (1) resident and accurately code the diagnoses for two (2) residents, the number of pressure sores for one (1) resident and behaviors for four (4) residents.	F 278	F 278 Resident Assessments 1. The MDS for Resident #3 was reviewed and R2 was corrected. The MDS for residents #4 and 5 was reviewed and diagnostic coding for resident #4 and pressure sore coding for resident #5 was corrected. Resident #7 and 16 were reviewed and assessed by the social work and nursing staff. The record reflected social work notes for Resident #7on 5/5/06 and social work notes for resident #16 on 4/21/06. Both social work notes include documentation on the behaviors. The behavioral monitoring record and nursing record did not consistently address the behaviors. Unable to retrospectively correct the documentation. The behavioral monitoring record and nursing notes currently reflect the behaviors. Residents #11 and 23 were reassessed by the nursing and social work staff. Unable to retrospectively correct the documentation. The record currently reflects the resident's behaviors. Resident #24 was reassessed by the nursing team and while the Mental Retardation was not addressed in the diagnosis section of the MDS it was included on the MDS background information section AB #10. The diagnostic codes have been updated to reflect the Mental Retardation. 2. All MDS from the previous quarter for residents who have behavioral problems and pressure sores have been reviewed for accuracy. Additionally, diagnostic coding will be reviewed and updated for all MDS quarterly, annually and if the resident has a significant change. All residents with behavior and mood problems have been re-evaluated. The Behavior monitoring record has been updated to reflect behaviors if indicated. In addition, section R has been reviewed for signature and no other resident was found to be affected.	

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F 278	Continued From page 3 Residents # 3, 4, 5, 7, 11, 16, 23 and 24. The findings include: 1. The registered nurse (RN) failed to sign Section R2, "Assessment Information" to indicate that the MDS assessment was complete for Resident #3. A review of Resident #3' s record revealed that a quarterly MDS was completed August 7, 2006. The RN failed to sign Section R2 to indicate that the assessment was completed by all disciplines participating in the assessment. A face-to-face interview was conducted with the Resident Care Coordinator (RCC) on September 20, 2006 at 9:10 AM. He/she acknowledged that Section R2 was not signed by the RN. The record was reviewed September 20, 2006. 2. Facility staff inaccurately included a diagnosis of Diabetes Mellitus (DM) in Section I, "Disease Diagnoses" of the annual MDS completed August 28, 2005 and quarterly assessments completed November 27, 2005, February 26, June 6, and September 9, 2006 for Resident #4. A review of Resident #4's record revealed no documented evidence in the physician's orders, History and Physical examinations for 2005 and 2006 and the Problem List that identified Resident #4 with a diagnosis of DM. A face-to-face interview with the RCC was conducted on September 20, 2006 at 9:10 AM. He/she reviewed the resident's record and acknowledged that the resident should not have	F 278	F 278 Resident Assessments Continue from Page 3 3. The RCCs and social work staff have been re-educated on accuracy of coding for the MDS particularly as it pertains to diagnosis, pressure sores and behavior monitoring. The education also included the importance of signing of section R2. 4. The MDS Coordinator will audit the MDS as part of the quality improvement program. The results will be shared with the IDT team. It is also presented at the quality improvement meetings.	10/30/06

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F 278	Continued From page 4 been coded with a diagnosis of DM. The record was reviewed September 20, 2006. 3. Facility staff failed to accurately code the number of pressure sores on the annual MDS for Resident #5. A review of Resident #5's quarterly MDS completed July 14, 2006, in Section M, "Skin Condition" coded the resident with four (4) Stage II and three (3) Stage III pressure sores. A review of the "Altered Skin Integrity Assessment" sheets and nurses' notes revealed that on July 14, 2006 the resident had two (2) Stage II pressure sores. A face-to-face interview was conducted with the RCC on September 20, 2006 at 11:20 AM. He/she acknowledged that the resident had two (2) pressure sores when the quarterly MDS was completed on July 14, 2006 and that the MDS was incorrectly coded. The record was reviewed September 20, 2006. 4. Facility staff failed to accurately code Resident #7's behaviors on the annual and quarterly MDS. A review of Resident #7's record revealed that the annual MDS completed May 5, 2006 and the quarterly MDS completed August 3, 2006, coded the resident as being verbally and/or physically abusive in Section E, "Mood and Behavior Patterns." A review of the Behavior Monitoring Flow Record, social service notes and nurses' notes from April through August 2006 revealed that there were no episodes of verbal and/or physical abuse that	F 278		

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F 278	Continued From page 5 occurred within 30 days of the Assessment Reference Date (ARD - end of the observation period) for the above cited MDS assessments. A face-to-face interview was conducted with the RCC on September 20, 2006 at 10:45 AM. After reviewing the record, he/she acknowledged that there was no documentation of episodes of physical and/or verbal abuse within the ARD for either MDS. The record was reviewed September 20, 2006. 5. Facility staff failed to accurately code Resident #11 for behaviors on the quarterly MDS completed September 7, 2006. A review of Resident #11's record revealed that the resident was coded in Section E, "Mood and Behavior Patterns" for being easily annoyed. There was no documentation of episodes in the social services notes, nurses ' notes or on Behavioral Monitoring Flow Record for August or September 2006 that the resident was easily annoyed. A face-to-face interview was conducted with the RCC on September 21, 2006 at 7:00 AM. He/she acknowledged that there was no documentation of episodes of the resident being easily annoyed within the ARD for the quarterly MDS. The record was reviewed September 21, 2006. 6. Facility staff failed to accurately code Resident #16 for behaviors on the annual MDS completed April 23, 2006 and quarterly MDS July 21, 2006. A review of Resident #16 revealed that the resident was coded in Section E, "Mood and	F 278		

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F 278	Continued From page 6 Behavior Patterns" for wandering, physically abusive, socially disruptive behaviors, and resisting care. There was no documentation of episodes of the above cited behaviors in the social service notes, nurses' notes and Behavioral Monitoring Flow Record from April through July 2006. A face-to-face interview was conducted with the RCC on September 19, 2006 at 3:00 PM. He/she acknowledged that there was no documentation of the above episodes within the ARD for the annual and quarterly MDS. The record was reviewed September 19, 2006. 7. Facility staff failed to accurately code Resident #23 for behaviors on the quarterly MDS completed July 11, 2006. A review of Resident #23's record revealed that the resident was coded for sad behaviors in Section E, "Mood and Behavior Patterns" on the quarterly MDS completed July 11, 2006. There was no evidence in the social service notes, nurses' notes and Behavioral Monitoring Flow Record for July 2006 that the resident expressed sad behavior. A face-to-face interview with the RCC was conducted on September 21, 2006 at 2:30 PM. He/she acknowledged that staff was monitoring the resident for sad behaviors. However, the resident had not expressed any sad behaviors during the month of July (2006) within the ARD date of the quarterly MDS. The record was reviewed September 20, 2006. 8. Facility staff failed to include the diagnosis of	F 278		

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F 278	Continued From page 7 Mental Retardation on the annual MDS completed November 8, 2005 for Resident #24. A review of Resident #24's record revealed a " Psychological Evaluation" dated August 27, 2002 . Under, "Previous Psychological Findings," was listed, "Adaptive: Severe Mental Retardation." The diagnosis was not included in Section I, " Disease Diagnoses" of the annual MDS completed November 8, 2006. The record was reviewed September 21, 2006.	F 278		
F 280 SS=D	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, 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 :	F 280	F-280 Comprehensive Care Plan 1. Resident #18 was re-assessed by the clinical team. The falls care plan was updated to reflect risk factors and appropriate interventions. 2. The care plan for all residents with a fall within the last quarter was reviewed. No other resident was affected by this practice. 3. The staff was re-educated on fall Prevention and post fall management and care planning. 4. The care plan audit is a part of the Quality Improvement tools submitted monthly. Additionally, focus audits of care plans following a fall will be incorporated into the audit and reported at the quality assurance meeting.	10/31/06

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F 280	Continued From page 8 Based on staff interview and record review for one (1) of 30 sampled residents, it was determined that facility staff failed to update the falls care plan to include approaches and interventions for Resident #18 following one (1) fall with a fracture. The findings include: A review of Resident #18's record revealed that on July 19, 2006 an x-ray report confirmed that the resident had a subcapital fracture to the right hip from a previous fall. The resident was sent out via stretcher with paramedic staff to the emergency room. The resident was readmitted to the facility on July 26, 2006 with diagnoses that included ORIF [Open Reduction Internal Fixation] to Right Hip. On September 20, 2006 at 12:20 AM a nurse's note documented the following: " Resident was noted on the floor sitting inside the closet ... Resident stated that he/she climbed out of the bed from the foot end [of the bed] and slide to the floor. " A review of Resident #18's " Resident Care Plan " revealed that upon readmission to the facility on July 26, 2006 the " Falls Care Plan " was not updated or revised with new approaches or interventions to address the resident's fall status. Subsequently, the resident sustained a fall without injury on September 20, 2006. A face-to-face interview was conducted with the Resident Care Coordinator on September 20, 2006 at 9:15 AM. He/she acknowledged that no interventions were initiated after the above cited	F 280		

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F 280	Continued From page 9 fall. The record was reviewed September 20, 2006.	F 280		
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 30 sampled residents, it was determined that facility staff failed to follow the interventions for the care plan problem, "Severe Alzheimer's Disease" for Resident #12. The findings include: According to the quarterly Minimum Data Set (MDS) completed September 1, 2006, the resident was coded with long and short-term memory problems and severely impaired skills for cognitive decision-making (Section B). Resident #12 was observed from 11:10 AM until 12:50 PM on September 19, 2006. The resident was accompanied by his/her daughter from 11:10 AM until 12:10 PM. The resident was positioned facing away from the other residents gathered in the day room. Facility staff acknowledged the daughter but failed to address the resident. The	F 309	F 309 Quality of Care 1. Resident #12 was re-assessed by the RCC and the Recreation Director. Following the reassessment the team decided to continue with current approaches. Additionally, the resident was involved in an activity later that same afternoon. Music was played and interaction took place. No adverse reaction was noted to resident. 2. A review of the residents with "Severe Alzheimer's Disease" was conducted to ensure appropriate care plan in place and being followed. No other resident was found to be affected by this practice. 3. The Director of Nursing and Director of Therapeutic Recreation had a meeting regarding approaches for residents with Alzheimer's disease. The staff have been re-educated regarding following approaches as indicated in the care plan. 4. The comprehensive care plan is audited monthly. Additionally the audit tool has been updated to reflect the care plan being followed as written. This information is presented at the quality assurance meetings.	10/31/06

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F 309	Continued From page 10 resident's position in the day room was not changed when his/her daughter left. Two (2) recreational therapists came into the day room at 11:50 AM and left at 12:20 PM. There was no interaction between the recreational therapists and Resident #12. Facility staff approached the resident at 12:40 PM . The staff member spent one (1) minute standing beside the resident checking the feeding tube pump. He/she did not touch or talk to the resident. According to the resident's care plan for "Severe Alzheimer's Disease," reviewed September 9, 2006, approaches included the following: "Talk to resident throughout the day, including topics of current events. Touch resident while taking. Position for maximum stimulation." According to the evaluation of the approaches dated September 7, 2006, "Resident responds to verbal and tactile stimulation." A face-to-face interview with the Resident Care Coordinator was conducted on September 19, 2006 at 1:00 PM. He/she reviewed the resident ' s record and acknowledged that the resident's care plan interventions were not followed. The record was reviewed September 19, 2006.	F 309		

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F 333 SS=D	483.25(m)(2) MEDICATION ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by : Based on observation, staff interview and record review, it was determined that one (1) significant and one (1) non-significant error occurred during the morning medication pass on September 20, 2006 for Resident #7. The findings include: At approximately 9:05 AM on Wednesday, September 20, 2006, the medication nurse prepared medication for Resident #7. The nurse administered five (5) morning medications. A review of the resident's Medication Administration Record (MAR) revealed that the nurse omitted two (2) medications from the morning medication pass, Spironolactone 50mg tablet, taken daily for Congestive Heart Failure (CHF) and Oyst-Cal-D 500mg/200u tablet taken daily as a nutritional supplement. The physician's order for Spironolactone and Oyst-Cal-D was written on December 6, 2005 and renewed on September 12, 2006. A face-to-face interview was conducted with the medication nurse immediately after he/she administered medications to Resident #7. After reviewing the MAR, the nurse acknowledged his/ her error and administered the Spironolactone 50 mg tablet and Oyst-Cal-D 500mg/200u.	F 333	F 333 Medication Errors 1. The physician's orders and MARs for Resident #7 were reviewed and medications were administered. No adverse reaction was noted to resident. 2. The physician's orders and MARs for the residents have been reviewed to ensure that MARs reflect the current needs of the residents. No other resident was found to be affected by this practice. 3. The nurse responsible for the error was in-serviced and counseled. The licensed staff have been re-educated on medication administration and requirements. 4. Medication pass audits and tool has been reviewed and updated to include formula for calculation of medication error. These audits continue to be done monthly and additional audits are done by pharmacy. This is presented at the Quality Improvement Meetings.	10/31/06

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F 432 SS=D	483.60(e) STORAGE OF DRUGS AND BIOLOGICALS 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, staff interview and record review, it was determined that the refrigerator temperatures were out of range for the 3 Orange medication refrigerator. The findings included: The Facility's policy, "5.3 - Storage and Expiration Dating of Drugs, Biologicals, Syringes and Needles," stipulates under, "(8) Drugs and biologicals are stored at their appropriate temperatures. (8.2) Refrigeration: 36° F - 46° F (Fahrenheit) or 2° to 8° C." On September 19, 2006, at approximately 9:30 AM and 3:30 PM the refrigerator temperature on 3 Orange was 60° F. The medication refrigerator stores vaccines, insulins and suppositories.	F 432	F 432 Storage of Drugs and Biologicals 1. The medications in the identified refrigerator were removed immediately. The thermostat in the refrigerator had been changed within the last month and the temperature readings were within the appropriate range with some fluctuations, as a result a new refrigerator was purchased, installed and checked for appropriate temperature. 2. All medication refrigerators were checked and no other refrigerator was found to be affected by this practice. 3. The medication refrigerators will continue to be checked by the nursing department. Additionally, the engineering department will include the medication refrigerators on their preventive maintenance program. 4. Checking the medication temperatures is a part of the daily nursing and monthly pharmacy inspections. This is also now included in the engineering inspections. The information will be presented at the quality assurance meetings.	10/6/06

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	09/22/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON CTR FOR AGING SVCS	2601 18TH STREET NE WASHINGTON, DC 20018

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F 432	Continued From page 13 The Facility's "Refrigerator Temperature Record" and the pharmacist's "Monthly Inspection" report revealed that the refrigerator had fluctuating temperatures in August and September 2006 between 56 and 60 degrees F. The 3 Orange Resident Care Coordinator stated that a work order request had been sent to the maintenance department. The work order was unable to be located at time of inspection. On September 19, 2006, at approximately 4:30 PM, a face-to-face interview was conducted with the engineer. He/she stated, "The work order is being filled out now. I just replaced the refrigerator. There was no work order submitted for the refrigerator before today."	F 432		