	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL1		(X3) DATE SUF	
		095022	B. WING		01/1	5/2009
NAME OF PR	OVIDER OR SUPPLIER	• •	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
WASHING	GTON NURSING FACI	LITY		2425 25TH STREET SE WASHINGTON, DC 20020		
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F 000	An annual recertific January 12 through	S ation survey was conducted on 16, 2009. The following ased on record review,	F 00	not constitute an admission deficiencies actually did in Plan of Correction is filed a of the facility's desire to co	n that the fact exist. This as evidence mply with the	
	facility staff. The sa based on a census	nterviews with residents and the ample included 30 residents of 349 residents on the first day pplemental residents.		regulatory requirements of these citations and to cont quality resident care.	inue to provide	
F 157 SS=D		FICATION OF CHANGES	F 15	 7 483.10(b)(11) Notification Resident S5 1. Physician was notified, I 	-	3/6/09
	consult with the resident's notify the resident's interested family me involving the resider	diately inform the resident; ident's physician; and if known, legal representative or an ember when there is an accident nt which results in injury and has uiring physician intervention; a		order change documented resident was notified of the order. The order includes of as to which medication is t mild, moderate and severe	, and the change of differentiation o be given for	
	significant change in or psychosocial stat mental, or psychoso threatening condition need to alter treatm	in the resident's physical, mental, tus (i.e., a deterioration in health, ocial status in either life ns or clinical complications); a ent significantly (i.e., a need to ting form of treatment due to		 All medical records iden physician order change we documentation of the reas order was changed, if the notified of the change and resident notification was do 	tified with a ere audited, on why the resident was that the	3/31/0
	form of treatment); o	ces, or to commence a new or a decision to transfer or ent from the facility as specified	·	in the resident's medical re 3. The Nursing Quality Imp Program will monitor for no	ecord. provement ptification	
	The facility must als and, if known, the re	o promptly notify the resident esident's legal representative or		of changes in medication c will be submitted to the Dir Nursing (DON) for evaluat Implementation of an actio	ector of on and the	3/31/0
	room or roommate a §483.15(e)(2); or a	ember when there is a change in assignment as specified in change in resident rights under v or regulations as specified in this section.		 Necessary. 4. The Department Head a report of the data collect action plans implemented sustained compliance at the sustaine	will present ed and any to ensure	
	The facility must rec	cord and periodically update	·	Quality Improvement Com is chaired by the Administr	mittee which	4/309
DODATODY			77			
BURATORY	UIRECTOR'S OR PROVIDER	/SUPPLIER REPRESENTATIVE'S SIGNATURE	Ad	unitration	3/23/0	(X6) DATE

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	: 03/04/2009 APPROVEI . 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT		(X3) DATE SUF COMPLET	
		095022	B. WING		01/1	5/2009
	ROVIDER OR SUPPLIER	LITY		REET ADDRESS, CITY, STATE, ZIP CODE 2425 25TH STREET SE WASHINGTON, DC 20020	· · ·	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION SHO REFERENCED TO THE APPROPRI	DULD BE CROSS-	(X5) COMPLETION DATE
F 000	An annual recertifica January 12 through deficiencies were ba observations, and in facility staff. The sa based on a census	S ation survey was conducted on 16, 2009. The following ased on record review, iterviews with residents and the mple included 30 residents of 349 residents on the first day pplemental residents.	F 00	O The filing of the Plan of Cornot constitute an admission deficiencies actually did in the Plan of Correction is filed at of the facility's desire to corregulatory requirements of these citations and to continuality resident care.	that the act exist. This s evidence nply with the responding to	
F 157 SS=D	A facility must imme consult with the resi notify the resident's interested family me involving the resider the potential for requ significant change ir or psychosocial stat mental, or psychoso threatening condition need to alter treatme discontinue an exist adverse consequent form of treatment); or discharge the reside in §483.12(a). The facility must als and, if known, the re- interested family me room or roommate a §483.15(e)(2); or a of Federal or State law paragraph (b)(1) of	FICATION OF CHANGES diately inform the resident; dent's physician; and if known, legal representative or an ember when there is an accident at which results in injury and has uiring physician intervention; a the resident's physical, mental, us (i.e., a deterioration in health, cial status in either life ns or clinical complications); a ent significantly (i.e., a need to ing form of treatment due to ces, or to commence a new or a decision to transfer or ent from the facility as specified o promptly notify the resident esident's legal representative or ember when there is a change in assignment as specified in change in resident rights under or regulations as specified in this section. ord and periodically update	F 15	 483.10(b)(11) Notification Resident S5 Physician was notified, resident was notified of the order change documented, resident was notified of the order. The order includes d as to which medication is to mild, moderate and severe All medical records ident physician order change well documentation of the reaso order was changed, if the resident notification was do in the resident's medical records ident resident notification was do in the resident's medical referses and the submitted to the Direc Nursing (DON) for evaluation of will be submitted to the Direc Nursing (DON) for evaluation implementation of an action Necessary. The Department Head was report of the data collecter action plans implemented to the sustained compliance at the Quality Improvement Commis chaired by the Administration of the compliance at the program with the Administration of the compliance at the program with the Administration of the Administra	eason for the and the change of ifferentiation b be given for pain. ified with a re audited, in why the esident was hat the cumented cord. rovement tification rders. Data ector of on and the plan when vill present d and any o ensure e monthly nittee which	3/6/09 3/31/09 3/31/09 4/309

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED:	03/04/2009
FORM /	APPROVED
OMB NO	0938-0391

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI		CONSTRUCTION	(X3) DATE SUI COMPLET	
		095022	B. WING	3 <u> </u>		01/1	6/2009
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F 157		ge 1 one number of the resident's or interested family member.	F 1	57	· · ·		
	Based on record revi interviews, it was de supplemental reside notify Resident S5 of The findings include A face-to-face intervi Resident S5 on Jan Resident S5 on Jan Resident S5 stated, changed, I didn't sed didn't ask for a char told me about it." A review of Resident telephone order date PM, signed by the p that directed: " 1. D/C (discontinue hrs PRN (as needed 2. Darvocet - N50 C (three times daily) P 3. Motrin 800 mg po	Int that facility staff failed to of a change in medications. The was conducted with uary 14, 2009 at 4:30 PM. "My pain medicine was the doctor to talk about it, I age in medication and no one to the doctor to talk about it, I age in medication and no one to the doctor to talk about it, I age in medication and no one to the doctor to talk about it, I age in medication and no one to the doctor to talk about it, I age in medication and no one to the doctor to talk about it, I age in medication and no one to talk about it, I age in medication about it, I age in medicatit, I age in medication about it, I age					
	documenting the reachanged. There wa requested a change	cian's or nurse's note ason the medication was s no evidence that the resident in medication. ras no differentiation among	· · · · · · · · · · · · · · · · · · ·				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WPBP11

Facility ID: WASHNURS

If continuation sheet Page 2 of 121

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 03/04/2009 APPROVED : 0938-0391
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL		PLE CONSTRUCTION	(X3) DATE SUF COMPLET	
		095022	B. WIN	G		01/10	6/2009
	OVIDER OR SUPPLIER	ודץ		2	REET ADDRESS, CITY, STATE, ZIP CODE 2425 25TH STREET SE VASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFI TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIATE DE	E CROSS-	(X5) COMPLETION DATE
F 157 F 161 SS=C	Strength, all prescrib A face-to-face interv Employee #5 on Jan He/she acknowledge consulted or notified was changed. Further interview wit 2009 at 4:30 PM rev controlled with the u reviewed January 15 483.10(c)(7) ASSUF SECURITY The facility must pur otherwise provide as Secretary, to assure funds of residents de This REQUIREMEN The facility Staff faile coverage to assure to of residents deposite The findings include A review of the Sure 12:01 PM indicated to facility was in the arr	 N50, Motrin and Tylenol Extra bed for moderate pain. iew was conducted with huary 16, 2009 at 8:45 AM. ed that the resident was not when his/her pain medication h Resident S5 on January 15, ealed that his/her pain was se of Motrin. The record was 5, 2009. CANCE OF FINANCIAL chase a surety bond, or surance satisfactory to the the security of all personal eposited with the facility. T is not met as evidenced by: ed to provide surety bond he security of all personal funds ed with the facility. 		157		actice with the very day ability ferred ime, lave a 000. which by the ator will of the e basis fund ator will strator	3/12/09 3/12/09 3/12/09
	revealed the balance on: October 2, 2008	e in the resident fund account as \$283, 939.08; October 31, 0 and December 2, 2008 as			Committee.	ะาน	41309
					<u> </u>		

Facility ID: WASHNURS

If continuation sheet Page 3 of 121

		AND HUMAN SERVICES			FORM	: 03/04/2009 APPROVED
		& MEDICAID SERVICES				0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDI		(X3) DATE SUR COMPLETI	
	•	095022	B. WING		01/16	6/2009
NAME OF PF		<u></u>	s	TREET ADDRESS, CITY, STATE, ZIP CODE		
WASHING	GTON NURSING FACI	LITY		2425 25TH STREET SE		
	CURRADY CT			WASHINGTON, DC 20020		
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F 161	Continued From pag	ge 3	F 16	1		
	Employee #1 on Jai	view was conducted with nuary 14, 2009 at 12:30 PM. owledged the findings.				
F 164 SS=D	483.10(e), 483.75(l) CONFIDENTIALITY		F 16	483.10(e), 483.75 (l)(4) Privacy a Confidentiality	and	
		e right to personal privacy and or her personal and clinical		Resident #11 1. Employees involved were cour of the importance of providing priv by making ours that the privacy of	vacy to	3/10/09
	medical treatment, v communications, pe meetings of family a	cludes accommodations, written and telephone ersonal care, visits, and and resident groups, but this e facility to provide a private ent.		by making sure that the privacy c pulled completely around the resi during the performance of any assessment and/or any treatment 2. Rounds were made by the Clin designee to ensure that privacy c were completely pulled around all res	dent t. iical Mgr./ urtains	3/10/09
	section, the residen release of personal individual outside th	in paragraph (e)(3) of this t may approve or refuse the and clinical records to any e facility. to refuse release of personal		 during wound treatments. 3. Inservice education was given members of the nursing staff to en compliance in providing privacy to residents during wound treatment The Nursing Quality Improvement 	nsure o all ts.	3/31/09
	and clinical records resident is transferre	does not apply when the ed to another health care release is required by law.		Program will collect data on the the nurse's adherence to privacy confidentiality while rendering wo and will present their findings to the	und	
	contained in the res the form or storage	ep confidential all information ident's records, regardless of methods, except when release er to another healthcare		 DON. 4. The Department Head will pre- a report of the data collected and action plans implemented to ensure 	any	
		party payment contract; or the		sustained compliance at the mon Quality Improvement Committee is chaired by the Administrator.	thly	4/309
	This REQUIREMEN	IT is not met as evidenced by:				
	Based on observatio	ons for two (2) of 30 sampled				
FORM CMS-25	57(02-99) Previous Versions O	bsolete Event ID: WPBP1	1	Facility ID: WASHNURS If contir	nuation sheet	Page 4 of 121

DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT OF DERCENCIES [P1] PROVEERSUPPLIERCIAN CAM LTPLE CONSTRUCTION PD-DATE SUPPLY CAM DEVENCE MASHINGTON NURSING FACILITY Setter Address, CITV, STATE, 2IP CODE 2428 35TH STREET 3E VASHINGTON, DC 2002 01/16/2009 MME OF PROVEER OR SUPPLIER Setter Address, CITV, STATE, 2IP CODE 2428 35TH STREET 3E VASHINGTON, DC 2002 2428 35TH STREET 3E VASHINGTON, DURSING FACILITY PD/DATE PLANOF CREATED BY CODE Confidentiality (Continued) Confidential	_CENTER	<u>RS FOR MEDICARE</u>	<u>& MEDICAID SERVICES</u>				OMB NO	<u>. 0938-0391</u>
NME OF PROVIDER OR SUPPLIER O1/16/2009 WASHINGTON NURSING FACILITY STREET ADDRESS, CITX: STATE 2P: CODE 243: 25TH STREET SE WASHINGTON, DC 20020 Composition of the construction of the provide proceed and the residents and one (1) supplemental resident, it was determined that facility staff failed to provide privacy by completely pulling the privacy curtain for two (2) residents and one (1) supplemental resident, and during a radiology procedure for one (1) resident. Residents #11, #27 and A1. The findings include: 1. Facility staff failed to provide privacy to Resident #11's left lower leg ulcer was conducted on January 14, 2009 at approximately 11:30 AM. Employee #26 failed to completely pulled around all residents assessment and or assessment. The record was reviewed January 15, 2009 at approximately 31:2009 at approximately 31:2009 at approximately 31:2009 at approximate								
WASHINGTON NURSING FACILITY 2425 25TH STREET SE WASHINGTON, DC 2020 PRETX TAG SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY) DR LSC DEMIFYING INFORMATION D PRETX TAG PREVUER'S PLANOF CORRECTION (EACH CORRECTIVE ACTION SOLUD BE CROSS- TAG CONTINUED (1) (1) (1) (1) (1) (1) (1) (1) (1) (1)			095022	B. WIN	G		01/1	6/2009
WASHINGTON NURSING FACILITY 242 32TH STREET SE WASHINGTON, DC 20020 PREFX TAC SUMMARY STATEMENT OF DEFICIENCIES URANDER/STATEMENT OF DEFICIENCIES TAC PREVIDENT SPLM OF CORRECTION (EACH CORRECTIVE ACTON SPCULD BE CROSS, TAC Continued From page 4 Continued From page 4 Confidentiality (continued) Confidentiality (continued) F 164 Continued From page 4 F 164 483.10(e), 483.75 (I)(4) Privacy and Confidentiality (continued) Confidentiality (continued) Confidentiality (continued) F 164 Continued From page 4 F 164 483.10(e), 483.75 (I)(4) Privacy and Confidentiality (continued) Confidentiality (continued) Confidentiality (continued) Confidentiality (continued) A cound care treatment. The findings include: 1. Facility staff field to provide privacy to Resident #11 during a wound care treatment. A wound care treatment description to resident #11 setift was field to completely pull the privacy curatin throughout the wound care treatment and assessment of the pressure ulcer. A tace-to-face interview was conducted on the resident was within view of any visitor to the room. A face-to-face interview was conducted with Employee #25 failed to providing the wound care treatment and sessesment. The resident was portioning the wound care treatment and will present their findings to the DON. 3/31/09 3/31/09 3/31/09 3/31/09 3/31/09 3/31/09 3/31/09 2. Facility staff fialed to provide privacy to Resident #27 sacral pre	NAME OF PR	OVIDER OR SUPPLIER	·		STR	EET ADDRESS, CITY, STATE, ZIP CODE		
Model Product Description Description Production Description Description <thdescription< th=""> <thdescription< th=""></thdescription<></thdescription<>	WASHING	GTON NURSING FACI	LITY		2	425 25TH STREET SE		
Princip TAGIEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DEMTRYING INFORMATION)PREFX TAGIEACH CORRECT ME ACTION SHOULD BE CROSS- REFERENCED TO THE APPROPRIATE DEFICIENCYCOMMETION DATEF 164Continued From page 4 residents and one (1) supplemental resident, it was determined that facility staff failed to provide privacy by completely pulling the privacy curtain for two (2) residents during a wound care treatment, A wound care treatment observation to Resident #11 set lower leg uber was conducted on lanuary 14, 2009 at approximately 11:30 AM. Employee #26 failed to completely pulled around the resident was within view of any visitor to the room. A face-to-face interview was conducted with temployee #26 on January 15, 2009 at approximately 3:00 PM. Heshe acknewledged that the privacy curtain was not completely pulled around the resident was sochducted on January 15, 2009 at approximately 1:15 PM. Employee #26 nalied to completely pulled around care treatment. A vound care treatment to sessment and close the door throughout the assessment of the pressure ulcer. Resident #11's bed was located by the entry door to the room. The resident was sochducted with temployee #26 nalied to completely pulled around the resident was conducted on January 15, 2009. 2. Facility staff failed to provide privacy to Resident #27 during a wound care treatment. A wound care treatment and sessement the resident was located ext to the window but within view of any visitor to the room. The resident was located next to the window but two marks to the prossure ulcer. Resident #11's Def was located form the chest down while Employee #27 failed to completely pulled around the resident was conducted on yanuary 15, 2009 at approximately 1:15 PM. Employee #27 failed to completely pulled prowide pr		0/11/1/07						
 residents and one (1) supplemental resident, it was determined that facility staff failed to provide privacy by completely pulling the privacy curtain for two (2) residents during a radiology procedure for one (1) resident. Residents 411, #27 and A1. The findings include: Facility staff failed to provide privacy to Resident #11 sheft lower leg ulcer was conducted on January 14, 2009 at approximately 11:30 AM. Employee #26 failed to completely pull the privacy curtain throughout the wound care treatment and assessment and/or any treatment. A wound care treatment conservation to the room. The resident was within view of any visitor to the room. The resident was so conducted with Employee #26 on January 15, 2009 at approximately 3:00 PM. Helshe acknowledged that the privacy torain was not completely pulled around the resident while providing privacy to Resident #27 sacral pressure ulcer was conducted on January 15, 2009 at approximately 1:15 PM. Employee #27 failed to completely pulled around the resident was located next to the window but within view of any visitor to the room. The resident was located next to the window but within view of any visitor to the room. The resident was bacesment. The record was reviewed January 15, 2009 at approximately 1:15 PM. Employee #27 failed to completely pulled room. The resident was located next to the window but within view of any visitor to the indow but within view of any visitor to the room. The resident was located next to the window but within view of any visitor to the room. The resident was located next to the window but within view of any visitor to the room. The resident was located next to the window but within view of any visitor to the room. The resident was located next to the window but within view of any visitor to the room. The resident was located next to the window but within view of any visitor to the room. The resident was located next to the window but within view of any visitor to the room.	PREFIX	(EACH DEFICIENCY MUST	BE PRECEDED BY FULL REGULATORY	PREF		(EACH CORRECTIVE ACTION SHOULD E	BE CROSS-	
	F 164	residents and one (determined that faci by completely pullin residents during a w during a radiology p Residents #11, #27 The findings include 1. Facility staff failed #11 during a wound A wound care treatm #11's left lower leg of 14, 2009 at approxim Employee #26 failed curtain throughout th assessment of the p bed was located by resident was within A face-to-face interv Employee #26 on Ja approximately 3:00 the privacy curtain w around the resident treatment and asses reviewed January 13 2. Facility staff failed #27 during a wound A wound care treatm #27's sacral pressur January 15, 2009 at Employee #27 failed curtain and close the assessment and tre The resident was low within view of any vi was unclothed from #27 was providing w	 supplemental resident, it was lity staff failed to provide privacy g the privacy curtain for two (2) yound care treatment, and rocedure for one (1) resident. and A1. d to provide privacy to Resident care treatment. nent observation to Resident ulcer was conducted on January mately 11:30 AM. d to completely pull the privacy he wound care treatment and pressure ulcer. Resident #11's the entry door to the room. The view of any visitor to the room. Yean to the factor of the room. Yean to completely pulled while provide privacy to Resident care treatment. Yean to the room. Yean to th	F	164	Confidentiality (continued) Resident #27 1. Employees involved were could of the importance of providing properties by making sure that the privacy pulled completely around the residuring the performance of any assessment and/or any treatment 2. Rounds were made by the Clinit designee to ensure that privacy were completely pulled around all re- during wound treatments. 3. Inservice education was given members of the nursing staff to compliance in providing privacy residents during wound treatment The Nursing Quality Improveme Program will collect data on the the nurse's adherence to privacy confidentiality while rendering we treatment and will present their for to the DON. 4. The Department Head will pre- action plans implemented to en- sustained compliance at the mo Quality Improvement Committee	unseled rivacy to curtain is sident nt. ical Mgr or curtains esidents n to all ensure to all nts. nt y and ound findings esent d any sure nthly	3/31/09 3/31/09

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WPBP11

Facility ID: WASHNURS

If continuation sheet Page 5 of 121

		AND HUMAN SERVICES				FORM APPROVE
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		095022	B. WIN	IG		01/16/2009
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F 164	the door was not clo not completely pulle providing the wound The record was revi 3. Radiology technic Resident A1 during Resident A1 was ob	anuary 15, 2009 at PM. He/she acknowledged that psed and the privacy curtain was of around the resident while treatment and assessment. ewed January 15, 2009 cian failed to provide privacy to a radiology procedure. pserved during a radiology	F	164	 483.10(e), 483.75 (I)(4) Privacy and Confidentiality (continued) 3. Resident A1 The radiology tech was counseled on the importance of providing privacy by making sure that the privacy curtain is pulled completely around the resident and the door is closed during the performance of any radiology procedure. 	3/10/09
F 167	extremities on Janua 11:30 AM. The resident The resident was un The radiologist faile curtain around the re- resident was partiall unnecessarily expos in the company of E	ultra sound to the lower ary 14, 2009 at approximately dent was on the bed by the door. Inclothed from the chest down. d to completely pull the privacy esident and close the door. The y unclothed and was sed. This observation was made mployee #9.	F	167	 Procedure. Rounds were made by the Clinical Mgr designee to ensure that privacy curtains were completely pulled around all resident and doors were closed during radiology procedures. Inservice education was given to members of the nursing staff and the radiology tech to ensure compliance in providing privacy to all residents during radiology procedures. The Nursing Quality Improvement Program will collect data on the 	3/10/09 s 331/09
SS=C	RESULTS A resident has the re- most recent survey Federal or State sur correction in effect w The facility must ma examination and mu accessible to reside	ight to examine the results of the of the facility conducted by veyors and any plan of vith respect to the facility. Ike the results available for ust post in a place readily ents and must post a notice of			 adherence to privacy and confidentiality while rendering radiology procedures and will present their findings to the DON. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator. 	. 4/3/09
	their availability. This REQUIREMEN	T is not met as evidenced by:			 483.10(g)(1) Examination of Survey Results 1. The most recent survey was posted on the 5 units immediately upon discor- 	
		ons during the survey period, for sing units, it was determined that post the				
FORM CMS-256	37(02-99) Previous Versions O	bsolete Event ID: WPBP11		Fa	cility ID: WASHNURS If continuation	sheet Page 6 of 1

		AND HUMAN SERVICES					03/04/2009 APPROVED
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	OVIDER OR SUPPLIER			24	EET ADDRESS, CITY, STATE, ZIP CODE 425 25TH STREET SE VASHINGTON, DC 20020		
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F 167	Continued From pag most recent survey		F	167	483.10(g)(1) Examination of Su Results (continued)	rvey	
	on January 13, 2009 AM and revealed the correction were post dated January 7 thro survey dated March " met " was hand w the plan of correctio 2008. A second follow-up 7, 2008 in which the compliance for all de	I nursing units was conducted of from 11:00 AM through 11:15 at survey results with the plan of ted for the standard survey bugh 14, 2008 and the follow-up 13 through 14, 2008. The word ritten on each deficiency tag for in for March 13 through 14, survey was conducted on April facility was found in eficiencies cited from the first inpleted March 13 through 14,			 Survey reports will be kept upd available and accessible for the re on all 6 units. The Assistant Administrator or will be responsible for ensuring th most recent survey is accessible a available to the residents. Report her efforts will be submitted month the administrator. The administrator will present findings and action plans for impro- to the Quality Improvement Comm which meets monthly. 	esidents designee hat the and ts of hly to her ovement	1/13/09 3/31/09 4/3/09
	correction not poste 19, June 6, June 18 A face-to-face interv conducted on Janua acknowledged that a posted. 483.10(g)(2) EXAMI	vith deficiencies and plans of d included the following: May , and September 25, 2008. iew with Employee #1 was iry 13, 2009 at 5:30 PM. He/she all survey information was not NATION OF SURVEY	F	168	483.10(g)(2) Examination of Sur	rvey	
SS=B	agencies acting as o afforded the opportu	ght to receive information from client advocates, and be inity to contact these agencies. T is not met as evidenced by:			Results 1. The contact information was m to the bulletin boards across from nursing stations upon discovery. been relocated to other bulletin bo the nursing units.	the They had	1/13/09
	7(02-99) Previous Versions O	bsolete Event ID: WPBP11		Ec	cility ID: WASHNURS If contin	nuation sheet	

PRINTED: 03/04/2009 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 095022 01/16/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2425 25TH STREET SE WASHINGTON NURSING FACILITY WASHINGTON, DC 20020 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX ۲D (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE OR LSC IDENTIFYING INFORMATION) TAG TAG F 168 Continued From page 7 F 168 483.10(g)(2) Examination of Survey **Results (continued)** Based on observations for four (4) of six (6) nursing 2. All bulletin boards across from the units, it was determined that facility staff failed to post contact information for agencies acting as nurse's station were reviewed and 1/1309 client advocates. corrections made when necessary. 3. This posting will be placed in a frame The findings include: and be permanently affixed to the wall, 3/31/09 in an area accessible to the residents, so Observations of all nursing units were conducted on that it cannot be moved. This will ensure January 13, 2009 at 11:00 AM through 11:15 AM. that residents will always have this Located on a bulletin board across from the nurse's posting available to them at all times station on two (2) nursing units was contact 4. The Administrator will monitor the information for agencies acting as client advocates. postings on an on-going bases as part of Four (4) nursing units had no contact information the Administrative Quality Improvement posted. Program and report her findings to the Quality Improvement Committee monthly. 4/3/09 A face-to-face interview with Employee #1 was conducted on January 13, 2009 at 5:30 PM. He/she acknowledged that contact information for agencies acting as client advocates was not posted. 483.13(a) Physical Restraints 1. Resident #15 1. The resident's responsible party was 1/14/09 F 221 F 221 483.13(a) PHYSICAL RESTRAINTS notified and a consent obtained for the SS=D use of full side rails. The resident has the right to be free from any 2. Medical records of all residents with 3/31/09 physical restraints imposed for purposes of full side rails were reviewed to ensure that discipline or convenience, and not required to treat a consent was obtained. Corrections were the resident's medical symptoms. made if necessary 3. Inservice education was given to all 3/31/09 nursing staff about the importance of This REQUIREMENT is not met as evidenced by: following the facility protocol in applying Physical Restraints. Physical restraint consents will be Based on observations, staff and resident interview Monitored through the Nursing Quality and record review for two (2) of 30 sampled Improvement Program. Data collection residents, it was determined that facility staff failed results will be presented to the DON. to inform the responsible party of the use of side 4. The Department Head will present rails for one (1) resident and applied an incorrect a report of the data collected and any restraint to one (1) resident. Residents #15 and 19. action plans implemented to ensure sustained compliance at the monthly The findings include: Quality Improvement Committee which 4/3/09 is chaired by the Administrator.

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

PRINTED: 03/04/2009 FORM APPROVED OMB NO. 0938-0391

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII			(X3) DATE SUI COMPLET	
		095022	B. WIN			01/1	6/2009
				2	EET ADDRESS, CITY, STATE, ZIP CODE 425 25TH STREET SE		6/2009
				V	VASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES I BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD E REFERENCED TO THE APPROPRIATE DE	BE CROSS-	(X5) COMPLETION DATE
F 221	Continued From page	-	F	221	483.13(a) Physical Restraints (continued)		
		t to inform the responsible party the use of side rails on the					
×	January 13 at 12:30	9 at approximately 4:00 PM, PM and January 14, 2009 at #15 was observed lying in bed o.		·			
	January 13, 2009 at he/she was asked w he/she responded,	erview with the resident on approximately 12:30 PM why the side rails were up and " They keep me from falling out					
	he/she could release responded, "No."	esident was then asked whether e the side rails. He/She cal record revealed a "Side Rail					
	Assessment Form" of documented the follo side rails indicated to	dated December 5, 2008 which owing; "Recommendation: Full o serve as enabler to promote here was no evidence in the					
	record that the bed r resident; or that con	rails were requested by the sent for the use of the side rails esident 's responsible party.				•	
	facility ' s Nursing Pl #1404399A.000 Pag "Procedure : Prior T	ormation documented in the hysical Restraint Policy ge 1 under the heading of o The Use Of A Restraint # 6 A					
	notify the Resident ' restraint use and ob for Restraint Form (\$	[Interdisciplinary Care] team will s Responsible Party of the tain signature on the Consent SM 152). " The facility staff					
	s responsible party p full side rails.	btain consent from the resident ' prior to implementing the use of ility 's aforementioned policy on					
	Page 1 of 2 under th	he heading of "Definition " was are any manual method					
		<u>,</u>					

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		AND HUMAN SERVICES			•		APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SUI COMPLET	RVEY
		095022	B. WIN	IG		01/1	6/2009
NAME OF PR		·		STR	REET ADDRESS, CITY, STATE, ZIP CODE		
WASHING	GTON NURSING FACI	ITY			425 25TH STREET SE VASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE (BE CROSS-	(X5) COMPLETION DATE
F 221	Continued From page	je 9	F	221	483.13(a) Physical Restraints	(continued	() ()
	equipment attached body that the individ restricts freedom of one 's body." In add aforementioned poli	anical device, material, or or adjacent to the resident ' s ual cannot remove easily which movement or normal access to lition, on Page 2 of 2 of the cy under the heading of aining Devices " the following					
	11. Bed against the	air without tray eri-chair with tray juested by the resident			 Resident #19 The resident's responsible p notified and a consent obtained use of a clamped seat belt. Medical records of all reside 	l for the nts with a	1/14/09
	3:00 PM. He/she ac lacked a consent for that he/she had faile Responsible Party v and stated, " I will c inform him/her of the obtain the consent."				eat belt were reviewed to ensu order reflected the correct type belt, the seat belt in use was co consent was obtained for the c seat belt. 3. Inservice education was given to nursing staff about the importance following the facility protocol in app	of seat prrect and prrect p all of	3/31/09 3/31/09
	had obtained a telep Responsible Party f the resident is in be January 13, 2009. 2. Facility staff appli	hed this investigator that he/she bhone consent from the or the use of full side rails while d. The record was reviewed on ed a clamp seat belt to Resident used for a Velcro seat belt.			Physical Restraints. Physical Restraint application and will be monitored through the Nurs Improvement Program. Data colle results will be presented to the DO 4. The Department Head will pres a report of the data collected and a action plans implemented to ensur sustained compliance at the month	ing Quality ction N. ent any e	
	A review of Residen	t #19's record revealed a			Quality Improvement Committee w is chaired by the Administrator.		4/3/09
ORM CMS-256	67(02-99) Previous Versions O	bsolete Event ID: WPBP11		Fa	If con	tinuation sheet I	Page 10 of 121

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD	TIPLE CONSTRUCTION	(X3) DATE SUF COMPLET	
		095022	B. WING		01/1	6/2009
	OVIDER OR SUPPLIER	LITY	s	TREET ADDRESS, CITY, STATE, ZIP CODE 2425 25TH STREET SE WASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	ATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION SHO REFERENCED TO THE APPROPRI	OULD BE CROSS-	(X5) COMPLETIO DATE
F 221	PM, signed by the p directed, "Obtain co from guardian. Resi belt on while sitting " Consent for the U a seat belt (Velcro) party on December Care plan #7, " Res	ed December 18, 2008 at 4:00 obysician on the same date that onsent for seat belt (self release) ident to have self release seat up in w/c (wheelchair). " Use of a Physical Restraint " for was signed by the responsible 22, 2008. straint device " was updated 008 when the Velcro seat belt	F 22	21		
F 226	the presence of Em at 2:15 PM. Resider clamp type seat bel belt. Employee # a was wearing a clam to open the belt. Th 15, 2009.	Resident #19 was conducted in ployee #13 on January 15, 2009 nt #19 was observed with a t and was unable to open the cknowledged that the resident of type seat belt and was unable he record was reviewed January REATMENT OF RESIDENTS	F 22	 483.13 © Staff Treatment 1. The 2 identified employe terminated prior to the start 2. Records of all new hires were audited to ensure Abu given. 26 3. Employees will be educa 	es had been of the survey from January ise training was	1/12/09 1/19/09 3/31/09
SS=D	The facility must de	velop and implement written ures that prohibit mistreatment, of residents and		Abuse at the time of hire wi Sheet in their employee file acknowledge receipt of the education will be reinforced Orientation. The Director of Resources will monitor this	th a sign off to training. This during General Human practice through	
	Based on record re (2) of 10 newly hire that the facility faile	IT is not met as evidenced by: view and staff interview for two d employees, it was determined d to provide abuse training prior were provided to the residents.		her HR Quality Improvemen 4. The Department Head w a report of the data collecte action plans implemented to sustained compliance at the Quality Improvement Comm is chaired by the Administra	vill present d and any o ensure e monthly nittee which	4/3/09

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

PRINTED: 03/04/2009 FORM APPROVED OMB NO: 0938-0391

STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL			(X3) DATE SUI COMPLET			
		095022	B. WING			01/1	6/2009		
	ROVIDER OR SUPPLIER	LITY		STREET ADDRESS, CITY, STATE, ZIP CODE 2425 25TH STREET SE WASHINGTON, DC 20020					
(X4) ID PREFIX TAG			ID PREFI TAG	x	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE	BE CROSS-	(X5) COMPLETION DATE		
F 226	Continued From page		F 2	226					
	and Mistreatment sta hires will receive ma identifying, preventir of potential resident mistreatment " A review of 10 perso 2009 revealed the fo Employee # 57 was nursing assistant an position. His/Her per documentation of ab Employee # 58 was the dietary department	.: 1401010A.DC Abuse, Neglect ates: " All employees and new indatory inservices on ng and notifying administration abuse, neglect, and onnel records on January 15, ollowing: hired December 29, 2008 as a d was currently working in that resonnel file lacked ouse training. hired December 31, 2008 in to ent and was currently working in r personnel file lacked							
	2009 at 11:00 AM w and Employee #4, that, "Staff sometim attending orientation held once a month. had been reschedul The facility's failure to policy prior to provid	it was stated by both employees es start to work before because orientation is only The last scheduled orientation				· ·			
F 241 SS=E	manner and in an er	mote care for residents in a ovironment that maintains or dent's dignity and respect in	F 2	241	483.15(a) Dignity 1. Resident #1				

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	03/04/2009 APPROVED 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		095022	B. WING 01/				6/2009
	OVIDER OR SUPPLIER	.iτγ		2	REET ADDRESS, CITY, STATE, ZIP CODE 425 25TH STREET SE VASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFI TAG	IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETION DATE
F 241	Continued From pag full recognition of his This REQUIREMEN		F	241	483.15(a) Dignity (continued) Resident # 1 (continued) 1. Facility staff of the unit where re resides was given an inservice reg that resident's needs specific to tra set-up.	arding	1/18/09
	residents and nine (was determined that and maintain residen by failure to: setup lu provide incontinence (1) resident, change pants, maintain com four (4) residents, kr prior to entry, preve exposed in a mirror assisting one (1) res resident in appropria			· · ·	 All residents who require assists tray set-up for meals were reviewe ensure the same deficient practice not occur. Clinical Managers or their design make rounds during meal times to that any resident identified to need during meal times receive the need setup help as soon as the tray is se An inservice training was given to a staff of all the units to ensure that assistance is provided to residents as needing help in setup of lunch to in a timely manner. Clinical Manago or their designee will monitor this p through the Nursing Quality Improv Program and report their findings to Director of Nurses. 	d to does nee will ensure setup help ded erved nursing identified ray gers practice vement o the	1/12/09 3/31/09
	 Facility staff failed Resident #1. On January 12, 200 the resident was obs the rear of the first fl lunch tray. The cont two (2) slices of brea pieces of chicken. The resident was ob bread. The resident The resident had to buttering the bread. 	to setup the lunch tray for 9 at approximately 12:25 PM, served seated in a geri chair at oor dinning room with his/her ent of the lunch tray included: ad, butter/spread and two (2) eserved struggling to butter the said, "I would like some help." call for help to assist in Employee #25 responded and the resident's bread.			4. The Department Head will prese a report of the data collected and a action plans implemented to ensur- sustained compliance at the month Quality Improvement Committee w is chaired by the Administrator.	iny e ily	4/3/09

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION		OMB NO. 0938-0	
		095022	B. WING		01/16		
	ROVIDER OR SUPPLIER	LITY		REET ADDRESS, CITY, STATE, ZIP CODE 2425 25TH STREET SE WASHINGTON, DC 20020			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES F BE PRECEDED BY FULL REGULATORY INTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION SHO REFERENCED TO THE APPROPRI	OULD BE CROSS-	(X5 COMPLE DAT	
F 241	The pieces of chicker resident was unable approximately 1:30 residents, Employeer resident with his/her chicken in managear According to the las (MDS) completed N G1(h): eating, the re- "Independent setup "Functional Limitation resident's hand inclu- with "Limitation on or voluntary movement Face-to-face intervise Employee #24 on Ja approximately. He/s staff failed to setup record was reviewed 2. Facility staff failed in unstained pants. An observation of R January 12, 2009 at wearing navy blue p light colored stain on The resident was as during the day (Janu that the pants were the stain. According to the qua (MDS) assessment Resident #5 was co	en were not cut up and the to eat the chicken. At PM, after assisting other #24 came to assist the meal. Employee #24 cut the ible bite sizes for the resident. t quarterly Minimum Data Set ovember 11, 2008, Section esident was coded as help only". Section G4 on in Range of Motion" the uding wrist or fingers presents ine side with partial loss of t". ew was conducted with anuary 12, 2009 at 2:45 PM he acknowledged that facility the resident's lunch tray. The d January 12, 2009. d to assist Resident #5 to dress esident #5 was conducted on 11:00 AM. He/she was pants. The pants had a large in the right knee and thigh area. sked if the stain happened uary 12, 2009). He/she stated returned from the laundry with arterly Minimums Data Set completed December 12, 2008, ded in Section B (Cognitive ing or short term memory	F,241	 483.15(a) Dignity (continue 4. A pair of pants without stain will residents requiring clothing and that the family is contacted for clothing which is both appropri Social Workers will monitor the clothing on an on-going basis a their findings to the Director of 4. The Department Head will p a report of the data collected a action plans implemented to en sustained compliance at the m Quality Improvement Committee is chaired by the Administrator 	as on the knees aspected from the clothing was ents. he laundry staff ins is pulled esidents. identify those d ensure ate and clean. e residents' and report 5 Social Work. resent nd any nsure onthly ee which	1/12/0 3/31/ 3/31/ 4/3/0	

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

PRINTED: 03/04/2009 FORM APPROVED OMB NO 0938-0391

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION NAME OF CORRECTION 095022 A. BUILDING NAME OF PROVIDER OR SUPPLIER B. WING WASHINGTON NURSING FACILITY STREET ADDRESS, CITY, STATE, ZIP CODE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHOL REFERENCED TO THE APPROPRIAT F 241 Continued From page 14 Functioning and Structural Problems) as requiring F 241 483.15(e) Dignity (continue		
U95022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE WASHINGTON NURSING FACILITY WASHINGTON NURSING FACILITY (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PROVIDER'S PLAN OF CORF F 241 Continued From page 14 F 241 483.15(e) Dignity (continued Functioning and Structural Problems) as requiring		6/2009
WASHINGTON NURSING FACILITY 2425 25TH STREET SE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PROVIDER'S PLAN OF CORF F 241 Continued From page 14 F 241 F 241 483.15(e) Dignity (continued From page 14		
WASHINGTON NURSING FACILITY 2425 25TH STREET SE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID F 241 Continued From page 14 F 241 F unctioning and Structural Problems) as requiring F 241 483.15(e) Dignity (continued From page 14		
WASHINGTON NURSING FACILITY 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 CORF (EACH CORRECTIVE ACTION SHOL REFERENCED TO THE APPROPRIATION) F 241 Continued From page 14 Functioning and Structural Problems) as requiring F 241 483.15(e) Dignity (continued)		
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX PREFIX TAG PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION SHOL TAG F 241 Continued From page 14 Functioning and Structural Problems) as requiring F 241 483.15(e) Dignity (continued)		
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOL REFERENCED TO THE APPROPRIATION) F 241 Continued From page 14 F 241 483.15(e) Dignity (continued Functioning and Structural Problems) as requiring	TON	
Functioning and Structural Problems) as requiring	D BE CROSS-	(X5) COMPLETION DATE
	 (t	
extensive assistance with dressing.		
 A face-to-face interview was conducted with Employee #5 on January 12, 2009 at 3:45 PM. He/she acknowledged that the resident's was wearing stained pants. The record was reviewed January 12, 2009. 3. Facility staff failed to maintain water temperatures at levels for residents to have personal care without having to use personal care without having the testing of the resident room water temperatures on January 13 and 14, 2009 the water temperature readings were as follows: Room Water temperatures on January 13, 2009 between 9:25 AM to 10:30 AM 137 84.4 141 79.3 109 85.0 121 77.2 159 82.8 A face-to-face interview was conducted with Employee #29 on January 13, 2009 at 10:07 AM. He/she stated, "The main boiler for the floors [that services the resident rooms] is down. The kitchen and the laundry boilers are okay. We [the facilit] have three (3) boilers. I spoke with the [name of boiler company] and they are on the way to repair the problem." A face-to-face interview was conducted with Employee #2 on January 13, 2009 at 10:20 AM. He/she stated, "The maintenance department A face-to-face interview was conducted with Employee #2 on January 13, 2009 at 10:20 AM. He/she stated, "The maintenance department 	Facility's as con- tures were urs on n was the use of ming water checked er exited the lowed out ' rooms until re returned. hent monitors s n and e facility's we Mainten- aintenance ng either could have he boilers o days. present on water ensure nonthly tee which	1/14/09 1/14/09 3/31/09 4/3/09

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		AND HUMAN SERVICES					APPROVED		
	RS FOR MEDICARE	MEDICAID_SERVICES		_	·		<u>. 0938-0391</u>		
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		095022	B. WIN	IG		01/16/2009			
NAME OF PR									
WASHING	WASHINGTON NURSING FACILITY			2425 25TH STREET SE WASHINGTON, DC 20020					
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY		ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD B REFERENCED TO THE APPROPRIATE DE	E CROSS-	(X5) COMPLETION DATE		
F 241	Continued From page made me aware of t We will use the wipe being notified to use	he water temperature problem. es. The CNA 's on all floors are	F	241	483.15(e) Dignity (continued)				
	Additional resident r follows:	oom temperatures were as							
	between 10:43 AM t 333 66.6 341 77.4 317 66.6 305 86.1 357 66.6 359 79.9 304 78.4 354 74.8 310 73.8 314 71.4 338 77.7 342 76.1	ratures on January 14, 2009							
	231 85.1 240 89.1 305 91.0 A face-to-face interv 14, 2009 at 8:15 AM stated, "The water boiler that provides of have the company of	iew was conducted on January with Employee #29. He/she temperatures are down. The water to the residents is down. I oming back out today to repair e water temperature is down we							
1									

Facility ID: WASHNURS

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B WING 095022 01/16/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2425 25TH STREET SE WASHINGTON NURSING FACILITY WASHINGTON, DC 20020 SUMMARY STATEMENT OF DEFICIENCIES ١D PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-PRÉFIX REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE OR LSC IDENTIFYING INFORMATION) TAG TAG F 241 Continued From page 16 483.15(e) Dignity (continued) F 241 implement the wipes that can be warmed for the residents to use for personal care. " A face-to-face interview was conducted on January 14, 2009 at 8:37 AM with Resident F7. He/she stated, "The water is cold. The water was cold vesterday. I haven 't seen any wipes in I don 't know when. " 4. Resident JH2 1.Facility staff of the unit where resident 1/18/09 A face-to-face interview was conducted on January JH2 resides was given an inservice to 14, 2009 at 8:45 AM with Resident F19. He/she remember always to knock on each stated. "The water is cold. I had to wait to get resident's door before entering. dressed. The water is just cold. I don't like the 2. Facility staff of all the nursing units were 1/18/09 wipes. People can 't get their hair done because given an inservice to remember always to the water is cold. " knock on each resident's door before enterina. A face-to-face interview was conducted on January Rounds will be conducted by Clin.Mgr.or 1/18/09 14, 2009 at 4:10 PM with Resident F12. He/she designee to ensure that the all facility's stated, "I couldn't 't get my hair done yesterday. I staff knock on resident's doors before had to reschedule my appointment for today at entry. Identified deficient practice will 10:00 AM. The water was still cold, so I didn't 't get be corrected on the spot. Repeat my hair done until today at 1:00 PM. " non-compliance will subject the employee to the facility disciplinary process. A face-to-face interview was conducted on January "Staff knocking on the Door 14, 2009 at 4:25 PM with Resident F14. He/she Before Entering the Resident's Room" stated, "The water is cold, it's cold now. I don't is a criteria that is studied through the sweat a lot so I just wash my arms.' Administration's Fresh Eyes Quality 4. Facility staff failed to knock on Resident JH2's Improvement Program. Data on this door before entry. criteria will be collected and action plans implemented if necessary. On January 12, 2009, at approximately 10:50 AM 4. The Administrator will present 4/3/09 during the medication pass, Employee a report of the data collected on #50 did not knock prior to entering Resident JH2 Staff Knocking on the Door Before room. Entering the Resident's Room and any action plans implemented to ensure A face-to-face interview was conducted on January sustained compliance at the monthly 12, 2009, at approximately 11:00 AM Quality Improvement Committee.

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO.	0938-039	
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION	(X3) DATE SUF COMPLET	VEY	
		095022	B. WING		01/16	16/2009	
	ROVIDER OR SUPPLIER	LITY		REET ADDRESS, CITY, STATE, ZIP CODE 2425 25TH STREET SE WASHINGTON, DC 20020		<u></u>	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION SHO REFERENCED TO THE APPROPRI/	ULD BE CROSS-	(X5) COMPLETION DATE	
F 241	Continued From page	je 17	F 241	483.15(e) Dignity (continu	ed)		
		He/she acknowledged that they entering Resident JH2 's room.		5. Resident S2	· .		
·	around Resident S2	I to draw the privacy curtain and prevent his/her unclothed ewed in a mirror from the		1. Facility staff where reside was given inservice training pulling privacy curtain comp the resident to provide priva resident.	on letely around	3/31/09	
	January 15, 2009 at unclothed from the v near the window in I unclothed reflection resident's room from was in the hallway a and acknowledged s reflection in the mirr "I just came out of th	esident S3 was conducted on 3:00 PM. The resident was vaist down, sitting in a chair nis/her room. The resident's was visible in the mirror in the the hallway. Employee #21 t the time of the observation seeing the resident's unclothed or from the hallway and stated, nat room. I just changed the] takes [his/her] clothes off all		 Rounds were made by the designee to ensure that priv were completely pulled around on all units while in the room. Inservice education was members of the nursing star compliance in providing priv residents. The Nursing Quality Improv Program will collect data on the nurse's adherence to private the start of the nurse's adherence to private the nurse's adherence to private the start of the nurse's adherence to private the start of the start of the nurse's adherence to private the start of the	racy curtains all residents given to all ff to ensure racy to all ement the	3/31/09 3/31/09	
	(January 15, 2009) a wearing a hospital g up around his/her w unclothed from the w reflection was visible room from the hallw position the resident	conducted on the same day at 4:05 PM. The resident was own and had pulled the gown aist. The resident was vaist down. His/her unclothed e in the mirror in the resident's ay. Employee #21 failed to 's privacy curtain to prevent the in the mirror to be seen from the		 the horse's adherence to proceed to the DON. 4. The Department Head wareport of the data collecter action plans implemented to sustained compliance at the Quality Improvement Commis chaired by the Administrational strategy in the administrational strategy in the administration of the strategy in the administrategy in	ent their findings ill present d and any ensure monthly hittee which	4/3/09	
	completed Novembe coded in Section B (and short term mem (Physical Functionin	erly MDS assessment er 11, 2008, Resident S3 was Cognitive Patterns)with long ory problems and in Section G g and Structural Problems) assistance for dressing.			,		

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	: 03/04/2009 APPROVED . 0938-0391			
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		(X3) DATE SURVEY COMPLETED				
		095022	B. WING_		01/1	6/2009			
	OVIDER OR SUPPLIER	LITY		STREET ADDRESS, CITY, STATE, ZIP CODE 2425 25TH STREET SE WASHINGTON, DC 20020					
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES I BE PRECEDED BY FULL REGULATORY INTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD E REFERENCED TO THE APPROPRIATE DE	E CROSS-	(X5) COMPLETION DATE			
F 241	 6. Employee #20 wa Resident S4 during him/her to eat. On January 14, 200 PM, Employee #20 eat the lunch meal. resident during the easisting the resider and carried on a core employee. According to the and completed January in Section B as havi problems and in Sec assistance with eatient 7. Resident S8 was pants. On January 15, 200 observed sitting in the his/her pants. The reapproximately eight 	as observed standing over the lunch meal while assisting 9 from 12:50 PM through 12:58 was assisting Resident S4 to Employee #20 stood over the eight (8) minutes he/she was nt, did not speak to the resident nversation with another nual MDS assessment 8, 2009, Resident S4 was coded ng long and short term memory ction G requiring limited	F 24	 483.15(e) Dignity (continued) 6. Resident S4 1. Inservice was given to the ento ensure her knowledge of Digripting 2. All staff on that resident's uninserviced on Dignity in Dining 3. The Charge Nurses and Clin Managers will monitor staff perforduring meal service. The Nutritivices Quality Improvement Prograta on Meal pass including the positioning while feeding a resid Such data will be analyzed and to the DON for review. 4. The Department Head will prareport of the data collected an action plans implemented to ensistanted compliance at the mo Quality Improvement Committee is chaired by the Administrator. 7. Resident S8 1. Resident was given a pair of with drawstring waist from the fastock. His family was contacted secure clothing for him. He had 	hity in hit was lical formance onal Ser- ram collects staff's lent. presented esent d any sure nthly e which scrubs ncility's to	3/31/ 4/3/09 1/16/09			
	about the pants at th Resident S8 stated, They are way too bi down. I need a belt A face-to-face interv Employee #19 on Ja Employee #19 ackn Resident S8 with the but didn't do anythin	ne time of the observation, "These are not my pants. g. If I stood up, they would fall " view was conducted with anuary 15, 2009 at 4:30 PM. owledged that he/she saw e oversized pants that morning		 recently admitted. 2. All residents were assessed to their clothes were not too big. Construction were made if necessary. 3. Social Work will assess the residence of the first 14 days after admission will be made to the family if additional clothing or better fitting clothing is Such data will be collected by the Workers and given to the Director Social Work for evaluation with the Quality Improvement Team. 	to ensure corrections esident's uring . Contact tional is needed. e Social or of	3/31/09 3/31/09			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE S COMPL A. BUILDING		
095022 ^{B. WING} 01	16/2009	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE		
WASHINGTON NURSING FACILITY 2425 25TH STREET SE		
WASHINGTON, DC 20020		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS- REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 241 Continued From page 19 F 241 483.15(e) Dignity (continued)		
January 15, 2009. A face-to-face interview was Resident S8		
conducted with Employee #17 on January 16, 2009 4. The Department Head will present		
at 10:30 AM. He/she stated, "I worked with a report of the data collected and any		
(Resident S8) yesterday (January 15, 2009). Those action plans implemented to ensure		
pants were about a size 56 and (Resident S8) is sustained compliance at the monthly		
probably a 32 or maybe even smaller. Usually [Resident S8] walks alone with a contact guard on [Resident S8] walks alone wal	4/3/09	
[Resident S8] walks alone with a contact guard on the parallel bars. I had to get another therapist tois chaired by the Administrator. 8. Resident S9		
help me hold up the pants so [Resident S8] could 1. Inservice training was given to this		
walk. "		
positioning before and after each	1/16/09	
According to the admission MDS assessment wound treatment		
completed January 5, 2009, Resident S8 was coded in Section B with short term memory problems and		
Section G requiring extensive assistance with were given inservice training in proper		
dressing positioning of residents before and after	1/16/09	
each wound treatment.		
8. Resident S9 was observed during a wound 3. Wound treatments will be observed		
treatment positioned so that his/her head was resting on the side rails by ADONs, Clinical Mgrs, & Nursing supervisors to ensure that residents	3/31/09	
resting on the side rails. Supervisors to ensure that residents positioning is proper and comfortable	5/5//05	
During a wound treatment observation, conducted during the treatment. Data collected		
on January 15, 2009 at 11:45 AM until 12:15 PM, it through the Nursing Quality Improvemen		
was observed that Resident S9 was positioned in Program's Treatment Observation Tool		
bed on his/her left side. The head of the bed was Will be forwarded to the Director of Nurse	s	
elevated and Resident S9's shoulders were located and her QI team for evaluation.		
at the fold of the upper part of the bed, with his/her head resting on the side rails.		
head resting on the side rails. a report of the data collected and any action plans implemented to ensure	1	
Employee #22 failed to reposition the resident sustained compliance at the monthly		
before or after the wound treatment was completed. Quality Improvement Committee which	4/3/09	
is chaired by the Administrator.		
According to the quarterly MDS assessment		
completed January 12, 2009, the resident was coded in Section B (Cognitive Patterns) for long and		
short term memory problems and in Section G		
(Physical Functioning and Structural Problems) as		
being totally dependent for bed mobility with		

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		AND HUMAN SERVICES			,	FORM	03/04/2009 APPROVED	
STATEMENT	S FOR MEDICARE &	X MEDICAID SERVICES	(X2) MU A. BUILI		LE CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED		
		095022	B. WINC	G		01/16	5/2009	
NAME OF PR				STR	EET ADDRESS, CITY, STATE, ZIP CODE	0	<u>"2000</u>	
WASHING	STON NURSING FACIL	LITY			425 25TH STREET SE VASHINGTON, DC 20020	·		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD B REFERENCED TO THE APPROPRIATE DE	SHOULD BE CROSS- COMPLE		
F 241	Continued From page	ge 20	F 2	241				
	full loss of voluntary his/her body.	movement on both sides of						
F 246 SS=D	-	MMODATION OF NEEDS	F 2	246	483.15(e)(1) Accommodation of Residents #27, JH6, F15, F18	of Needs		
00-0	services in the facilit accommodations of	individual needs and			 Call bells were appropriately for each resident upon discovery Rounds conducted throughout 	, /. ut the	1/16/09	
		when the health or safety of the esidents would be endangered.			facility to ensure proper placeme call bells was done. 3. An inservice training session to make sure that call bells are v reach of residents to accommod	was done vithin	1/16/09	
	This REQUIREMENT is not met as evidenced by: Based on observations of one (1) of 30 sampled residents and four (4) supplemental residents reviewed, it was determined that facility staff failed to ensure that the call bell was within reach to accommodate residents that may need reasonable assistance while in their rooms. Residents #27, JH6, F15, F16, and F18. The observations were made and acknowledged in the presence of Employees #11, 22, 27, 29, and 30.				those who may need assistance in their rooms. Rounds will be r nursing supervisors to ensure th	while made by	3/31/09	
					call bells are all within residents' The "Nursing Care Review" of th Quality Improvement Program s addresses the proper placement call bell. The Nursing Quality Im Team will collect data on this iss Forward their findings to the DO 4. The Department Head will pr a report of the data collected an action plans implemented to ens	reach. le Nursing pecifically t of the aprovement ue and N. esent d any		
	Resident #27 on Jar 1:30 PM, the resident rail to the resident's	are treatment observation for nuary 15, 2009 at approximately nt's call bell was tied to the bed left side. The bed rail was down ent's immediate reach.			sustained compliance at the mol Quality Improvement Committee is chaired by the Administrator.	nthly	4/3/09	
	2. Facility staff failed Resident JH6.	to place call bell in reach for						
	On January 13, 200	9, at approximately 11:55 AM,						

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		AND HUMAN SERVICES				FORM	03/04/2009 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII			(X3) DATE SURVEY COMPLETED	
		095022	B, WIN	G		01/16/2009	
	OVIDER OR SUPPLIER	LITY .		24	EET ADDRESS, CITY, STATE, ZIP CODE 425 25TH STREET SE VASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREF TAG	IL	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD E REFERENCED TO THE APPROPRIATE DE	E CROSS-	(X5) COMPLETION DATE
F 246	Resident JH6 was c	bserved sitting in a gerichair in all bell was on the bed and out	F	246	·	· .	
	out of the resident ' 3. During the enviro 2009 at approximate F16 were observed	owledged that the call bell was s reach. Inmental tour on January 12, ely 4:00 PM Residents F15 and in their rooms and the call bells he floor and not within reach of					
F 253 SS=E	at approximately 10 observed in his/her observed on the floo	nental tour on January 13, 2009 20 AM, Resident F18 was room and the call bell was or and not within reach. EKEEPING/MAINTENANCE	F	253	 483.15(h)(2) Housekeeping/Ma Soiled Ceiling Tiles 1. Ceiling tiles were changed up discovery. 2. Ceiling tiles throughout buildir assessed and changed if neede 3. All areas of the building are as 	on ng were d.	1/14/09 1/16/09
00-L	maintenance service sanitary, orderly, an	vide housekeeping and es necessary to maintain a d comfortable interior.			my maintenance on a frequent b soiled or damaged ceiling tiles. is a criteria for review under "Re Floor Maintenance" in the Mainte Quality Improvement Program.	asis for Ceiling Tile sident enance The	3/31/09
	Based on observation was determined that maintenance service that the facility was sanitary manner as tiles, floors, walls, w faucets, roller carts, tiles, doors, wheelch walls; excessive iter stored on the floor in	es were not adequate to ensure maintained in a safe and evidenced by: soiled ceiling heel chairs/chairs/gerichairs, and hair dryer; damaged ceiling nair arms, baseboards and ns in resident rooms; and items	÷.		Maintenance QI team will collect this criteria and forward it to the of Maintenance for review and e 4. The Department Head will pri- a report of the data collected and action plans implemented to ensisustained compliance at the mon Quality Improvement Committee is chaired by the Administrator.	Director valuation. esent d any ure nthly	4/3/09
ORM CMS-25	67(02-99) Previous Versions O	bsolete Event ID: WPBP11	l	Fac	cility ID: WASHNURS If conti	nuation sheet P	age 22 of 121

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 03/04/2009 APPROVED . 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI		LE CONSTRUCTION	(X3) DATE SUF COMPLET	
	• .	095022	B. WING	э		01/1	6/2009
NAME OF PR				STR	EET ADDRESS, CITY, STATE, ZIP CODE		
WASHING	TON NURSING FACIL	-ITY			425 25TH STREET SE		
		· · · · · · · · · · · · · · · · · · ·		N	VASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD E REFERENCED TO THE APPROPRIATE DI	BE CROSS-	(X5) COMPLETION DATE
F 253	January 13, 2009 fro January 14, 2009 8: presence of Employ findings were ackno observations. 1. The following are Ceiling Tiles Two (2) of six (6) so two (2) of six (6) so two (2) of six (6) cle of 31 resident rooms 231, 232,244, 206 a storage rooms, 1S; or oms, 1S; one (1) o bathrooms, 1S; and areas, 1N Floors- in the Rehab in the rehabilitation of Walls- in two (2) of 3	om 3:06 PM to 4:10 PM, om 9:25 AM to 4:20 PM and 15 AM to 4:25 PM in the ees #11, 29, and 30. The wledged at the time of the as were observed soiled: iled utility rooms, 1S and 2N; an linen rooms, 1N and 1S; 11 s, 137, 159, 110, 116, 122, 136, nd 333; one (1) of six (6) one (1) of six (6) nourishment of 12 resident hallway one (1) of 12 resident lounge	F 2	253	483.15(h)(2) Housekeeping/Ma Soiled Floors 1. The floor in the Rehab Gym v scrubbed and waxed upon disco 2. The floor in the Rehab Gym is scheduled for cleaning every aft 3. The Director of Housekeepin Team of supervisors visually ver cleanliness of the Rehab Gym fl morning and makes immediate when needed. Cleanliness of the found in the "Common Area" set Housekeeping Quality Improven Program. The Housekeeping Q will collect data on this criteria a forward their information and rea tions to the Director of Houseke 4. The Department Head will pr a report of the data collected an action plans implemented to ens sustained compliance at the mo Quality Improvement Committee is chaired by the Administrator Soiled Walls	vas overy. s ernoon. g and her rifies the loor each corrections e floor is ction of the nent I Team nd commenda- eping. esent d any sure nthly	1/15/09 1/15/09 3/31/09
	observed	ir- room 110 in one (1) of 39 three (3) of 12 soiled in the 3N			 Both resident rooms and dini walls were scrubbed upon disco Other resident rooms and the floor dining room were evaluated cleanliness and corrections mad indicated. Housekeeping Supervisors a 	very e 1 st d for le when	1/16/09 3/31/09
ORM CMS-256	hair roller carts; and were observed soile	is/areas were observed		Eacili	itoring the walls for on-going clea each day with a daily report of th findings done each day. Wall cle is part of the Housekeeping Qua Improvement Program. The Hou QI Team will collect data on this forward their information and rec tions to the Director of Housekee	anliness heir eanliness lity usekeeping criteria and commenda- eping.	3/31/09

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483.15(h)(2) Housekeeping and Maintenance (continuation sheet) Page 23A of 121

Soiled Walls (continued)

4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator

Soiled Chairs 1. The one geri-chair: and 3 arm chairs, identified at the time of the survey as being soiled was cleaned immediately. 1/16/09 2. All facility geri-chairs and wheelchairs were checked for cleanliness and corrections were made if any were necessary. 1/16/09 3. All geri-chairs and wheelchairs are on a routine monthly and PRN cleaning schedule. Chair cleanliness is part of the Housekeeping Quality Improvement Program. The Housekeeping 3/31/09 QI Team will collect data on this criteria and forward their information and recommendations to the Director of Housekeeping. 4. The Department Head will present

a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator

4/3/09

4/3/09

Soiled Items in the Beauty Shop 1. Items found soiled were cleaned upon discovery. 1/16/09 2. All areas of the Beauty Shop were evaluated for cleanliness and 1/16/09 corrections were made if necessary. 3. Cleanliness of the Beauty Shop Is included in the "Common Areas" Section of the Housekeeping QI Program. The Housekeeping 3/31/09 QI Team will collect data on this criteria and forward their information and recommendations to the Director of Housekeeping.

4. The Department Head will present

483.15(h)(2) Housekeeping and Maintenance (continuation sheet) Page 23B of 121

Soiled Items in the Beauty Shop (cont,)

a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator

A. Damaged Walls

 Noted wall damage was corrected Immediately upon discovery.
 Other wall areas were reviewed in the resident rooms and janitor's closets and corrections were made if necessary.
 Walls are included Maintenance QI Program. The Maintenance QI Team will collect data on this criteria and forward their information and recommendations to the Director of Maintenance for his review and evaluation.

4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator

4/3/09

1/16/09

1/16/09

3/31/09

4/3/09

		AND HUMAN SERVICES				FORM	03/04/2009 APPROVED		
STATEMENT	CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED			
		095022	B. WING	G	· · · · ·	01/16	6/2009		
NAME OF PR		·		STR	REET ADDRESS, CITY, STATE, ZIP CODE				
WASHING	GTON NURSING FACI	LITY		2425 25TH STREET SE WASHINGTON, DC 20020					
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES I BE PRECEDED BY FULL REGULATORY INTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIATE DEF	TION SHOULD BE CROSS-			
F 253	 A. Walls- in two (2) one (1) of six (6) jan B. Ceiling tiles-1N ref 109, C. The entry door to to be split at the top doors, room 257. D. Wheel chair - am 39 observed, wheel 126 A and 102 B E. Baseboards- in o in one (1) of six (6) n of 12 resident loung rooms 110 and 122 F. Walls - in one (1) in one (1) of six (6) sone (1) of six (6) and 3. The following item marred/scarred: Th 	of 31 rooms, 110 and 136; and itor ' s closet, 3S esident hallway bathroom, room president ' s room was observed in one (1) of 31 resident entry mrest was damaged in two (2) of chairs observed in room areas ne (1) of six (6) janitor ' s closet; nourishment rooms; in one (1) e areas; and in two (2) of 31 of six (6) clean linen rooms, 1N; soiled utility room, 1S; and in	F	253	 B. Ceiling Tiles 1. All damaged ceiling tiles noted time of the survey were replaced discovery. 2. Other ceiling tiles were review and corrections were made if necessary. 3. Ceiling tiles are included Maintenance QI Program. The Maintenance QI Team will collect on this criteria and forward their information and recommendations to the Director Maintenance for his review and evaluation. 4. The Department Head will pre a report of the data collected and action plans implemented to ensu- sustained compliance at the mon- Quality Improvement Committee is chaired by the Administrator C. Room Door 1. The door was replaced immed upon discovery. 2. Other doors were evaluated for and corrections were made if nec 	d at the upon ed in the data of sent any ure thly which liately or damage	1/16/09 1/16/09 3/31/09 4/3/09 1/16/09 1/16/09		
	observed and one (observed, room 232 4. Excessive items v in five (5) of 31 resid 110, 233, 317, 305 a 5. The following item floor(s):	1) of 31 resident rooms were observed in resident rooms dent rooms observed: rooms			 Door are included Maintenance QI Program. The Maintenance QI Team will collect on this criteria and forward their information and recommendations to the Director Maintenance for his review and evaluation. The Department Head will pre- a report of the data collected and action plans implemented to ensu- sustained compliance at the mont Quality Improvement Committee 	data of sent any ire thly	3/31/09		

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C. Room Door (continued) is chaired by the Administrator

D. Wheelchair Armrest 1. The two armrests were replaced upon discovery. 1/16/09 2. Other wheelchair armrests were evaluated and replaced if necessary. 1/16/09 3. Wheelchair repairs are included Maintenance QI Program. The Maintenance QI Team will collect data on this criteria and 3/31/09 forward their information and recommendations to the Director of Maintenance for his review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which 4/3/09 is chaired by the Administrator E. Damaged Baseboards 1. Damaged baseboards were replaced or repaired upon discovery. 1/16/09 2. Other baseboards were evaluated for the need for repair or replacement and action was taken when necessary. 3/31/09 3. Baseboards are included Maintenance QI Program. The Maintenance QI Team will collect data on this criteria and 3/31/09 forward their information and recommendations to the Director of Maintenance for his review and evaluation. 4. The Department Head will present

a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator

4/3/09

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F. Damaged Walls 1. Noted wall damage was corrected Immediately upon discovery. 1/16/09 2. Other wall areas were reviewed in Ancillary spaces and corrections were made if necessary. 1/16/09 3. Walls are included Maintenance QI Program. The Maintenance QI Team will collect data on this criteria and forward their information and 3/31/09 recommendations to the Director of Maintenance for his review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which 4/3/09 is chaired by the Administrator 3. Marred/Scarred Walls 1. The two wall areas noted as being marred or scarred at the time of the survey were repaired upon discovery. 1/16/09 2. Other wall areas were reviewed in Ancillary spaces and corrections were made if necessary. 1/16/09 3. Walls are included Maintenance QI Program. The Maintenance QI Team will collect data on this criteria and forward their information and 3/31/09 recommendations to the Director of Maintenance for his review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which 4/3/09 is chaired by the Administrator

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4. Excessive Items in Resident Rooms 1. Excessive items were removed upon discovery. 1/16/09 2. Resident rooms were evaluated for the storage of excess items. Family members were called and asked to remove the items whenever it was necessary to do so. 3/31/09 3 Resident Room Cleanliness/Clutter is part of the Housekeeping Quality Improvement Program. The Housekeeping 3/31/09 QI Team will collect data on this criteria and forward their information and recommendations to the Director of Housekeeping.

4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator

4/3/09

1/16/09

1/16/09

5. Items stored on the Floor

1. All items were removed and properly Stored upon discovery.

2. Other areas of Rehab were evaluated for proper storage and corrections made if necessary.

3. The Director of Rehabilitation inserviced his staff regarding the proper storage of rehab equipment kept in their department. 3/31/09

4. The Rehab Director will ensure, through monthly inspection and evaluation, that sustained correction has been made in this 4/3/09 area.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

	S FUR MEDICARE	& MEDICAID SERVICES					<u>. 0938-0391</u>
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	095022		8. WING			01/16/2009	
NAME OF PROVIDER OR SUPPLIER				STR	EET ADDRESS, CITY, STATE, ZIP CODE		
WASHINGTON NURSING FACILITY					425 25TH STREET SE VASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY INTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD E REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETION DATE
F 253	Continued From page	ge 24	F	253			·
	3N-five (5) of five (5 storage closet) boxes stored on the floor in the					
		ems and boxes were store on ge closet of the Rehabilitation					
F 278 SS=D	483.20(g) - (j) RESI	DENT ASSESSMENT	F	278	483.20(g)-(j) Resident Assess	ment	
55-0	The assessment mu resident's status.	ist accurately reflect the					
		nust conduct or coordinate each appropriate participation of					
	A registered nurse r assessment is comp	nust sign and certify that the pleted.					
		completes a portion of the gn and certify the accuracy of ssessment.					
	willfully and knowing statement in a resid- civil money penalty each assessment; o knowingly causes an	d Medicaid, an individual who gly certifies a material and false ent assessment is subject to a of not more than \$1,000 for r an individual who willfully and nother individual to certify a tatement in a resident					
	assessment is subje	ect to a civil money penalty of 0 for each assessment.					
	Clinical disagreemer and false statement	nt does not constitute a material					
	This REQUIREMEN	T is not met as evidenced by:				N	

FORM CMS-2567(02-99) Previous Versions Obsolete

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	APPROVED 0938-0391	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING			(X3) DATE SURVEY COMPLETED		
		095022	B. WING			01/16/2009	
NAME OF PROVIDER OR SUPPLIER					REET ADDRESS, CITY, STATE, ZIP CODE		
WASHING	GTON NURSING FACIL	_ITY			VASHINGTON, DC 20020		
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY		ID PREFI TAG		(X5) COMPLETION DATE		
F 278	Continued From pag Based on record rev (3) of 30 sampled re facility staff failed to resident ' s wound, o and one (1) resident Residents #4, 5 and The findings include 1. Facility staff failed #4's wound. The resident was ac February 21, 2007. physical assessment 2007 described a "c annual history and p December 22, 2008 "Chronic (right) leg u pressure area." According to the adr (MDS) assessment and the quarterly MI February 18 and Ma	ge 25 view and staff interview, for three esidents, it was determined that accurately code: one (1) one (1) resident for weight gain for being verbally abusive. 13. 4 to accurately code Resident lmitted to the facility on The admission history and t completed December 21, hronic right leg ulcer." The ohysical assessment completed described, ulcer at bottom of shin - non mission Minimum Data Set completed December 31, 2007 DS assessments completed by 15, 2008, the resident was 2 (Type of Ulcer) as a stasis		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-		nent tely reflect iewed unds were were codes were s on the ogram. team I forward eview esent d any ure	3/6/09 3/6/09 3/31/09 4/3/09
	completed on Augus assessment comple	arterly MDS assessment at 12, 2008 and the annual MDS ted on November 12, 2008, the for a pressure ulcer on the right			 is chaired by the Administrator 2. Resident #5 1. MDS was corrected to accurat resident's weight loss. Error was reviewed with the MDS nurse in 	-	3/6/09
	described as a stasi There was no evide	nce in the resident's record to usly identified stasis ulcer			2. MDS of all residents with identifi- loss was reviewed to ensure that was coded accurately. If identifie inaccurate codes were corrected coordinators.	ed weight t the loss ed,	3/6/09

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Facility ID: WASHNURS

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	03/04/2009 APPROVED . 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			RVEY ED
	095022		B. WIN	G		01/16/2009	
NAME OF PR					EET ADDRESS, CITY, STATE, ZIP CODE		
WASHING	GTON NURSING FACIL	ITY			425 25TH STREET SE /ASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD B REFERENCED TO THE APPROPRIATE DE	E CROSS-	(X5) COMPLETION DATE
F 278	A face-to-face interv 13, 2009 at 4:15 PM #18. He/she acknow was miscoded as a reviewed January 13 2. Facility staff failed for Resident #5. According to the addr completed July 11, 2 Section K2 (Height a pounds. According October 6, 2008, the K2 as weighing 192 weight loss. A face-to-face interv 12, 2009 at 3:45 PM #18, who acknowled miscoded for weight January 12, 2009. 3. Facility staff inaccover Verbally abusive bef A review of the quar Resident #13 was cover Patterns) as being v (3) time in the last se Assessment Reference observations) of Jul A review of the nurs Behavior Monitoring revealed no docume	iew was conducted on January with Employee wiedged that the stasis ulcer pressure ulcer. The record was 3, 2009. It to accurately code weight loss mission MDS assessment 2008, the resident was coded in and Weight) as weighing 178 to the quarterly MDS completed e resident was coded in Section pounds and was coded for iew was conducted on January with Employee lged that the MDS was loss. The record was reviewed curately coded Resident #13 for navior. terly MDS revealed that oded in Section E (Behavior erbally abusive one (1) to three even (7) days prior to the nce Date (last date for y 22, 2008. es' notes for July 2008 and the Flow Sheet for July 2008 ented episodes of verbal abuse.	F	278	 483.20(g)-(j) Resident Assessm 2. Resident #5(continued) 3. Appropriate recording of weig on the weight Change Review of Nursing Quality Improvement Pri The members of the Nursing QI will collect date on this issue and that information to the DON for re- and evaluation. 4. The Department Head will pre- a report of the data collected and action plans implemented to ensi- sustained compliance at the more Quality Improvement Committee is chaired by the Administrator 3. Resident #13 1. MDS was corrected to accurate reflect resident's verbally abusive behavior. Error was reviewed with MDS nurse in question. 2. MDSs of all residents with ver- abusive behavior were reviewed behavior was coded accurately in resident's MDS. 3. MDS of residents with verbally behavior and scheduled for week conference will be audited if the abusive behavior is accurately con- the MDS 4. The Department Head will pre- a report of the data collected and action plans implemented to ensi- sustained compliance at the more Quality Improvement Committee is chaired by the Administrator 	tely the bally if the ogram. team d forward eview esent d any ure othly twhich tely e th the bally if the n the y abusive kly care verbally oded in esent d any ure othly if any if the n the sent	3/31/09 4/3/09 3/6/09 3/10/09 4/3/09
	A face-to-face interv	iew with Employee #5 was					

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN		(X3) DATE SURVEY COMPLETED		
	095022		B. WING _		01/16/2009	
		LITY	Í	REET ADDRESS, CITY, STATE, ZIP CODE 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 CORRE (EACH CORRECTIVE ACTION SHOUL REFERENCED TO THE APPROPRIATE	D BE CROSS-	(X5) COMPLETION DATE
	Continued From page	je 27	F 27	8	· ·	
	acknowledged that t	ry 13, 2009 at 3:45 PM. He/she here were no documented buse for July 2008. The record ary 13, 2008.				
F 279 SS=D	483.20(d), 483.20(k) PLANS	(1) COMPREHENSIVE CARE	F 27	9 483.20(d), 483.20(k)(1) Com Care Plans	prehensive	
		ne results of the assessment to revise the resident's of care.				
	plan for each reside objectives and timet medical, nursing, an	velop a comprehensive care nt that includes measurable ables to meet a resident's d mental and psychosocial ified in the comprehensive				
	be furnished to attain highest practicable p psychosocial well-be and any services that under §483.25 but a resident's exercise of	describe the services that are to n or maintain the resident's obysical, mental, and eing as required under §483.25; at would otherwise be required re not provided due to the of rights under §483.10, refuse treatment under				
	This REQUIREMEN	T is not met as evidenced by:				
	interview for six (6) of determined that facil plans with appropria one (1) resident with	on, record review and staff of 30 sampled residents, it was lity staff failed to initiate care te goals and approaches for: Anemia and Multiple Sclerosis, anticoagulant therapy, two (2) ential				

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
095022		B. WIN	B. WING			01/16/2009	
NAME OF PR	OVIDER OR SUPPLIER		·		EET ADDRESS, CITY, STATE, ZIP CODE 425 25TH STREET SE		
WASHING	STON NURSING FACIL	.ity			VASHINGTON, DC 20020		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROS TAG REFERENCED TO THE APPROPRIATE DEFICIEN				(X5) COMPLETION DATE
F 279	medications, three ((1) resident for the u	for the use of nine (9) or more 3) resident for incontinence, one use of side rails and one (1)	F	279	Care Plans (continued) 1. Resident #2		-
	resident for abusive/aggressive behaviors. Residents # 2, 5, 6, 7, 13 and 15. The findings include: 1. Facility staff failed to initiate care plans with goals				 Resident #2's care plan was a o include a care plan with goals approaches for Anemia and Mult Sclerosis. 	and liple	3/13/09
	for Resident #2. According to the adr (MDS) assessment of the resident was coor Diagnoses) for Aner A review of the resident November 24, 2008, appropriate goals ar Anemia or MS. A face-to-face interviresident at approxim	Anemia and Multiple Sclerosis nission Minimum Data Set completed November 24, 2008, ded in Section I (Disease nia and Multiple Sclerosis (MS). lent's care plans initiated , revealed that no care plan with nd approaches was initiated for iew was conducted with the nately 8:15 AM on January 13,			 Care Plans of all residents wit Diagnoses of Anemia and Multip Sclerosis were reviewed for the s deficient practice and changes m as needed. Appropriate care plans with g Approaches for Anemia and Mul Sclerosis will be evaluated using "Care Plan Audit" of the Nursing Quality Improvement Pro The members of the Nursing QI 	le same nade oals and tiple the ogram. team	3/13/09 3/31/09
	he/she had a diagnor resident stated, "I v years ago [not sure I Avonex injections or not had any [injectio didn't 't get any injection hospital either. I tho	owledged being aware that sis of Multiple Sclerosis. The vas diagnosed with MS many how many]. I used to receive nce a week for MS but I have ns] since I have been here. I ctions while I was in the other ught I told someone about the t got here but I am not sure who			 will collect date on this issue and that information to the DON for r and evaluation. 4. The Department Head will pre a report of the data collected and action plans implemented to ens sustained compliance at the mon Quality Improvement Committee is chaired by the Administrator. 	eview esent d any ure nthly	4/3/09
	A face-to-face interv Employee #9 on Jan 9:00 AM. He/she sta diagnoses of Anemia	iew was conducted with the puary 15, 2009 at approximately ated she was not aware of the a and Multiple Sclerosis.			 Resident #5 Resident #5's care plan was a to include goals and approaches resident receiving anticoagulant Care Plans of all residents received 	for a therapy.	3/6/09 3/10/09
	" In another face-to-fa Employee # 9 at app	ill look into that [the diagnoses]. ice interview conducted with proximately 9:30 AM on e employee stated, " I have			anticoagulant therapy were revie goals and approaches for antico therapy and amended as needed	wed for agulant	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 03/04/2009 FORM APPROVED

<u>CENTER</u>	S FOR MEDICARE	& MEDICAID SERVICES				OMB NO	<u>. 0938-0391</u>		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL			(X3) DATE SURVEY COMPLETED			
	095022		B. WING			01/16/2009			
NAME OF PR			-	STR	EET ADDRESS, CITY, STATE, ZIP CODE				
					425 25TH STREET SE				
WASHING	STON NURSING FACIL	LITY		WASHINGTON, DC 20020					
							•		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	BE PRECEDED BY FULL REGULATORY	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD B REFERENCED TO THE APPROPRIATE DE	E CROSS-	(X5) COMPLETION DATE		
F 279	DYIDER OR SUPPLIER STON NURSING FACILITY SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 29 spoken to the physician and the resident will be evaluated for Anemia and MS. " The record was reviewed on January 12, 2009. 2. Facility staff failed to initiate a care plan for anticoagulant therapy for Resident #5. According to the preprinted "Physician's Orders" signed by the physician on December 23, 2008, the resident was prescribed Plavix 75 mg daily. A review of the resident's care plans revealed that there was no care plan initiated with appropriate goals and approaches for the use of anticoagulant therapy. A face-to-face interview was conducted with Employee #5 on January 12, 2009 at 3:45 PM. He/she acknowledged that there was no care plan for the use of Plavix. The record was reviewed January 3. Facility staff failed to initiate a care plans with appropriate goals and approaches for the potential adverse interactions for the use of nine (9) or more medications for Resident #6. A review of the clinical record for Resident #6 revealed a Physician 's Order Sheet (POS) signed on January 6, 2009 with medications which included Colace, Folic Acid, Furosemide, Labetalol, Keppra, Procardia, Coumadin, Dilantin, Senokot, Dulcalox Suppository, Citrate of Magnesia and Tylenol tablets. Further review of the record revealed that no care plan was initiated for the potential adverse interactions for the use of nine or medications. A face-to-face interview was conducted with Employee #6 on January 14, 2009 at approximately 11:00 AM. He/she acknowledged that the care plan for the potential interaction of the use of nine or more medications was not on		F :	279	 483.20(d), 483.20(k)(1) Compre Care Plans (continued) 3. Appropriate care plans with goals Approaches for Anticoagulant Thera will be evaluated using the "Care Pla Audit" of the Nursing Quality Improve Program. The members of the Nursing QI tear will collect date on this issue and for that information to the DON for revise and evaluation. 4. The Department Head will present a report of the data collected and an action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee whi is chaired by the Administrator. 3. Resident #6. 1. Resident #6's care plan was amer to include appropriate goals and app for the potential adverse interactions use of 9 or more meds. 2. Medical records of all residents we more medications were reviewed if a corresponding care plan with approp goals and approaches for the potentian adverse interactions. 3. Appropriate care plans with goals Approaches for Adverse Interactions Use of 9 or More Meds will be evaluated using the "Care Pla Audit" of the Nursing Quality Improve Program. The members of the Nursing QI tear will collect date on this issue and for that information to the DON for revise and evaluation. 4. The Department Head will present a report of the data collected and an action plans implemented to ensure 	s and py an ement mward w nt y ich nded oroaches s for the ith 9 or a oriate tial s and s for the an ement mward w w	3/31/09 4/3/09 3/6/09 3/6/09		
					sustained compliance at the monthly Quality Improvement Committee wh is chaired by the Administrator.		4/3/09		

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<u> </u>	<u>RS FOR MEDICARE (</u>	& MEDICAID SERVICES				<u>OMR NŌ.</u>	<u>0938-0391</u>
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		095022	B. WINC	G		01/16/2009	
NAME OF PF	OVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP CODE		
	GTON NURSING FACI			24	25 25TH STREET SE		
WASHIN				W	ASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES F BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE OF REFERENCED TO THE APPROPRIATE DEFICI	ROSS-	(X5) COMPLETION DATE
F 279	Continued From pag the record. He/she now." The record y 2009. 4. Facility staff failed anticoagulant therap #7. A. Facility staff failed anticoagulant therap Review of Resident physician's order ini renewed with each p January 6, 2009, for po (by mouth). " A review of the resid there was no care p goals and approach therapy. A face-to-face interv Employee #6 on Jar He/she acknowledg for the use of Plavix January 13, 2009. B. Facility staff failed incontinence. A review of Resident	ge 30 added, " I will put one on right was reviewed on January 13, d to initiate a care plan for by and incontinence for Resident d to initiate a care plan for		279	 483.20(d), 483.20(k)(1) Comprehe Care Plans (continued) 4. Resident #7 A. Anticoagulant Therapy 1. Resident # 7's care plan was amend to include goals and approaches for a resident receiving anticoagulant therapy 2. Care Plans of all residents receiving anticoagulant therapy were reviewed fo goals and approaches for anticoagulant therapy and amended as needed. 3. Appropriate care plans with goals and Approaches for Anticoagulant Therapy will be evaluated using the "Care Plan Audit" of the Nursing Quality Improvem Program. The members of the Nursing QI team will collect date on this issue and forwat that information to the DON for review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator. 4. Resident #7 B. Incontinence 1. Resident #7s care plan was amend to include goals and approaches for resident who has incontinence. 2. Care Plans of all residents who h incontinence were reviewed for goals and approaches for incontine and amended as needed. 	ensive ded by. for nt nent ard ard or a has ence	3/6/09 3/10/09 3/31/09 4/3/09 3/6/09 3/31/09
	as frequently inconti function in Section F	er 2, 2008 coded the resident inent of bowel and bladder H (Continence in last 14 days). assessment completed			3. Appropriate care plans with goals ar Approaches for Incontinence will be evaluated using the "Care Plan Audit" of the Nursing Quality Improvem Program. The members of the Nursing will collect date on this issue and forwar that information to the DON for review and evaluation.	nent QI team	3/31/09

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		AND HUMAN SERVICES				FORM	: 03/04/2009 APPROVED
	, , , , , , , , , , , , , , , , , , , ,	MEDICAID SERVICES			· · · · · · · · · · · · · · · · · · ·		0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		PLE CONSTRUCTION G	(X3) DATE SUF COMPLET	
		095022	B. WING			01/16/2009	
NAME OF PR	OVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·		STR	REET ADDRESS, CITY, STATE, ZIP CODE		
		177.4		2	2425 25TH STREET SE		,
WASHING	GTON NURSING FACIL			V	WASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD B REFERENCED TO THE APPROPRIATE DE	E CROSS-	(X5) COMPLETION DATE
F 279	December 2, 2008 c incontinent of bladde stool in Section H. A review of the resid there was no care pl goals and approache incontinence. A face-to-face interv Employee #6 on Jan He/she acknowledge for incontinence. Th 13, 2009. 5. Facility staff failed Resident #13 for inc abusive behaviors. A. Facility staff failed incontinence for Resi Review of Resident admission MDS com resident as usually in incontinent of bladde assessments comple 2008 and January 2 Section H as usually bladder. A review of the resid there was no care pl goals and approache incontinence. A face-to-face interv Employee #5 on Jan	er and frequently incontinent of lent's care plans revealed that an initiated with appropriate es for bowel and bladder iew was conducted with huary 13, 2009 at 2:25 PM. ed that there was no care plan ie record was reviewed January I to initiate care plans for ontinence and aggressive/	F	279	 483.20(d), 483.20(k)(1) Compre Care Plans (continued) 4. Resident #7 (continued) 4. The Department Head will pro a report of the data collected and action plans implemented to ensisustained compliance at the mor Quality Improvement Committee is chaired by the Administrator. 5. Resident #13 A. Incontinence 1. Resident # 3s care plan was a to include goals and approaches resident who has incontinence. 2. Care Plans of all residents whincontinence were reviewed for goals and approaches for incont and amended as needed. 3. Appropriate care plans with goals Approaches for Incontinence will be evaluated using the "Care Pla Audit" of the Nursing Quality Improv Program. The members of the Nursi will collect date on this issue and for that information to the DON for revie and evaluation. 4. The Department Head will prov a report of the data collected and action plans implemented to ensisustained compliance at the mor Quality Improvement Committee is chaired by the Administrator. 	esent d any ure hthly which amended f for a o has inence s and an ement ing QI team ward av esent d any ure hthly	4/3/09 3/6/09 3/31/09 3/31/09 4/3/09
	Employee #5 on Jar	nuary 13, 2009 at 11:00 AM.					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	03/04/2009 APPROVED 0938-0391	
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		095022	B. WIN	IG		01/16/2009		
NAME OF PR			STREET ADDRESS, CITY, STATE, ZIP CODE 2425 25TH STREET SE					
WASHING	STON NURSING FACIL	.ITY		WASHINGTON, DC 20020				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD B REFERENCED TO THE APPROPRIATE DE	E CROSS-	(X5) COMPLETION DATE	
F 279	January 13, 2009. B. Facility staff failed aggressive/abusive #13. According to a revie "Initial Psychiatric Ev 2008, "[Resident] abusive to other pati assaultive off and or prescribed Seroquel Klonopin 1 gm orally According to a quart completed July 24, 2 Section E (Mood and A review of the "Ps Flow Sheet " which medication side effe November, Decemb A review of the resid there was no care pl goals and approach behaviors. A face-to-face interv Employee #5 on Jar He/she acknowledge for incontinence and The record was review	 Je 32 The record was reviewed to initiate a care plan for behaviors for Resident w of Resident #13's of the valuation" dated October 9, admits to being verbally ents at times and physically n " The resident was 50 mg orally twice daily and daily for agitated behaviors. erly MDS assessment 2008, the resident was coded in d Behaviors) for verbal abuse. ychoactive Medication Monthly monitored target behaviors and cts were blank for October, er 2008 and January 2009. lent 's care plans revealed that an initiated with appropriate es for abusive/aggressive iew was conducted with fuary 13, 2009 at 11:00 AM. ed that there was no care plan aggressive/abusive behaviors. to initiate a care plans with 	F 2		 483.20(d), 483.20(k)(1) Compression Care Plans (continued) 5. Resident #13 B. Aggressive/abusive behavior 1. The care plan was amended to include goals and approachess resident exhibiting both aggress abusive behaviors. 2. Medical records of all resident who exhibit aggressive/abusive behaviors were reviewed for corr goals and amended as needed. 3. Appropriate care plans with goal Approaches for aggressive/abusive will be evaluated using the "Care Pl Audit" of the Nursing Quality Improv Program. The members of the Nurs will collect date on this issue and for that information to the DON for revia and evaluation. 4. The Department Head will pr a report of the data collected and action plans implemented to ensistained compliance at the mod Quality Improvement Committee is chaired by the Administrator. 	s for a ive/ ts responding behaviors an ement ing QI team rward ew esent d any ure nthly	3/6/09 3/6/09 3/31/09 4/3/09	

Facility ID: WASHNURS

continuation sheet Page 32 of 121

DEPART	MENT OF HEALTH	AND HUMAN SERVICES					: 03/04/2009 APPROVED
		& MEDICAID SERVICES					<u>093</u> 8-0391
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	,	095022	B. WIN	G		01/10	6/2009
NAME OF PR				STR	REET ADDRESS, CITY, STATE, ZIP CODE		
WASHING	GTON NURSING FACI	LITY			2425 25TH STREET SE NASHINGTON, DC 20020		
		ATEMENT OF DEFICIENCIES		(75)			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	PREFI TAG		PROVIDER'S PLAN OF CORRECTIN (EACH CORRECTIVE ACTION SHOULD BI REFERENCED TO THE APPROPRIATE DE	E CROSS-	(X5) COMPLETION DATE
F 279	Continued From page	ge 33	F	279	483.20(d), 483.20(k)(1) Compre	hensive	
		nd approaches for the potential			Care Plans (continued)		
		for the use of nine (9) or more the use of full side rails for			5. Resident #15 A. Adverse Interactions for 9+ m	odioations	
	Resident #15.	the use of full side fails for			1.Resident #15's care plan was ame		3/6/09
	A. Review of the cli	nical record for Resident #15			to include appropriate goals and app	oroaches	
	-	n 's Order Sheet (POS) signed			for the potential adverse interactions use of 9 or more meds.	for the	
		with medications which included x, Glipizide, Keppra, Synthroid,			2. Medical records of all residents w	ith 9 or	3/6/09
		sone, Zantac, Zaroxylin and			more medications were reviewed if a		
	Tylenol tablets. Fur	ther review of the record			corresponding care plan with approp goals and approaches for the potent		
		e plan was initiated for the use			adverse interactions.	iai	
		lications for Resident #15. view was conducted with			3. Appropriate care plans with goals		
		nuary 14, 2009 at approximately			Approaches for Adverse Interactions Use of 9 or More Meds	s for the	
		knowledged that the care plan			will be evaluated using the "Care Pla	an	
		e interaction for the use of nine s was not on the record. He/she			Audit" of the Nursing Quality Improv		
		ne on right now. " The record			Program. The members of the Nursing QI tear	n	3/31/09
	was reviewed on Ja	nuary 13, 2009.			will collect date on this issue and for		0/01/03
	-	d to initiate a care plan for the			that information to the DON for revie	w	
	use of full side rails Resident #15 was o	bserved lying in bed with full			 and evaluation. 4. The Department Head will preser 	nt	
		uary 13, 2009 at approximately			a report of the data collected and an		
	12:30PM and 4:10P	M on January 14, 2009. The			action plans implemented to ensure		
		why the side rails were up and hey keep me from falling out of			sustained compliance at the monthly Quality Improvement Committee whi		4/3/09
		dent was then asked whether			is chaired by the Administrator.		1,0,00
		e side rails. She responded, "					
	No. "	The last free of the links t			B. Full Side Rails		
		ility ' s policy entitled " Nursing Policy # 1404399A.000 " Page			1. Resident #15's care plan was	amended	3/6/09
		iding of "Definition" it is stated			to include a care plan for the use		
	"Physical restraints	are any manual method or			full side rails.		
		cal device, material, or or adjacent to the resident ' s			2. Medical records of all resident	-	3/6/09
		ual cannot remove easily which			full side rails were reviewed for a corresponding care plan for the u		
	restricts freedom of				side rails and care plan amended		
			*		needed.		

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Facility ID: WASHNURS

If continuation sheet Page 34 of 121

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMP B. WING B. WING B. WING B. WING			AND HUMAN SERVICES				FORM	0: 03/04/2009 APPROVED 0938-0391
NAME OF PROVIDER OR SUPPLIER Usadd2 Image: Continued Property Street Address: CITY, STATE, 2p CODE WASHINGTON NURSING FACILITY Street Address: CITY, STATE, 2p CODE 2425 25TH STREET SE WASHINGTON, NURSING FACILITY Street Address: CITY, STATE, 2p CODE 2425 25TH STREET SE WASHINGTON, NURSING FACILITY Street Address: CITY, STATE, 2p CODE 2425 25TH STREET SE WASHINGTON, NURSING FACILITY Street Address: CITY, STATE, 2p CODE 2425 25TH STREET SE WASHINGTON, NURSING FACILITY Street Address: CITY, STATE, 2p CODE 2425 25TH STREET SE WASHINGTON, NURSING FACILITY Street Address: CITY, STATE, 2p CODE 2425 25TH STREET SE WASHINGTON, NURSING FACILITY Street Address: CITY, STATE, 2p CODE 2425 25TH STREET SE WASHINGTON, NURSING FACILITY Street Address: CITY, STATE, 2p CODE 2425 25TH STREET SE WASHINGTON, NURSING FACILITY Street Address: CITY, STATE, 2p CODE 2425 25TH STREET SE WASHINGTON, NURSING FACILITY Street Address: CITY, STATE, 2p CODE 2425 25TH STREET ADDRESS, CITY, STATE, 2p CODE F 279 Continued From page 34 F F restreating Devices: The following: "Examples of Restraining Devices: The following: "Examples of Restraining Devices: The following: "Examples of Restraining Centrem Without Tray S. Stresse addelt Addit of the Centrem Without Tray S. Stradph Back Geri-chair without tray S. Straight	STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	. ,			(X3) DATE SU COMPLET	RVEY
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2425 25TH STREET SE WASHINGTON NURSING FACILITY Magnetic Propriet IEACH DEFICIENCY WIGT SE PRECEDED FILL REGULATORY TAG IP If EACH DEFICIENCY WIGT SE PRECEDED FILL REGULATORY TAG IP F279 Continued From page 34 movement or normal access to one 's body." In addition, on Page 2 of 2 of the aforementioned policy under the heading of '' Examples of Restraining Devices " the following examples are listed: " 1. Merry Walker 2. Veicro seat belt 3. Soft waist belt 5. Lap buddy 6. Lap Tray F 279 483.20(d), 483.20(k)(1) Comprehensive Care Plans (continued) 5. Resident #15 (continued) 5. Reading Geri-chair without tray 8. Straight back Geri-chair with tray 9. Straight back Geri-Ghair with tray 9. Straight back Geri-Chair was no evidence in the resident. 1. A face-to-face interview w			095022	B. WING			01/1	6/2009
WASHINGTON NURSING FACILITY WASHINGTON, DC 20020 (%) ID PREFIX TAG ISUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PREFIX (EACH CORRECTIVE ACTION BOLD DEFICIENCIES (EACH CORRECTIVE ACTION SIDE DEFICIENCY) F 279 Continued From page 34 movement or normal access to one 's body, '' In addition, on Page 2 of 2 of the aforementioned policy under the heading of '' Examples of Restraining Devices '' the following examples are listed: '' 1. Merry Walker 2. Velcro seat belt 3. Soft waist belt 4. Clip belt 5. Lap buddy 6. Lap Tray 10. Bed rails not requested by the resident 11. Bed against the wall. A review of the clinical record revealed a "Side Rail Assessment Form' dated December 5, 2008 which documented the following: "Recommendation: Full side rails indicated to serve as enabler to promote independence." There was no evidence in the record that the side rails were requested by the resident. A face-to-face interview was conducted with Employee # 6 on January 13, 2009. F 280 483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS F 280 SS=D 483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS F 280 A83.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS	NAME OF PR			•	STR	EET ADDRESS, CITY, STATE, ZIP CODE		
Prize TAGCEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)PRECY TAGCHARTON RECORRECTIVE ACTION SHOULD BE CROSS- REFERENCED TO THE APPROPRIATE DEFICIENCYF 279Continued From page 34 movement or normal access to one 's body. " In addition, on Page 2 of 2 of the aforementioned policy under the heading of "Examples of Restraining Devices " the following examples are listed: T. Merry WalkerVelcro seat beltSoft waist beltCup buddyLap TrayStraight back Geri-chair without trayStraight back Geri-chair without trayStraight back Geri-chair without trayStraight back Geri-chair with trayMeeries of the following: "Recommendation: Full side rails indicated to serve as enabler to promote independence." There was no evidence in the resident. A face-to-face interview was conducted with Employee # 6 on January 14, 2009 at approximately 3:00 PM. He/she acknowledged that there was no care plan on the record for the use of side rails and stated, " I will add the care plan to the record." The resident has the right, unless adjudged incompetent or otherwise found to be incapacitatedF 280483.20(d)(3), 483.10(k)(2) COMPREHENSIVE Care PlansF 280	WASHING	STON NURSING FACIL	lity					
 movement or normal access to one 's body." In addition, on Page 2 of 2 of the aforementioned policy under the heading of "Examples of Restraining Devices "the following examples are listed: "1. Merry Walker Velcro seat belt Soft waist belt Clip belt Lap buddy Lap Tray Reclining Geri-chair without tray Straight back Geri-chair with tray Bed rails ont requested by the resident A review of the clinical record revealed a "Side Rail Assessment Form" dated December 5, 2008 which documented the following; "Recommendation: Full side rails indicated to serve as enabler to promote independence. "There was no evidence in the resident. A face-to-face interview was conducted with Employee # 6 on January 14, 2009 at approximately 3:00 PM. He/she acknowledged that there was no care plan on the record for the use of side rails and stated, "I will add the care plan to the record." F 280 F	PREFIX	(EACH DEFICIENCY MUST	BE PRECEDED BY FULL REGULATORY	PREF		(EACH CORRECTIVE ACTION SHOULD B	BE CROSS-	(X5) COMPLETION DATE
planning care and treatment or changes in care and treatment.	F 280	movement or norma addition, on Page 2 policy under the hea Restraining Devices listed: " 1. Merry Walker 2. Velcro seat belt 3. Soft waist belt 4. Clip belt 5. Lap buddy 6. Lap Tray 7. Reverse Seat bel 8. Reclining Geri-ch 9. Straight back Ge 10. Bed rails not req 11. Bed against the A review of the clinic Assessment Form" of documented the follo side rails indicated to independence. " Th record that the side resident. A face-to-face interv Employee # 6 on Jai 3:00 PM. He/she ad care plan on the rec stated, " I will add to The record was review 483.20(d)(3), 483.10 CARE PLANS The resident has the incompetent or other under the laws of the planning care and to	I access to one 's body." In of 2 of the aforementioned uding of "Examples of " the following examples are " the following examples are tair without tray eri-chair with tray uested by the resident wall. " cal record revealed a "Side Rail dated December 5, 2008 which owing; " Recommendation: Full o serve as enabler to promote here was no evidence in the rails were requested by the iew was conducted with nuary 14, 2009 at approximately knowledged that there was no ord for the use of side rails and he care plan to the record. " ewed on January 13, 2009. 0(k)(2) COMPREHENSIVE e right, unless adjudged rwise found to be incapacitated e State, to participate in			 Care Plans (continued) 5. Resident #15 (continued) B. Full side Rails 3. Appropriate care plans with goal Approaches the use of Full Side Rawill be evaluated using the "Care Pl Audit" of the Nursing Quality Improver Program. The members of the Nursing QI tea will collect date on this issue and for that information to the DON for revier and evaluation. 4. The Department Head will prese a report of the data collected and arraction plans implemented to ensure sustained compliance at the monthl Quality Improvement Committee whis chaired by the Administrator. 483.20(d)(3), 483.10(k)(2) Compresent Committee Complex Statement Committee Complex Statement Complex Statement Committee Whis Chaired by the Administrator. 	is and iils an vement m rward ew ent hy hich	3/31/09 4/3/09

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Facility ID: WASHNURS

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	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIP A. BUILDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		095022	B. WING		01/1	6/2009
NAME OF PR		-	STR	EET ADDRESS, CITY, STATE, ZIP CODE		
WASHIN	GTON NURSING FAC	ILITY		425 25TH STREET SE VASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MU	STATEMENT OF DEFICIENCIES ST BE PRECEDED BY FULL REGULATORY DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE [BE CROSS-	(X5) COMPLE DATE
F 280	Continued From pa	-	F 280			
• • •	within 7 days after comprehensive as interdisciplinary tea physician, a registe the resident, and c disciplines as dete and, to the extent the resident, the re- legal representativ	care plan must be developed the completion of the sessment; prepared by an am, that includes the attending ered nurse with responsibility for other appropriate staff in rmined by the resident's needs, practicable, the participation of esident's family or the resident's e; and periodically reviewed and of qualified persons after each				
				483.20(d)(3), 483.10(k)(2)		
	This REQUIREME	NT is not met as evidenced by:		Comprehensive Care Plans (1. Resident #5 1.Resident# 5's care plan may		
	(4) of 30 sampled facility staff failed t four (4) residents v	rview and resident review for four residents, it was determined that o review and revise care plans for vith multiple falls with no injury		amended retrospectively. 2. Medical records of residents multiple falls were audited to er that the care plan was reviewed revised after each fall with addi	nsure d and tional	1/16
	Residents #5, 13,	ident for smoking marijuana. 19 and 25.		goals and approaches to preve falls.3. Appropriate care plans with generations.		3/31
		le: ed to review and revise Resident lan after multiple falls.		Approaches for Falls will be evalua "Care Plan Audit" of the Nursin Improvement Program. The members of the Nursing Q	ated using g Quality I team	3/31/0
		ent #5's record revealed the in the the resident fell on August 8 and		will collect date on this issue ar that information to the DON for and evaluation.4. The Department Head will p a report of the data collected ar	review resent	
	2008 revealed that	an #7 " Falls " initiated July 3, both falls were hand written on r "Problems." The "Risk		action plans implemented to en sustained compliance at the mo Quality Improvement Committe is chaired by the Administrator.	sure onthly e which	4/3/0
ORM CMS-25	67(02-99) Previous Versions	Obsolete Event ID: WPBP11	Fa	cility ID: WASHNURS If con	tinuation sheet F	Page 36

DEPARTMENT C	OF HEALTH	AND HUMAN	SERVICES
CENTERS FOR I		& MEDICAID	SERVICES

	OT ON MEDICANE O	X WEDICAID SERVICES					. 0930-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		095022	B. WIN	IG		01/1	6/2009
NAME OF PF				STR	EET ADDRESS, CITY, STATE, ZIP CODE		
WASHING	GTON NURSING FACIL	LITY			425 25TH STREET SE VASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIATE DE	E CROSS-	(X5) COMPLETION DATE
F 280	Continued From pag	je 36	F	280	483.20(d)(3), 483.10(k)(2)		
		Interdisciplinary Care Plan" nber 26, 2008. The care plans October 14, 2008.			Comprehensive Care Plans (co	ontinued)	. ·
	revised and reviewe	nce that either care plan was d after either fall with additional es initiated to prevent further	·				
	Employee #5 on Jar He/she acknowledge	iew was conducted with nuary 12, 2009 at 3:45 PM. ed that additional care plan ted after either fall. The record ary 12, 2009.			 Resident #13 1.Resident# 13's care plan was a with additional goals and approace 		1/18/09
	#13's care plan after According to Reside resident was found of	to review and revise Resident multiple falls. Int #13's nurses' notes, the on the floor in his/her room on mber 6, December 8, 2008 and	l		to prevent further falls 2. Medical records of residents w multiple falls were audited to ensith that the care plan was reviewed a revised after each fall with addition goals and approaches to prevent falls. 3. Inservice training was given to	ure and onal t further	
-	entry dated Decemb	lent's fall care plan revealed an er 6, 2008, to seek assistance during			staff on all units learning wide green to and approaches to implement in effort to prevent further falls Appropriate care plans with goals Approaches for Falls will be evalu	t goals an s and	3/31/09
	revised and reviewe falls with additional of to prevent further fal				"Care Plan Audit" of the Nursing Improvement Program. The members of the Nursing QI t will collect date on this issue and that information to the DON for re	eam forward	
	Employee #5 on Jar He/she acknowledge not revised and revise	iew was conducted with nuary 13, 2009 at 11:00 AM. ed that the falls care plan was ewed after each of the above rd was reviewed January 13,			 and evaluation. The Department Head will pre- a report of the data collected and action plans implemented to ensu- sustained compliance at the mon Quality Improvement Committee is chaired by the Administrator. 	l any ure ithly	4/3/09

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Facility ID: WASHNURS

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING	<u> </u>		
		095022	B. WING		01/16	5/2009
AME OF PF			STR	REET ADDRESS, CITY, STATE, ZIP CODE		
VASHING	GTON NURSING FAC	ILITY,		425 25TH STREET SE VASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES IT BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION SH REFERENCED TO THE APPROPR	OULD BE CROSS-	(X5) COMPLETI DATE
F 280	3. Facility staff faile	ge 37 d to review and revise Resident an after multiple falls without	F 280	Comprehensive Care Pla 3. Resident #19 1.Resident#19's care plan with additional goals and a	was amended	1/18/0
	Injury. A review of Resident #19 's nurses ' notes revealed the following: November 22, 2008 at 11:00 PM: "Resident observed on the floor at 8 PMno injury " November 26, 2008 at 7:00 AM: "Resident observed on the floorno injury " November 28, 2008 at 2:00 PM: "Observed on the floorno injury " December 12, 2008 at 4:00 AM: "At 1:30 AM observed lying beside bedno injury." A review of the two (2) care plans marked #7, " Interdisciplinary Care Plan for Falls " and "			 to prevent further falls. 2. Medical records of residents who had multiple falls were audited to ensure that the care plan was reviewed and revised after each fall with additional goals and approaches to prevent further falls. 3. Inservice training was given to IDTeam/ staff on all units learning different goals and approaches to implement in an effort to prevent further falls Appropriate care plans with goals and Approaches for Falls will be evaluated 		3/6/09
	Potential for injury r the date and time o written onto the car The care plan, "#7 Falls " was initiated Interventions initiated included, "PT (Phy	elated to falls " , revealed that f each fall cited above was hand		using "Care Plan Audit" of Quality Improvement Progr The members of the Nursir will collect date on this issu that information to the DON and evaluation. 4. The Department Head v a report of the data collecte action plans implemented t	ram. ng QI team le and forward N for review will present ed and any	3/31/(
	bed at lowest possible setting when in bed to prevent falling from position of bed, Use of safety devices as appropriate, Monitor behavior, Keep call light within reach at all times & encourage use of, Frequent reminders of safety issues, ex., refrain from sitting at the edge of the bed and chair, take a nap if you feel sleepy, hold on to something steady during ambulation or use walker at all times secondary to unsteady gait, Refer to PMD (Private Medical Doctor) and psychiatrist as needed. "			sustained compliance at th Quality Improvement Com is chaired by the Administr	e monthly nittee which	4/3/09

FORM CMS-2567(02-99) Previous Versions Obsolete

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		AND HUMAN SERVICES				FORM	: 03/04/2009 APPROVED
STATEMENT	S FOR MEDICARE OF DF DEFICIENCIES CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SUI COMPLET	
		095022	B. WIN	IG		01/16/2009	
	OVIDER OR SUPPLIER	LITY		24	EET ADDRESS, CITY, STATE, ZIP CODE 425 25TH STREET SE VASHINGTON, DC 20020		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS				BE CROSS-	(X5) COMPLETION DATE	
F 280	after the above cited The care plan, " Inte " was initiated Octo dated November 22 the predisposing con- seizure activity, Prov- Interventions dated Keep call bell in read Interventions dated Place resident ' s be Encourage resident An intervention hand 2 dated December 1 monitored at the nur- bed). " Interventions docum Car Plan for Falls " related to Falls " alt essentially the same There was no evided	ventions identified as initiated I falls. erdisciplinary Care Plan for Falls ber 18, 2008. Interventions , 2008 included, " Determine inditions to falls: Previous vide a safe environment. " November 26, 2008 included, " ch." December 11, 2008 included, " ch." December 12, 2008, included, " ch."	F	280	483.20(d)(3), 483.10(k)(2) Comprehensive Care Plans (c	continued)	
	Employee #13 on Ja He/she acknowledg care plans were the	iew was conducted with anuary 15, 2009 at 2:15 PM. ed that the interventions in both same and additional ot initiated after the November ord was reviewed					
					· · · · · · · · · · · · · · · · · · ·		

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Facility ID: WASHNURS

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM OMB NO.	APPRO\ 0938-0
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		095022	B. WING		01/16	5/2009
	OVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE	·	
WASHING		LIF1	V	VASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	ATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE I	BE CROSS-	(X5) COMPLE DATE
F 280	Continued From pag January 15, 2009.	ge 39	F 280	483.20(d)(3), 483.10(k)(2) Comprehensive Care Plans (continued)	
	4. Facility staff failed #25's "Substance A	d to review and revise Resident buse" care plan after multiple I resident smoking marijuana."		 Resident #25 Resident care plan was ame to include additional goals and to prevent further incident of sr marijuana while waiting for app 	approaches noking	3/10/
	following nurses' no February 13, 2008 a smoking marijuana	at 12AM, "Resident was seen		placement in a therapeutic sett 2. Records of residents with "si abuse" care plans were review to determine if care plans in pla goals and approaches to allevi	ing. ubstance ed ace include	
	MD [Physician] notif specimen to test for and tested, result w	e while on the patio(unknown) fied, order given to obtain urine marijuana, specimen collected as positive for mAmp d THC (tetrahydrocannabinol)		incidents of further drug seekin 3. IDTeam staff were given insi- training to review and revise ca of residents with " substance a to include additional goals and	g behaviors. erivce ire plans buse " approaches	3/13/0
	positive for THC. W he/she was given w	was tested and the result was hen questioned, resident stated eed by another resident "		to alleviate/prevent incidents of drug seeking behaviors. Appropriate care plans with go Approaches for Substance Abu evaluated using "Care Plan Au	als and Ise will be	
	observed smoking r " July 20, 2008 at 10:	0 PM, "Resident was narijuana in the smoking patio 30 PM, "Resident was reported ne drug test was done with		Nursing Quality Improvement F The members of the Nursing Q will collect date on this issue at that information to the DON for	Program. I team nd forward	3/31/
	negative result" November 2, 2008 a seen with a bag of v obtained from his/he	at 3:00 PM, "Resident was veeda bag of marijuana was		and evaluation.4. The Department Head will p a report of the data collected a action plans implemented to er	present nd any isure	
	that patient was sme November 8, 2008 a observed smoking n December 2, 2008 a	at 11.00 PM "was mormed oking marijuana on the patio" at 11:00 PM ."Resident was narijuana on the patio " at 9:00 PM, "Patient was narijuana in his/her room "		sustained compliance at the m Quality Improvement Committe is chaired by the Administrator	e which	4/3/0

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Facility ID: WASHNURS

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PRINTED: 03/04/2009 FORM APPROVED OMB NO 0938-0391

	S FUR MEDICARE	S MEDICAID SERVICES					0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUII			(X3) DATE SUF COMPLET	
_		095022	B. WIN	G <u> </u>		01/10	6/2009
NAME OF PR	OVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE		
WASHING	GTON NURSING FACIL	LITY			425 25TH STREET SE /ASHINGTON, DC 20020		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTI PREFIX (EACH CORRECTIVE ACTION SHOULD B TAG REFERENCED TO THE APPROPRIATE DE		BE CROSS-	(X5) COMPLETION DATE	
TAG F 280	Continued From page December 8, 2008 a observed smoking n January 3, 2009 at 5 observed smoking n January 7, 2009 at 1 smoking marijuana i A review of the social followings: March 13, 2008 "I smoking policy " April 9, 2008 "IDT fa caught with a little m he/she continues to May 14, 2008 "IDT fa caught with a little m he/she continues to May 14, 2008 "Interior smelled like he/she July 2, 2008 "Interior smoking marijuana . that the resident rec forward this recomm supervisor" July 11, 2008 "IDT fa continue to be caugh matches, marijuana, Consequently there no plan to dischard July 21, 2008 "Interior by security to be sm November 3, 2008 " with a bag of marijuan observed smoking m 08, and the resident marijuana, but I don	ge 40 at 9:45 PM, "Patient was harijuana in the room" 5:00 AM, "Resident was harijuana in his/her bedroom" 1:00 AM, "Resident observed n his/her room" al work notes revealed the Discharge if he/she violates the hvite Note[Resident] was harijuana piece today, and present behavioral problems" rim Note: Resident was e piece of marijuana stick and was smoking marijuana" n Note: Resident caught the nursing staff recommends eives talk therapy. Writer will hendation to the social service Quarterly Note:[Resident] ht with contraband (cigarettes, and stolen nutritional drinks) is no change in his behavior ge the resident at this time" m Note: Resident was reported oking marijuana" Interim Note: Resident was seen ana on 11-2-08 " ' Interim Note: Resident was harijuana on the patio on 11-5- said, I want to stop smoking 't want to go to a drug program		280			
	placement within a t	worker will seek appropriate herapeutic					

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Facility ID: WASHNURS

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		AND HUMAN SERVICES & MEDICAID SERVICES			· · · · · · · · · · · · · · · · · · ·	FORM	: 03/04/2009 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL			(X3) DATE SUF COMPLET	RVEY
		095022	B. WIN	G		01/16/2009	
	OVIDER OR SUPPLIER	ITY		24	EET ADDRESS, CITY, STATE, ZIP CODE #25 25TH STREET SE /ASHINGTON, DC 20020		
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY			PROVIDER'S PLAN OF CORRECTION			(X5) COMPLETION DATE
F 280	setting for this reside November 10, 2008 observed smoking in Worker) is seeking a setting for this reside December 2, 2008 I observed smoking in This writer is current therapeutic setting for December 11, 2008 with [representative] Resident 's name w writer will be contact December 15, 2008 scheduled to go to [] 12-15-08 at 9:00 AM refused to go" January 8, 2009 "In date of 12-24-08, Repiece of marijuana s nursing station" January 9, 2009 "ID is on waiting list for A review of the Inter "Substance abuse" i lacked evidence tha and revised between with additional goals further marijuana us A face-to-face intern Employee #28 on Ja approximately 9:20 / additional goals and	ent" "Interim Note: resident was harijuana This SW (Social an appropriate therapeutic ent" Interim Note: Resident was harijuana in bed on 12-2-08 ently seeking an appropriate for this resident" "Interim Note: Writer spoke from [program] on 12/8/08. Tas placed on the waiting list and ted in 2 weeks." "Interim Note:Resident was program] drug treatmenton Ihowever, the resident terim Note: Late Entry for the esident allegedly dropped a tick on the floor in front of the PT Quarterly Note:[Resident] Program]" disciplinary (IDT) Care Plan #9 nitiated January 18, 2008 t the care plan was reviewed the April 9, and November 3, 2008 and approaches to prevent e. view was conducted with muary 16, 2009 at AM. He/she acknowledged that approaches were not initiated 9, 2008. The record was	F	280	483.20(d)(3), 483.10(k)(2) Comprehensive Care Plans (co	ntinued)	
F 309 SS=G	483.25 QUALITY OI	CARE	FS	309	483.25 Quality of Care		

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<u>CENTEF</u>	RS FOR MEDICARE	& MEDICAID SERVICES	<u> </u>			OMB NO	<u>. 0938-0391</u>
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) M			(X3) DATE SUI COMPLET	
		095022	B. WIN			01/4	612000
	ROVIDER OR SUPPLIER			2	REET ADDRESS, CITY, STATE, ZIP CODE 425 25TH STREET SE VASHINGTON, DC 20020	<u> </u>	6/2009
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	ATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETION DATE
F 309	provide the necessa maintain the highes and psychosocial w comprehensive assist This REQUIREMEN Based on observative interview, for nine (S five (5) supplements that facility staff failed treatments to re-assist of pain for three (3) administration of top (3) residents, follow with skin cream for physician's order for resident, administer for one (1) resident, discontinue a foley of obtain a physician's for one (1) resident, belt for one (1) resident, belt for one (1) resident, belt for one (1) resident, belt for one (1) resident to fluff gauze for one physician's order for two (2) residents an prior to medication a	receive and the facility must any care and services to attain or t practicable physical, mental, ell-being, in accordance with the essment and plan of care. IT is not met as evidenced by: on, record review and staff (a) of 30 sampled residents and al residents, it was determined ed to: stop wound care sess the residents for complaints residents, follow an order for bical antifungal cream for three the physician's order to treat one (1) resident, follow up with a r a cardiology consult for one (1) dilantin as per physician's order obtain a physician's order to catheter for one (1) resident, order for use of full side rails obtain an order for velcro seat lent, follow a wound care order e (1) resident, failed to follow the r administration of medication for d obtain the physician's order administration for three (3) s #11, 20, 27, 1, 2, 8, 14, 15, 19, 9 and JH10.	F	309	 483.25 Quality of Care (contin 1. A. Resident #11 Staff where resident resides were given inservice on facility on Pain Management focusing assessment and intervention do wound treatment. Facility staff on all units were inservice training on facility poli on Pain Management focusing assessment and intervention do wound treatment. Observation of wound treatment will be done by Nursing Superv to ensure compliance with the f pain management protocols. Wound care will be evaluated ut the "Treatment Observation" to Nursing Quality Improvement P The members of the Nursing Q will collect date on this issue ar that information to the DON for and evaluation. The Department Head will p a report of the data collected ar action plans implemented to ensustained compliance at the model of the Administrator. 	policy on pain uring given cy on pain uring eents isors acility's sing ol of the rogram. I team of forward review resent ad any sure onthly	1/18/09 1/18/09 3/31/09 4/3/09
	1. Facility staff failed	d to stop a wound care					
	<u> </u>						

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING		SURVEY LETED
		095022	B. WING	o [,]	1/16/2009
	ROVIDER OR SUPPLIER		24	EET ADDRESS, CITY, STATE, ZIP CODE 425 25TH STREET SE /ASHINGTON, DC 20020	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS- REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIC DATE
F 309	Continued From pa	ge 43	F 309	483.25 Quality of Care (continued)	
	pain. Residents #1	· · · ·		B. Resident #201. Staff where resident resides	
		d to stop and re-assess complaint of pain during a wound		were given inservice on facility policy on Pain Management focusing on pain assessment and intervention during wound treatment including fluffing the	1/18/0
	on January 14, 200	ment observation was conducted 9 at approximately 11:30 AM for had left lower lateral leg wound.		wound treatment gauze per MD order.2. Facility staff on all units were given inservice training on facility policy	1/18/0
	2009 with Tylenol 3	re-medicated on January 14, 25 mg two (2) tablets at 11:00 an's orders dated December 15,		on Pain Management focusing on pain assessment and intervention during wound treatment including fluffing the wound treatment gauze per MD order.	
	physician's order si 2008 that directed ' with NS [normal ste	dent's clinical record revealed a gned and dated December 15, 'Cleanse left lower lateral leg rile saline]. Apply thin layer of over with dry gauze and change		3. Observation of wound treatments will be done by Nursing Supervisors to ensure compliance with the facility's pain management protocols including following the physician's wound treatment order. Wound care will be evaluated using	
	explained what he/s #11 was positioned the pant leg on the wound to be dresse the left lower latera grimaced and said,	duced self to the resident and she intended to do. Resident on his/her right side, pulled up left lower leg to expose the ed. As Employee #26 cleansed I leg wound, the resident "That's sore" Employee #26 corry." Employee #26 continued		the "Treatment Observation" tool of the Nursing Quality Improvement Program. The members of the Nursing QI team will collect date on this issue and forward that information to the DON for review and evaluation. 4. The Department Head will present a report of the data collected and any	3/31/0
	to wipe the area will with normal sterile s	h 4x4 gauze pads moistened saline, applied Silvadene with apped the dressing and secured		action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator.	4/3/09
	Employee #26 faile treatment to re-ass	d to stop the wound care			

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DEPART	MENT OF HEALTH	AND HUMAN SERVICES): 03/04/2009 APPROVED	
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			· · · · · · · · · · · · · · · · · · ·	OMB NO. 0938-0391		
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SU COMPLET		
		095022	B. WIN	IG		01/1	6/2009	
NAME OF PR	OVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE			
WASHING	GTON NURSING FACI	ITY		2	425 25TH STREET SE			
				V	VASHINGTON, DC 20020			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE [BE CROSS-	(X5) COMPLETION DATE	
F 309	Continued From pag	ge 44	F	309	483.25 Quality of Care (contin	ued)		
	face-to-face intervie	w was conducted with				··-,		
•	Employee #26 on Ja							
		PM. He/she acknowledged that						
		the wound care treatment to re- s complaint of pain. The record						
	was reviewed on Ja							
		, 2000.						
	B. Facility staff faile	d to reassess Re s ident #20 for						
		I treatment and failed to follow						
		r to fluff the wound treatment						
	gauze.							
		observation was conducted on 12:00 PM for Resident #20 who al wounds.			· · ·			
	The resident was pr	e-medicated on January 14,						
		two (2) tablets at 11:00 AM, as						
		rs dated November 8, 2008.						
		vsician's telephone order dated						
	December 22, 2008	nium with normal sterile saline						
		k with fluffy gauze and Santyl						
	ointment. Cover with	a 4 x 4 (gauze) and Coversite			· · ·			
		daily and as needed					ļ	
		vound with NSS and pat dry.						
		ds) and ABD (abdominal pad)	,					
	then tape until heale							
	-							
		sitioned on his/her left side, ds. The nurse cleaned the left						
		loyee #23 cleansed the interior						
	of the wound twice a	and the exterior of the wound						
		nployee #23 cleansed the						
		moaned loudly. Employee #23						
	applied the 4 x 4 ga	uze paus anu						
				-				

Facility ID: WASHNURS

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

PRINTED: 03/04/2009 FORM APPROVED OMB NO 0938-0391

STATEMENT OF DEFICIENCE AND PLAN OF CORRECTION	ES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l' í			(X3) DATE SURVEY COMPLETED	
		095022	A. BUI B. WIN		;	01/1	c/2000
NAME OF PROVIDER OR SU						U1/1	6/2009
WASHINGTON NURS		LITY		2	EET ADDRESS, CITY, STATE, ZIP CODE 425 25TH STREET SE VASHINGTON, DC 20020		
	CIENCY MUS	ATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETION DATE
the wound, #23 failed reassess After com wound, Er sacral wou of the sac wound thr cleansed cleansing #23 stated but we are Employee Santyl oin the wound then appli during the failed to fli wound as C. Facility Resident a care treatr A wound con Januar Resident a	tment and d as per th to stop th the reside pleting the mployee # und. Emp ral wound ee times. the wound the sacra d to the re e almost d #23 appli tment and d as per pl ed the Co applications were col #23 faile wound the uff the 4 x per physi staff faile #27 for co ment. care treator y 15, 200 #27 who h	I failed to fluff the gauze to pack e physician's order. Employee e wound treatment and nt's pain. e treatment on the left ischial 23 began treatment on the loyee #23 cleansed the interior twice and the exterior of the Each time Employee #23 d, the resident moaned. After I wound the first time Employee sident, "I know it hurts. I'm sorry		309	 483.25 Quality of Care (contined to the second se	policy on pain uring e given icy on pain uring tments visors facility's Vound e f the Program. I Team nd forward review resent nd any sure ponthly	1/18/09 1/18/09 3/31/09 4/3/09

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WPBP11

Facility ID: WASHNURS

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DEPARTMENT OF HEALTH AN CENTERS FOR MEDICARE & M					FORM	: 03/04/2009 APPROVED 0938-0391	
STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION	1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL		PLE CONSTRUCTION	(X3) DATE SUF COMPLET		
	095022	B. WIN	G		01/16/2009		
NAME OF PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE			
WASHINGTON NURSING FACILIT	Y		2425 25TH STREET SE WASHINGTON, DC 20020				
PREFIX (EACH DEFICIENCY MUST BE	MENT OF DEFICIENCIES PRECEDED BY FULL REGULATORY FYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD B REFERENCED TO THE APPROPRIATE DE	E CROSS-	(X5) COMPLETION DATE	
 orders of December 16 A review of the residen December 16, 2008, rephysician's telephone of sacral area Stage III with Santyl, pack with fluffy tape till healed " The resident was positi soiled with contents of exposing the sacral pre- cleansed the sacral und cleansed the ulcer, the grimaced. Employee # care treatment. Employ fluffy 4 x 4 gauze pads secured the dressing with Employee #27 failed to re-assess the resident" Facility staff failed to podiatrist's plan of care (OTC) topical anti-fung 1 and 11. Facility staff failed to fungal medication for R Resident #1 was seen November 25, 2008. This included the following: debridedThe patient antifungal. OTC topical fungal medication was Use of a topical antifund 	d physician 's telephone 5, 2008. It's clinical record dated evealed an unsigned order that directed "Cleanse ith NSS, pat dry, apply gauze daily, cover with 4 x 4, ioned on his/her left side, the resident's ostomy bag, essure ulcer. Employee # 27 cer. As the Employee #27 resident moaned and f27 continued with the wound yee #27 applied Santyl on , packed the wound and with pre-labeled tape. o stop the wound treatment to s complaint of pain. o follow-up with and clarify the e for use of over the counter ral medication for Residents # o clarify an order for an anti- Resident #1. by the podiatrist on he podiatrist's plan of care "All mycotic nails were is not a candidate for oral i may be used. Tinactin anti-	F	309	 483.25 Quality of Care (continued) 483.25 Quality of Care (continued) A. Resident #1 Podiatrist order for antifungal was clarified. PMD notified. Medical records of all resident the podiatrist with an order for ar fungal medication were reviewed ensure that the order was clarified necessary. Routine review of medical records and other orders for antifungal and other orders were clarified we necessary. Clinical Mangers will the results of this review and data to the Director of Nurses. The Department Head will preareport of the data collected and action plans implemented to ensist sustained compliance at the mor QI Committee which is chaired be Administrator. 	medication ts seen by n anti- d to ed if ords of will be medication /henever I report collection esent d any ure nthly	3/13/09 3/31/09	

Facility ID: WASHNURS

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	03/04/2009 APPROVED 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		095022	B. WING			01/16	5/2009
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE				
WASHING	GTON NURSING FACI	LITY		2425 25TH STREET SE WASHINGTON, DC 20020			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIATE DE	CROSS-	(X5) COMPLETION DATE
TAG F 309	Continued From pag 30, 2008. There was no evide staff clarified the po- use of anti-fungal m primary physician. A review of the resid Record (MAR) for Ju- lacked evidence that any topical antifunga A face-to-face interver Employee #6 on Jar 11:30 AM. He/she at failed to follow-up w plan of care for the medication on the re- reviewed January 10 B. Resident #11 wat 15, June 17, August The Podiatrist's plar "All mycotic nails w antifungals may be of There was no evide staff clanfied the po- use of anti-fungal m primary physician.	ge 47 nce in the record that facility diatrist's recommendation for the edication with the resident's dent's Medication Administration uly 2008 through January 2009 t the resident was administered al medication for the feet. New was conducted with huary 16, 2009, at approximately acknowledged that facility staff ith and clarify the podiatrist's use of topical antifungal esident's feet. The record was 5, 2009. s seen by the podiatrist on April 26, and November 11, 2008. n of care included the following: were debrided todayTopical used as needed." nce in the record that facility diatrist's recommendation for the edication with the resident's			 483.25 Quality of Care (continue) 8. Resident #11 1. Podiatrist order for antifungal resident was clarified. PMD notified. 2. Medical records of all resident the podiatrist with an order for an fungal medication were reviewed ensure that the order was clarifie necessary. 3. Routine review of medical recorresidents seen by the podiatrist vireviewed if orders for antifungal readiant other orders were clarified was clarified. 	ed) medication s seen by n anti- to d if ords of vill be medication henever	3/6/09 3/13/09 3/31/09
	through January 200 resident was admini medication:	lent's MAR for July 2008 09 lacked evidence that the stered any topical antifungal iew was conducted with			necessary. Clinical Managers wi the results of this review and data to the Director of Nurses. 4. The Department Head will pre a report of the data collected and action plans implemented to ensu	collection esent l any ure	
					sustained compliance at the mon QI Committee which is chaired by Administrator.		4/3/09

Facility ID: WASHNURS

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CENTER	S FOR MEDICARE	& MEDICAID SERVICES				APPROVE 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE SUF COMPLET	
		095022	B. WING		01/10	6/2009
NAME OF PR	OVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE		
WASHING	STON NURSING FACI	LITY		2425 25TH STREET SE WASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	ATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SHO REFERENCED TO THE APPROPRIA	ULD BE CROSS-	(X5) COMPLETION DATE
F 309	Continued From pa	-	F 30	09 483.25 Quality of Care (cor	ntinued)	
	11:30 AM. He/she a failed to follow-up w plan of care for the	nuary 16, 2009, at approximately acknowledged that facility staff <i>i</i> th and clarify the podiatrist's use of topical antifungal esident's feet. The record was 6, 2009.		 Resident #2 		
	to apply Kenalog C timely manner. A review of Resider	Facility staff failed to follow the physician's order apply Kenalog Cream to Resident # 2's chest in a nely manner. review of Resident # 2's clinical record revealed a lephone order dated January 12, 2009 which ated, "Kenalog Cream to incision site on chest tid aree times a day] for two (2) weeks for itching." aily review of the MAR on January 12, 13 and 14, 009, revealed that the medication was not dministered. According to the January 2009 MAR, e medication was administered on January 15, 009. face-to-face interview was conducted with mployee #9 at approximately 3:00 PM on January		 Incident report completed was notified. Discovered that Cream was placed in the tree instead of the Medication cat 2. MARs were audited to revo ordered were administered 	it the Kenalog atment cart rt. view that meds	1/15/09
	[three times a day] Daily review of the 2009, revealed that administered. Acco the medication was 2009. A face-to-face inter			manner for all residents. 3. Facility staff were given an inservice training on Medication Administration placing special emphasis on calling pharmacy for meds. Telephone Orders will be evaluated using the "Telephone/Verbal Orders" tool of the Nursing Quality Improvement Program. The members of the Nursing QI Team		3/31/09
	was not getting the record was reviewe 4. Facility staff faile order for a cardiolog	cream. I will check on it." The d on January 12, 2009. d to follow up with a physician's gy consult for Resident # 8. dent's clinical record revealed an		 will collect data on this issue that information to the DON and evaluation. 4. The Department Head w a report of the data collected action plans implemented to 	e and forward for review ill present d and any	3/31/09
	"Interim Order Form	" dated and signed November ed "Cardiology consult: confirm		sustained compliance at the QI Committee which is chair Administrator.	monthly	4/3/09
		dent's record lacked evidence owed up with the physician's gist consult.			· · ·	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPR									
CENTER	S FOR MEDICARE	& MEDICAID SERVICES					0938-0391		
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SUR COMPLETE			
		095022	B. WIN	IG		01/16/2009			
NAME OF PR		· · ·		STR	REET ADDRESS, CITY, STATE, ZIP CODE	_			
WASHING	GTON NURSING FACIL	_ITY			425 25TH STREET SE VASHINGTON, DC 20020				
			ID		PROVIDER'S PLAN OF CORRECTIO				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIATE DE	E CROSS-	(X5) COMPLETION DATE		
F 309	Continued From pag	ge 49	F	309	483.25 Quality of Care (continue	ed)			
	Employee #12 on Ja	view was conducted with anuary 16, 2009 at AM. He/she acknowledged that			5. Resident #14				
	facility staff followed	al record lacked evidence that lup with the physician's order nsult. The record was reviewed			 MD notified and order carried Medical records of all resident discontinued foley catheters were 	s with	1/16/09 3/31/09		
	January 16, 2009.		•		to ensure the presence of a physic order prior to discontinuing the ca	sician's	5/51/09		
	5. Facility staff failed to obtain a physician's order to discontinue Resident #14's foley catheter.				3. Facility staff were given an inservice on the facility protocol for Insertion and removal of a foley catheter.				
	(MDS) completed S	nission Minimum Data Set eptember 22, 2008 Resident #			Discontinued catheter orders will evaluated using the "urethral Cat				
	2008. Section H3	the facility on September 17,			of the Nursing Quality Improvement The members of the Nursing QI	Team			
	-	n indwelling catheter.			will collect data on this issue and that information to the DON for re and evaluation.		3/31/09		
	"Admission Order Sl sheet " that "Foley	dent's clinical record revealed a heet and Physician Plan of Care Catheter16FR [French], until al Doctor] " routine care			 The Department Head will pre a report of the data collected and action plans implemented to ensiti action pl	l any			
	change cath. [Catl				sustained compliance at the mor QI Committee which is chaired b	nthly	4/3/09		
				Administrator.					
		lent ' s clinical record lacked staff obtained a physician ' s the foley.			· .				
	Employee #9 on Jar 12:45 PM. He/she a clinical record lacked	iew was conducted with nuary 15, 2009 at approximately cknowledged that the resident's d evidence of that facility staff							
	obtained a physiciar								

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DEPART	MENT OF HEALTH	AND HUMAN SERVICES					03/04/2009/ APPROVED
CENTER	S FOR MEDICARE	MEDICAID SERVICES				OMB NO. 0938-0391	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		PLE CONSTRUCTION	(X3) DATE SUF COMPLETI	
	· · ·	095022	B. WIN	IG		01/10	6/2009
NAME OF PR	OVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE		
					2425 25TH STREET SE		
WASHING	STON NURSING FACIL		WASHINGTON, DC 20020				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIN (EACH CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIATE DE	E CROSS-	(X5) COMPLETION DATE
F 309	Continued From page	ue 50	 F	309	483.25 Quality of Care (continue	ed)	
		t #14's foley catheter. The	•	000	6. Resident #11	cuj	
	record was reviewed				1. Involved nursing staff was con	unseled	
					for not administering/not docume		
	6. Facility staff failed	I to administered Dilantin as per			Dilantin 100 mg (2capsules 200n	ng)	
	the physician's orde	r. Resident #11.			by mouth twice daily for seizures		3/6/09
	• • • • • • •				was notified of the lack of eviden	ce that the	
		dated November 20, 2008 and			Dilantin was administered.		
		cian on December 13, 2008, 100mgDilantin2			2. MARs were audited for similar	over-	2/24/00
		y mouth twice daily for			sight of documentation. Non-compliance with the facility's	s policy	3/31/09
	seizures."				for MAR documentation will resu		
					employee being subjected to the		
		lent's MAR for the month of			disciplinary process.	,.	
		evidence that the resident was			MAR documentation will be		
		n at 8:00 PM on August 26 and ed by absence of initials for			evaluated using the "Medication		
		forementioned dates indicating			of the Nursing Quality Improvement		
		ninistered. The resident's clinical			The members of the Nursing QI		
		nentation as to why Dilantin was			will collect data on this issue and that information to the DON for re		3/31/09
		here was no evidence in the			and evaluation.	SVIEW	3/31/09
	effects from the omit	ent experienced untoward			4. The Department Head will pre	esent	
	enects not the oran	aeu Dhantin uoses.			a report of the data collected and		
	A face-to-face interv	iew was conducted with			action plans implemented to ens		
1		nuary 14, 2009 at approximately			sustained compliance at the mor		
		cknowledged that the resident's			QI Committee which is chaired b	y the	4/3/09
		te that facility staff administered n as per the physician 's order.			Administrator.		
		ewed January 14, 2009.					
					7. Resident #15		
	7. Facility staff failed	l to obtain a physician's order			1. Physician's order obtained for	use of full	1/16/09
		e rails for Resident #15.			side rails for resident.		
		9 at approximately 4:00 PM,			2. Medical records of all resident		1/16/09
		PM and 4:10 PM on January #15 was observed lying in bed			side rails were reviewed to ensur	-	
	with full side rails up				the presence of a physician's ord		2/12/00
		erview with the resident on			 Inservice training was given to staff on the facility protocol for us 		3/13/09
					full side rails		
						ļ	

Event ID: WPBP11 Facility ID: WASHNURS

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES		OMB NO. 0938-039					
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		LE CONSTRUCTION	(X3) DATE SUF COMPLET			
		095022	B. WIN	IG		01/16	5/2009		
NAME OF PF			•	STR	EET ADDRESS, CITY, STATE, ZIP CODE				
	GTON NURSING FACIL	ITY		2	425 25TH STREET SE				
WASHIN			_	V	VASHINGTON, DC 20020				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD B REFERENCED TO THE APPROPRIATE DE	E CROSS-	(X5) COMPLETION DATE		
F 309	he/she was asked w he/she responded, " of the bed." The resi- he/she could release responded, "No." A review of the clinic was no physician's of for Resident # 15. A face-to-face interv Employee #6 at app 14, 2009. He/she ac order for the use of f The employee adde order for the use of f reviewed on Januar 8. Facility staff failed use a Velcro seat be A review of Residen telephone order date PM, signed by the p directed, "Obtain con from guardian. Resident belt on while sitting f "Consent for the Us seat belt (Velcro) wa party on December 2 Care plan #7, "Resident An observation of R the presence of Employee	approximately 12:30 PM why the side rails were up and They keep me from falling out ident was then asked whether e the side rails. The resident cal record revealed that there order for the use of full side rails riew was conducted with roximately 4:00 PM on January knowledged that there was no full side rails for Resident #15. d, "I will call the physician for an the side rails." The record was y 13, 2009. I to follow physician's orders to let for Resident #19. t #19's record revealed a ed December 18, 2008 at 4:00 hysician on the same date that nsent for seat belt (self release) dent to have self release seat up in w/c (wheelchair)." the of a Physical Restraint" for a as signed by the responsible 22, 2008. traint device" was updated on when the Velcro seat belt was		309	 483.25 Quality of Care (continue) Restraint documentation will be evaluated using the "Physical Restrated of the Nursing Quality Improvement The members of the Nursing QI will collect data on this issue and that information to the DON for mand evaluation. 4. The Department Head will preareport of the data collected and action plans implemented to ensistained compliance at the more QI Committee which is chaired by Administrator. 8. Resident #19 1. The clamp style seat belt was distand replaced with the Velcro seat physician's order. RP was notified consent obtained. 2. Medical records of all resident using a clamp style seat belt were to ensure a corresponding physic Changes were made whenever mand a clamp style seat belt that a resist unable to self release(Physical Restraint documentation will be evaluated using the "Physical Restraint documentation will be evalu	aint" tool Program. Team I forward eview esent d any ure hthly y the continued, it belt per d and s re audited cian order. hecessary. f re' release ease sident estraint) aint" tool Program. Team I forward eview ht y action	3/31/09 4/3/09 3/13/09 3/13/09 3/31/09 4/3/09		
	1				compliance at the monthly QI Comm which is chaired by the Administra	nittee			

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		AND HUMAN SERVICES					: 03/04/2009 APPROVED
CENTER	S FOR MEDICARE	& MEDICAID SERVICES				OMB NO	0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		LE CONSTRUCTION	(X3) DATE SUF COMPLET	
•		095022	B. WIN	G		01/1	6/2009
NAME OF PR			_ -	STR	EET ADDRESS, CITY, STATE, ZIP CODE		
					425 25TH STREET SE		
WASHING	STON NURSING FACIL	_ITY			VASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD B REFERENCED TO THE APPROPRIATE DE	E CROSS-	(X5) COMPLETION DATE
F 309	Continued From page	ge 52	F	309	483.25 Quality of Care (continu	ed)	
	with a clamp type se	eat belt and was unable to open			9.		
		. Employee #13 acknowledged			A. Resident JH!		
		s wearing a clamp type seat belt			1. The involved staff member wa	as	
· · · · ·		pen the belt. The record was			counseled with inservice given.	-	1/16/09
	reviewed January 1				2. Subsequent observations have	ve	
		to follow the physician's order			been done on all nurses to ensu		
		medication for Residents JH1			ability to pass medications as or		3/31/09
	and JH2.				3. MAR documentation will be		
	A. Facility staff failed	d to administer medication as			evaluated using the "Medication Pas	ss" tool	
	per physician's orde	rs to Resident JH1.			of the Nursing Quality Improvement		
				1	The members of the Nursing QI		
		9, at approximately 11:40 AM ,			will collect data on this issue and		
		on pass, Employee #22			that information to the DON for r		3/31/09
		tamin, Plavix 75mg, Glipizide	· · .		and evaluation.		
		50mg, Amlodipine 5mg, Geodon			4. The Department Head will prese	nt	
	•	x EC 500mg to Resident JH1			a report of the data collected and ar plans implemented to ensure sustai	ny action	4/3/09
		Physicians Orders Sheet		- {	compliance at the monthly QI Comn	nittee	
	the Medication Adm	ated on January 10, 2009 with inistration Record (MAR) for			which is chaired by the Administra	itor.	
		s discovered that Simvastin 20			B. Resident JH2		
	mg was omitted duri	ng the medication pass.			1. The involved staff member wa	as	
					counseled with inservice given.		1/16/09
		view was conducted on January	•		2. Subsequent observations have	ve	
		mately 1:05 PM, Employee #22 nedication during the			been done on all nurses to ensu	re their	
		t morning." the medication was			ability to pass medications as or	dered.	3/31/09
		ng administered during the			3. MAR documentation will be		
	morning medication				evaluated using the "Medication Pas		
	ine ing ine				of the Nursing Quality Improvemen		
	B. Facility staff failed	d to administer medication as			The members of the Nursing QI		
	per physician's orde				will collect data on this issue and		
					that information to the DON for r	eview	3/31/09
	On January 13, 200	9, at approximately 9:50 AM,			and evaluation.	- 4	
		n pass, Employee 40#			 The Department Head will prese a report of the data collected and ar 		
		tamin, Amlodipine 10mg,			plans implemented to ensure sustain		4/3/09
	Isoniazid 300mg, AS	SA 325 mg, Vitamin B-6 50			compliance at the monthly QI Comm which is chaired by the Administra	nittee	-1010 0
					· · · · · · · · · · · · · · · · · · ·		
		; ·					

Facility ID: WASHNURS

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONSTRUCTION	(X3) DATE SU COMPLET	
		095022	B. WING		01/1	6/2009
	OVIDER OR SUPPLIER	LITY	2	REET ADDRESS, CITY, STATE, ZIP COD 2425 25TH STREET SE WASHINGTON, DC 20020	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	ATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION S REFERENCED TO THE APPROP	HOULD BE CROSS-	(X5) COMPLETIO DATE
F 309	mg, Lisinopril 20 mg Resident JH2. After reconciling the (POS) signed and c an Interim order sig 2008 with the Medie (MAR) for January Alphagan 0.15% op ophthalmic drops, C Ranitidine 150 mg f medication pass. A face-to-face inter 16, 2009, at approx stated, "I am not far asked someone to the all medication b 10. Facility staff faile prior to medication JH9, and JH10. A. Facility staff faile prior to medication Review of the physi signed and dated J [Discontinue] Perco [every] Monday bef before tx [treatment	g, and Haloperidol 1 mg to e Physicians Orders Sheet lated on December 18 2008 and ned and dated December 16, cation Administration Record 2009, it was discovered that ohthalmic drops, Cospt Cardiazem ER180mg and ablets were omitted during the view was conducted on January imately 1:15 PM, Employee #40 miliar with this floor. I looked and help me find it. I administered	F 309	 483.25 Quality of Care (a 10. A. Resident JH8 1. Employee involved wareceived education regard Pharmacy policies and properties and properties of the sets for all resident reviewed to ensure compliare to ensure compliare the Nursing Quality Improperties of the Nursing Quality Impropriate to the Nursing Quality Impropriate to the Nursing Content of the Nursing that information to the DC and evaluation. 4. The Department Head with a report of the data collected plans implemented to ensure compliance at the monthly Q which is chaired by the Administration of the Administratic of the Administratic of the Adminis	as counseled and ding the facility's ocedures. Substance sign- ts were liance. ill be tion Pass" tool ovement Program. sing QI Team sue and forward DN for review Il present and any action e sustained Il Committee	1/31/09 1/31/09 3/31/09 4/3/09
	during the inspection South, a blister pace	on of the medication carts for 1 kage containing 10 tables of 5/325mg (Percocet) tablets				

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Facility ID: WASHNURS

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<u>CENIER</u>	<u>IS FOR MEDICARE</u>	<u>& MEDICAID SERVICES</u>				<u> </u>	<u>. 0938-0391</u>
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) Mi A. BUIL		PLE CONSTRUCTION	(X3) DATE SUI COMPLET	
		095022	B. WIN	G		01/1	6/2009
NAME OF PR				STR	EET ADDRESS, CITY, STATE, ZIP CODE		
					425 25TH STREET SE		
WASHING	GTON NURSING FACI	LITY		۷	VASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES F BE PRECEDED BY FULL REGULATORY INTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOULD E TAG REFERENCED TO THE APPROPRIATE D		BE CROSS-	(X5) COMPLETION DATE
F 309	Continued From page	ge 54	F:	309			
	were observed store	ed in the medication cart.					
	A review of the Controlled Drug Record documented that medication was removed on July 7, 8, 19 and 20, 2008 and August 24, 2008. This medication was dispensed after the physician had discontinued the order.				483.25 Quality of Care (continu	ued)	
	onto the MAR for Ju was discontinued. T	/325mg was not transcribed Ily and August 2008 because it here was no evidence that the e medication on the above cited					
	15, 2009 at approxim	view was conducted on January mately 12:15 PM with Employee wiedged the above stated			· · ·		
		led to obtain the physician's ation administration for JH9			B1. Resident JH91. Employee involved was cour received education regarding the		
		sician 's order signed for			Pharmacy policies and procedure 2. MARs and Controlled Substa	res.	1/31/09
	Tylenol #3, two tabs	ated July 11, 2008, directed, " s stat, i [one] q4h [every 4 hours] n for five days for dental ets were dispensed.			Out sheets for all residents were reviewed to ensure compliance. 3. MAR documentation will be evaluated using the "Medication Pa	e	1/31/09
	during the inspectio South, a blister pack	09, at approximately 10:00 AM n of the medication carts for 2 kage containing 22 tablets of		•.	of the Nursing Quality Improvemen The members of the Nursing QI will collect data on this issue an	nt Program. Team d forward	
		mg/ 15mg (Tylenol #3) tablets ed in the medication cart.			that information to the DON for r and evaluation. 4. The Department Head will prese		3/31/09
	5/325mg was remov	blets of Oxycodone/APAP ved on September 16, October ember 13, 2008, for a total of			a report of the data collected and an plans implemented to ensure sustai compliance at the monthly QI Comm which is chaired by the Administra	ny action ined nittee	4/3/09
ļ i							

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Event (D: WPBP11

Facility ID: WASHNURS

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	S FOR MEDICARE	& IVIEDICAID SERVICES				DINU.	<u>0938-0391</u>
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) Mu A. BUILI		· · · · · · · · · · · · · · · · · · ·	(X3) DATE SURVEY COMPLETED	
		095022	B. WINC	G		01/16	/2009
NAME OF PR				STR	EET ADDRESS, CITY, STATE, ZIP CODE		
WASHING	GTON NURSING FACI	LITY		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)		PREFIX (EACH CORRECTIVE ACTIO		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROS) REFERENCED TO THE APPROPRIATE DEFICIENC		(X5) COMPLETION DATE
F 309	1 3		F 3	309	483.25 Quality of Care (continued)		
	medication was disc	continued.					
	There was no evidence on the September, October and November 2008 MAR that the medication was administered to the resident.					-	
	15, 2009 at approximent Employees #8 and 9 above stated finding B2. Facility staff faile order phor to medica A physician's order of "APAP W/codeine # every 6 hours as ne tablets were dispense The physician did ne when orders were s 22, and November 2 According to the Co #3, two (2) tablets w September 1 (twice) November 22, Nove 2008.	ed to obtain the physician's ation administration for JH9. dated April 15, 2008 directed, 3 (Tylenol #3) two (2) tablets po eded for pain" for JH9. 30 sed. of renew the above cited order igned on August 21, September 24, 2008. ntrolled Drug Record Tylenol vere removed on August 24, 0, October 17, October 22, mber 24 and November 28,	· ·		 B2. Resident JH9 1. Employee involved was counseled received education regarding the facilit Pharmacy policies and procedures. 2. MARs and Controlled Substance sig Out sheets for all residents were reviewed to ensure compliance. 3. MAR documentation will be evaluated using the "Medication Pass" too of the Nursing Quality Improvement Progr The members of the Nursing QI Team will collect data on this issue and forwathat information to the DON for review and evaluation. 4. The Department Head will present a report of the data collected and any actio plans implemented to ensure sustained compliance at the monthly QI Committee which is chaired by the Administrator. 	ity's gn- pl ram. י ard י	1/31/09 1/31/09 3/31/09 4/3/09
	October and Novem resident received th				· 		
	15, 2009 at approxir	view was conducted on January mately 12:15 PM with 54. They acknowledged the as.			C. Resident JH101. Employee involved was counseled received education regarding the facili		
		d to obtain the physician's			Pharmacy policies and procedures. 2. MARs and Controlled Substance sig		1/31/09
	<u></u>				Out sheets for all residents were reviewed to ensure compliance.		1/31/09

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CENTER	S FOR MEDICARE	& MEDICAID SERVICES			OMB NO	I APPROV . 0938-03
TATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		095022	B. WING		01/1	6/2009
NAME OF PR			STF	REET ADDRESS, CITY, STATE, ZIP CODE		
WASHING	GTON NURSING FAC	LITY		2425 25TH STREET SE WASHINGTON, DC 20020		
(XA) ID	SUMMARY ST			PROVIDER'S PLAN OF CORR		(75)
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	T BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU REFERENCED TO THE APPROPRIAT	LD BE CROSS-	(X5) COMPLETI DATE
F 309	Continued From pa	ge 56	F 309	483.25 Quality of Care (cont		
	order prior to medic	ation administration for JH10.		C. Resident JH10 (continued	i)	
		ician 's order for Resident JH10,		3. MAR documentation will be		
		october 2, 2008, directed, " ery 6 hours] prn [as needed] pain		evaluated using the "Medication of the Nursing Quality Improven		
	for 4 (four) days, de	ental extractions. " 16 tablets		The members of the Nursing	QI Team	
	were dispensed.			will collect data on this issue that information to the DON f		2/24/
	On January 14, 200	9, at approximately 3: 30 PM		and evaluation.		3/31/(
		n of the medication carts on the		4. The Department Head will provide the second seco	esent	
		er package containing seven (7) mg/ 15mg (Tylenol #3) tablets		a report of the data collected and plans implemented to ensure su		4/3/0
		ed in the medication cart.		compliance at the monthly QI Co which is chaired by the Adminis	mmittee	
	tablet was removed was removed on Oc	ontrolled Drug Record, one (1) I on October 7 and one (1) tablet ctober 8, 2008, after the ontinued by the physician.				
	2008 that the medic	ence on the MAR for October cation was administered to the ced by no initials were recorded				
	15, 2009 at approxi	view was conducted on January mately 3: 45 PM with Employee wledged the above stated				
F 311 SS=E	483.25(a)(2) ACTIV	TIES OF DAILY LIVING	F 311	483.25(a)(2) Activities of Da	ily Living	
00-L	services to maintain	the appropriate treatment and or improve his or her abilities uph (a)(1) of this section.				
	This REQUIREMEN	NT is not met as evidenced by:				
	Based on observation	on, staff interview and record				

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Facility ID: WASHNURS

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<u>CENTER</u>	<u>RS FOR MEDICARE a</u>	<u>& MEDICAID SERVICES</u>			<u>OWB NO</u>	<u>. 0938-0391</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SU COMPLET	
÷.		095022	B. WING		01/1	6/2009
NAME OF PF	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STAT	TE, ZIP CODE	
		ITV		2425 25TH STREET SE		
WASHING	GTON NURSING FACIL	_++ +		WASHINGTON, DC 20	0020	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY INTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROS		(X5) COMPLETION DATE
F 311	Continued From page		F 3	11 483.25(a)(2) Activ	vities of Daily Living	
	supplemental reside facility staff failed to grooming for seven restore bladder func- management progra 1, 3, 5, 7, 10, 13, 14 S6 and S7. The findings include 1. Facility staff failed bladder continence A review of the resid quarterly Minimum E November 11, 2008 Section H1-Continent incontinent. An "Interdisciplinar 12, 2008 revealed "it the resident was def Upon further review that additional assess completed to further status per the facility A face-to-face interv Employee #6, on Ja 11:30 AM. He/she a no additional assess the Resident's #1 in that the current assess	d to complete Resident #1's assessment. dent 's clinical record revealed a Data Set (MDS), completed , that coded the resident in ' nce ' as occasionally bladder y Care-plan" dated December ncontinence" . [indicating that termined to be incontinent]. , the record lacked evidence ssments and/or screens were assess the resident's bladder y's policy. view was conducted with nuary 16, 2009 at approximately acknowledged that there were sments completed to determine continent status. He/she added assment tool was not in use at ent 's admission. The record		 done upon discow 2. Clinical records reviewed for docu continence assess made whenever r 3. Facility staff we on the facility prot Assessment. Continence assess will be evaluated u Bladder Status" too Improvement Progr The members of t will collect data or that information to and evaluation. 4. The Department a report of the data plans implemented compliance at the m 	s of all residents were imentation of a bladder isment. Corrections were necessary. ere given inservice training tocol on Continence ment and documentation sing the "Bowel and I of the Nursing Quality am. the Nursing QI Team in this issue and forward of the DON for review	1/16/09 3/31/09 3/31/09 3/31/09 3/31/09 4/3/09

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Event ID: WPBP11

Facility ID: WASHNURS

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		AND HUMAN SERVICES & MEDICAID SERVICES					APPROVED 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI			(X3) DATE SURVEY COMPLETED	
	· · ·	095022	B. WIN	IG		01/1	6/2009
NAME OF PR		<u> </u>		STR	EET ADDRESS, CITY, STATE, ZIP CODE		
WASHING	STON NURSING FACI				425 25TH STREET SE VASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETION DATE
F 311	Continued From page 2. Facility staff failed bladder continence The "Resident Admi August 20, 2008 rev was checked "yes" determined to be ind The record revealed August 8, 2008, incl resident having blac Continence]. The "Nursing Care 11, 2008 revealed ' [indicating that the incontinent]. Upon further review that additional asses completed to further status per the facility A face-to-face interv Employee #5, on Ja He/she acknowledg assessments compl #3's incontinent stat on January 12, 2009 3. Facility staff failed management progra A review of Residen "Resident Admission July 2, 2008. Under Bladder Assessment	ge 58 d to complete Resident #3's assessment. ssion Evaluation Form" dated realed that bladder incontinence indicating that the resident was continent]. d an admission MDS, completed uded an assessment of the lder incontinence [Section H- -Plan " evaluated November Care for urinary incontinence " resident was determined to be , the record lacked evidence ssments and/or screens were assess the resident's bladder y's policy. tiew was conducted with nuary 12, 2009 at 11:00 AM. ed that there were no additional eted to determine the Resident us. The record was reviewed b. d to initiate an incontinence im for Resident #5. t #5 's record revealed a n Evaluation Form" completed the section " Bowel and t and Management " the as " 6. " The legend on the		311	 483.25(a)(2) Activities of Daily 2. Resident #3 1. Bladder continence assessment done upon discovery. 2. Clinical records of all residents w reviewed for documentation of a bl continence assessment. Correctio made whenever necessary. 3. Facility staff were given inservice on the facility protocol on Continent Assessment. Continence assessment and docur will be evaluated using the "Bowel Bladder Status" tool of the Nursing Improvement Program. The members of the Nursing QI Te will collect data on this issue and for that information to the DON for rev and evaluation. 4. The Department Head will press a report of the data collected and a plans implemented to ensure susta compliance at the monthly QI Com which is chaired by the Administri 3. Resident #5 1. An incontinence management program 3. Resident #5 1. An incontinence management program 3. Facility staff were given an inser training on the facility policy on how to develop an incontinence manage program. Continence assessment and docur will be evaluated using the "Bowel Bladder Status" tool of the Nursing Improvement Program. 		1/16/09 3/31/09 3/31/09 3/31/09 4/3/09 3/6/09 3/13/09
	form documented, '				that information to the DON for revi and evaluation.	ew	3/31/09

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WPBP11

Facility ID: WASHNURS

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		AND HUMAN SERVICES & MEDICAID SERVICES				: 03/04/20 APPROVE 0938-03	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI	TIPLE CONSTRUCTION	(X3) DATE SUF COMPLET		
		095022	B. WING		01/16/2009		
NAME OF PR			s	TREET ADDRESS, CITY, STATE, ZIP CODE			
WASHING	GTON NURSING FACI	LITY		2425 25TH STREET SE WASHINGTON, DC 20020			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	ATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PRÉFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SHO REFERENCED TO THE APPROPRI/	ULD BE CROSS-	(X5) COMPLETI DATE	
F 311	incontinence manager A care plan for " Inc was initiated Decen	ng programs/likely candidate for gement program. " continence of urine and stool " nber 24, 2008. There was no dividualized incontinence	F 31	 Resident #5 (continued) The Department Head will p a report of the data collected a plans implemented to ensure s compliance at the monthly QI (which is chaired by the Admir 4. Resident #7 	present nd any action ustained Committee	4/3/09	
	• • •	view was conducted on January		A. 1. Facility staff cleaned and the resident's fingernails.	trimmed	1/13/	
	#5, who acknowled incontinence manage	Iged that no individualized gement program was initiated for ecord was reviewed January 12,		2. Facility residents identifie extensive assistance for per hygiene were inspected and assistance (i.e. cleaning an fingernails) provided.	rsonal I needed	1/13/	
	cleaning and trimmi toileting program. A. An observation o January 13, 2009 at fingernails were long the nails.	d to assist Resident #7 with ng fingernails and develop a f Resident #7 was conducted on t 9:00 AM. The resident ' s g with accumulated debris under		3. Inservice training was prosist staff responsible for providir to residents requiring extension for personal hygiene. Fingemail cleanliness will be evaluated using the "Nu Review" tool of the Nursing Qu Improvement Program. The members of the Nursing Qu	ng assistance sive assistance rsing Care ality I Team	3/13/0	
	completed on Dece	arterly MDS assessment mber 2, 2008, the resident was as requiring extensive onal hygiene.		 will collect data on this issue at that information to the DON for and evaluation. 4. The Department Head will p a report of the data collected at 	review present nd any action	3/31/09	
	B. Facility staff faile for Resident #7.	d to develop a toileting program		plans implemented to ensure s compliance at the monthly QI 0 which is chaired by the Admir B. Resident #7	Committee	4/3/09	
	Resident Admission December 11, 2007 additional bowel and completed after Dec	at #7 's record revealed a " Evaluation Form " completed There was no evidence that d bladder assessment were cember 11, 2007. Under the d Bladder Assessment and resident was		 A prompted toileting/hab program was developed for Medical records of any rescored 7-14 from the bowel assessment were reviewed documentation of prompted training. 	the resident. esident who and bladder for	3/6/09	

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI			(X3) DATE SUR COMPLETE	VEY [.]
		095022	B. WIN	IG	ŕ.	01/16	5/2009
NAME OF PR					REET ADDRESS, CITY, STATE, ZIP CODE		
WASHING	STON NURSING FACIL	JTY	2425 25TH STREET SE WASHINGTON, DC 20020				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD BI REFERENCED TO THE APPROPRIATE DE	E CROSS-	(X5) COMPLETION DATE
F 311	Candidate for promp There was no evident toileting/habit trainin Resident #7. A face-to-face interv Employee #6 on Jan He/she acknowledge needed to be cleaned prompted toileting/h initiated for Residen January 13, 2009. 5. Facility staff failed cleaning and trimmin toileting program. A. An observation of on January 14, 2008 fingernails were long the nails. According to the Qu completed on Nover coded in Section G a personal hygiene. B. Facility staff failed management program	form documented, " 7-14 bed toileting/habit training." Ince that a prompted g program was initiated for iew was conducted with huary 13, 2009 at 2:25 PM. ed that the resident's fingernails ed and trimmed and that a abit training program was not t #7. The record was reviewed I to assist Resident #10 with ng fingernails and develop a Resident #10 was conducted at 8:50 AM. The resident 's g with accumulated debris under arterly MDS assessment mber 11, 2008, the resident was as being totally dependent for I to develop an incontinence m for Resident #10.	F	311	 (continued) 3. Facility staff were given inserved of the facility Incontinence Manager Program. Toileting status will be evaluated usi "Bowel and Bladder Status" tool of the Quality Improvement Program. The members of the Nursing QI Teatwill collect data on this issue and for that information to the DON for revise and evaluation. 4. The Department Head will preserve a report of the data collected and an plans implemented to ensure sustain compliance at the monthly QI Commwhich is chaired by the Administrate 5. Resident #10 A. Facility staff cleaned and trimmethe resident's fingernails. Facility residents identified to extensive assistance for personal hygiene were inspected and nee assistance (i.e. cleaning and trimfingernails) provided. Inservice training was provided to staff responsible for providing assist to residents requiring extensive assist or personal hygiene. Fingernail cleanliness will be evaluated using the "Nursing Review" tool of the Nursing Quality Improvement Program. The members of the Nursing QI Teatwill collect data on this issue and for that information to the DON for reviet and evaluation. The Department Head will presera a report of the data collected and an plans implemented to ensure sustain for that information to the DON for reviet and evaluation. 	vice training ment ing the he Nursing ward ward ward ward hy action ned nittee or ed need al ded mming facility ance stance Care ward ward al ded mming facility ance stance	3/13/09 3/31/09 4/3/09 1/13/09 3/31/09 3/31/09 4/3/09
		t #10 ' s record revealed a " Evaluation Form " completed			compliance at the monthly QI Comm which is chaired by the Administra	nittee	4/3/09

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DEPART	MENT OF HEALTH	AND HUMAN SERVICES					APPROVED
	S FOR MEDICARE	& MEDICAID SERVICES					0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		IPLE CONSTRUCTION	(X3) DATE SUF COMPLET	
		095022	B. WIN	IG	· · · ·	01/10	5/2009
NAME OF PR	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE				
					2425 25TH STREET SE		
WASHING	GTON NURSING FACII	-11 1		\	WASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION REFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS- TAG REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
F 311	Continued From page	ne 61	F	311	1 B.		
		anagement " the resident was	•	· ·	1.An Incontinence Management	Program	
	scored as "2." The legend on the form				was developed for this resident.		1/31/09
	documented, "0-6	Poor candidate for toileting			2. Medical records of residents w	ho scored	1/31/09
		didate for incontinence			0-6 from the bowel and bladder		
	management progra	ım. "			assessment were reviewed for		
	There was no ovider	nce that an incontinence			initiation of an incontinence man	agement	
		am was initiated for Resident			program. 3.Toileting status will be evaluated u	cina the	
	#10.				"Bowel and Bladder Status" tool of th		
	A face-to-face interview was conducted with			-	Quality Improvement Program.		
					The members of the Nursing QI Tea		
		anuary 14, 2009 at 3:30 PM.			will collect data on this issue and for		2/04/00
		ed that the resident's fingernails			that information to the DON for revie and evaluation.	W	3/31/09
		nd trimming and that an			4. The Department Head will preser	nt	
		ement program was not t #7. The record was reviewed			a report of the data collected and an		
	January 13, 2009.				plans implemented to ensure sustair		4/3/09
	· · · · · · · · · · · · · · · · · · ·				compliance at the monthly QI Comm which is chaired by the Administrate		
		to assist Resident #13 with			6. Resident #13 A.	ות	
		ng fingernails and develop a			1. Facility staff cleaned and trimr	ned	1/13/09
	toileting program.				Fingernails of this resident.		
	A An observation of	f Resident #13 was conducted			2. Facility residents identified as	being	1/13/09
		at 2:30 PM. The resident 's			totally dependent for personal hy	giene	
		g with accumulated debris under			were assessed and needs attend		
	the nails.	5			3. Inservice training was provide		3/13/09
					staff responsible for providing pe		
		arterly MDS assessment			hygiene care for residents identified being totally dependent for personance of the second se		
		er 16, 2008, the resident was as requiring extensive			hygiene. Fingernail cleanliness		
	assistance for perso				will be evaluated using the "Nursing	Care	
					Review" tool of the Nursing Quality		
	B. Facility staff failed	d to develop a toileting program			Improvement Program.		
1	for Resident #13.				The members of the Nursing QI Tea will collect data on this issue and for		
					that information to the DON for revie		3/31/09
•		t #13 's record revealed a " Evaluation Form " completed			and evaluation.		
		ider the section " Bowel and			4. The Department Head will preser		
	Bladder Assessmen				a report of the data collected and an		4/3/09
					plans implemented to ensure sustair compliance at the monthly QI Comm		413109
					which is chaired by the Administra		
FORM CMS-256	67(02-99) Previous Versions O	bsolete Event ID: WPBP11		Fa	-		Page 62 of 121

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

<u>_CENTER</u>	SFOR MEDICARE	& MEDICAID SERVICES					0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SUR COMPLETE	
		095022	B. WIN	IG		01/16	5/2009
NAME OF PF	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE		
WASHIN	GTON NURSING FACI	ITY		2	425 25TH STREET SE		
				۷	VASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES F BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD E REFERENCED TO THE APPROPRIATE DE	SHOULD BE CROSS-	
F 311	Continued From page	ge 62	F	311	483.25(a)(2) Activities of Daily	Living	
	Management " the	resident was scored as "16."			(continued)	-	
		orm documented, "15-20			6. Resident #13		
÷		for retraining or individualized			B.		
	training."				1. An Incontinence Managemen		4/24/00
	There was no evide	nce that a retraining or			was developed for this resident. 2. Medical records of residents		1/31/09 3/13/09
		aining program was initiated for			16 from the bowel and bladder	who scored	3/13/08
	Resident #13.				assessment were reviewed for	initiation of	
					a retraining or individualized tra		
		view was conducted with			program.	5	
		nuary 13, 2009 at 11:00 AM.			3. Toileting status will be evaluated	using the	
		ed that the resident's fingernails d trimming and that a retraining			"Bowel and Bladder Status" tool of t	he Nursing	
		ning program was not initiated			Quality Improvement Program. The members of the Nursing QI Tea	m	
		he record was reviewed			will collect data on this issue and fo		
	January 13, 2009.				that information to the DON for revie		3/31/09
	•				and evaluation.		
		t to initiate a toileting program			4. The Department Head will prese		
	for Resident #14.				a report of the data collected and an plans implemented to ensure sustai		4/3/09
		nt #14 ' s record revealed a n Evaluation Form" completed			compliance at the monthly QI Comr which is chaired by the Administrat	nittee	4/3/09
		B. Under section "Bowel and					
		resident had an indwelling					
	catheter.						
		tober 2008 Medication					
		ord (MAR), the resident 's was discontinued on October 8,					
	2008.						
		oserved during physical therapy					
		at approximately 10:00 AM.					
		hat his/her goal was to return					
		he/she was glad the catheter nt stated that he/she calls for					
	help when there was						
	····						
	· ·						

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Facility ID: WASHNURS

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PRINTED: 03/04/2009 FORM APPROVED

_ CENTER	<u>RS FOR MEDICARE (</u>	& MEDICAID SERVICES			0	<u>MB NO.</u>	0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL	•		(X3) DATE SURVEY COMPLETED	
		095022	B. WIN	G		01/16	/2009
NAME OF PR				STR	EET ADDRESS, CITY, STATE, ZIP CODE		
	GTON NURSING FACI	ITY					
WASHIN				V	VASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CRO REFERENCED TO THE APPROPRIATE DEFICIE		(X5) COMPLETION DATE
F 311	Continued From page	ge 63	F	311	483.25(a)(2) Activities of Daily Liv	ving	
	quarterly MDS, com coded the resident i bladder incontinent.	dent ' s clinical record revealed a pleted December 18, 2008 that n ' Section H1-Continence ' as					
	A review of a care plan for "Incontinence Bowel and Bladder" dated December 18, 2008, lacked evidence that a toileting program was develop for Resident #7.						
	15, 2009 at approxir #9. He/she acknowl clinical record lacke individualized toiletin resident after the res	view was conducted on January nately 12:30 PM with Employee edged that the resident 's d evidence that an ng program was initiated for the sident 's foley catheter was ecord was reviewed January 16,			Resident #18 1. Bladder continence assessment w Completed. 2. Clinical records of all residents on unit were reviewed for documentatio	n the on of a	1/16/09 3/6/09
	 8. Facility staff failed to complete Resident #18's bladder continence assessment. A review of Resident #18's record on January 13, 2009 at 10:00 AM revealed that the "Resident Admission Evaluation Form " was not in the resident's record. There was no evidence that additional bowel and bladder assessment were 				completed bladder continence assess 3.Toileting status will be evaluated using the "Bowel and Bladder Status" tool of the Nurs Quality Improvement Program. The members of the Nursing QI Team will collect data on this issue and forward that information to the DON for review and evaluation. 4. The Department Head will present		3/31/09
	2008 revealed care incontinence of uring resident was determ	-plan " evaluated January 10, for " Alteration in elimination: e and stool " . [indicating that the ined to be incontinent].			a report of the data collected and any ac plans implemented to ensure sustained compliance at the monthly QI Committee which is chaired by the Administrator		4/3/09
	December 18, 2008	, included an assessment of the Ider incontinence [Section H-					

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Event ID: WPBP11

Facility ID: WASHNURS

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		AND HUMAN SERVICES				FORM	APPROVED	
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 095022		(X2) MULTIPLE CONSTRUCTION			OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED			
		095022	B. WING			01/16/20		
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	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS- TAG REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE	
F 311	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY		F	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-		Program s on the ure using the he Nursing am rward ew nt ny action ned nittee	3/6/09 3/31/09 3/31/09 4/3/09	
		r toileting and in Section H ontinent of bowel and bladder.						

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Facility ID: WASHNURS

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

PRINTED: 03/04/2009 FORM APPROVED OMB NO. 0938-0391

						OMD NO. 0300-0391		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		095022	B. WIN	B. WING		01/16/2009		
NAMÉ OF PR				STR	REET ADDRESS, CITY, STATE, ZIP CODE			
WASHINGTON NURSING FACILITY				2425 25TH STREET SE TABLE SE T				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF O PREFIX (EACH CORRECTIVE ACTION TAG REFERENCED TO THE APPRO		E CROSS-	(X5) COMPLETION DATE	
F 311	Continued From page 65 A face-to-face interview was conducted on January 15, 2009 at 2:15 PM with Employee #5, who acknowledged that an individualized toileting program was not initiated for Resident #19. The record was reviewed January 12, 2009.		F	311	 483.25(a)(2) Activities of Daily 10. Resident #20 A. 1. Facility staff cleaned and trime Fingernails of this resident. 2. Facility residents identified as 	ned	1/13/09	
	10. Facility staff faile	ed to assist Resident #20 with ng fingernails and develop an		·	totally dependent for personal hy were assessed and needs attend 3. Inservice training was provide staff responsible for providing per hygiene care for residents identi	/giene ded to d to facility ersonal		
	on January 14, 2009	f Resident #20 was conducted 9 at 12:00 PM. The resident ' s g with accumulated debris under			being totally dependent for person hygiene. Fingernail cleanliness will be evaluated using the "Nursing Review" tool of the Nursing Quality Improvement Program.	onal		
	assessment comple resident was coded dependent for perso		·		The members of the Nursing QI Tea will collect data on this issue and for that information to the DON for revie and evaluation. 4. The Department Head will presen	ward w	3/31/09	
	management progra	d to develop an incontinence am for Resident #20. ht #20 ' s record revealed a "			a report of the data collected and ar plans implemented to ensure sustain compliance at the monthly QI Comm which is chaired by the Administra	ned nittee	4/3/09	
	Resident Admission December 19, 2008 Bladder Assessmen	Evaluation Form " completed . Under the section " Bowel and it and Management " the l as " 3. " The legend on the			 B. 1.An Incontinence Management Prowas developed. 2. Medical records of residents on the second secon	-	3/6/09	
	form documented, "	' 0-6 Poor candidate for toileting didate for incontinence			same unit were reviewed to ensure compliance. 3.Toileting status will be evaluated u "Bowel and Bladder Status" tool of the Oueling Improvement Decarem		3/31/09	
		nce that an incontinence am was initiated for Resident			Quality Improvement Program. The members of the Nursing QI Tea will collect data on this issue and for that information to the DON for revie	ward	3/31/09	
	Employee #12 on Ja	view was conducted with anuary 15, 2009 at 9:45 AM. ed that the resident's			 and evaluation. 4. The Department Head will present a report of the data collected and any ac plans implemented to ensure sustained compliance at the monthly QI Committee which is chaired by the Administrator 		4/3/09	

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Facility ID: WASHNURS

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<u> </u>	<u>RS FOR MEDICARE (</u>	& MEDICAID SERVICES				<u>OMB NO.</u>	<u>. 0938-0391</u>
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI			(X3) DATE SUR COMPLETE	
		095022	B. WIN	IG		01/16	5/2009
NAME OF PR				STR	EET ADDRESS, CITY, STATE, ZIP CODE		
WASHING	GTON NURSING FACIL	LITY		2	425 25TH STREET SE VASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD B REFERENCED TO THE APPROPRIATE DE	E CROSS-	(X5) COMPLETION DATE
F 311	Continued From page	ge 66	F	311		Living	
		leaning and trimming and that			11. Resident #23		
		nagement program was not			1.An Incontinence Management	Program	3/6/09
		t #20. The record was reviewed			was developed.		2/24/00
	January 15, 2009.				Medical records of residents of same unit were reviewed to ensure		3/31/09
	11 Facility staff faile	d to complete Resident #23's			compliance.	ле	
	bladder continence	•			3. Toileting status will be evaluate	ed usina	3/31/09
					The "Bowel and Bladder Status"	Ŷ I	
		t #23 ' s medical record on			Nursing Quality Improvement Pr		
		10:00 AM revealed that a "			The members of the Nursing QI		
		Evaluation Form " was not as no evidence that additional			will collect data on this issue and		
		as no evidence that additional			that information to the DON for r	eview	
	after November 30,				and evaluation.		
					 The Department Head will pro a report of the data collected and 		
		a significant change in status			plans implemented to ensure su		4/3/09
		tober 3, 2008, included an			compliance at the monthly QI Co		
		esident having bladder			which is chaired by the Adminis		
	incontinence [Section	in H-Continencej.					
		Plan " evaluated January 14, for " Incontinence of urine ".			•		
	[indicating that the reincontinent].	esident was determined to be					
	The "Nursing Mont	hiy Summary Note " dated					
		documented that the resident					
		ontinent of bowel and bladder.					
		hly Summary Note " dated					
		documented that resident was					
	incontinent of bowel						
	Upon further review	, the record lacked evidence					
		ssments and/or screens were					
		assess the resident's bladder.			· .		
					· · · · · · · · · · · · · · · · · · ·		
		view was conducted with					
	Employee #5 on Jar	nuary 14, 2009 at 10:30 AM.			, ·		

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PRINTED: 03/04/2009 FORM APPROVED OMB NO 0938-0391

_CENTER	<u>(SFOR MEDICARE</u>	& MEDICAID SERVICES					0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI			(X3) DATE SUF COMPLET	
		095022	B. WINC	G <u>·</u>		01/10	6/2009
NAME OF PR	OVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP CODE		
WASHING	STON NURSING FACI	LITY			25 25TH STREET SE		
				vv	ASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	ATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD I REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETION DATE
F 311	- · • • •		F 3	311	483.25(a)(2) Activities of Daily	Living	
	assessments comp	ed that there were no additional leted to determine the Resident atus. The record was reviewed			1.An Incontinence Managemen was developed.	t Program	3/6/09
	January 14, 2009.	led to initiate an individualized			2. Medical records of residents same unit were reviewed to ens compliance.		3/31/09
	toileting program fo the care plan/program not be trained. Review of an annua quarterly MDS asse October 13, 2008 of	r Resident # 24 or to indicate in ess note that the resident could al MDS dated April 16, 2008, essments dated July 5 and coded the resident as being			3. Toileting status will be evalua The "Bowel and Bladder Status Nursing Quality Improvement P The members of the Nursing QI will collect data on this issue an that information to the DON for	" tool of the rogram. Team d forward	3/31/09
	Section H (Continer A review of the Inco 10, 2009 revealed t under approaches: incontinence; Good wetness/BM [Bowe	ntinent Care Plan dated January he following documentation " Briefs to manage skin care; Check for Movement] q 2 hrs and prn d as needed]; Use skin barrier			 and evaluation. 4. The Department Head will prain a report of the data collected an plans implemented to ensure su compliance at the monthly QI C which is chaired by the Administration of the data collected and the monthly QI C which is chaired by the Administration of the data collected and the monthly QI C which is chaired by the Administration of the data collected and the data collected a	resent d any action ustained ommittee	4/3/09
	Employee # 8 on Ja AM. He/she acknow	view was conducted with nuary 16 at approximately 11:00 wledged that an individualized im was not initiated for this			13. Resident #271.An Incontinence Managemen was developed	t Program	3/6/09
		d was reviewed on January 16,			 Medical records of residents same unit were reviewed to ens compliance. 		3/31/09
	13. Facility staff faile Resident #27.	ed to initiate toileting program for			3. Toileting status will be evaluated the "Bowel and Bladder Status"	' tool of the	3/31/09
· · ·	"Bowel and Bladder completed Septemb scored as "11" The	at #27 ' s record revealed a Assessment and Management" per 11, 2008. The resident was legend on the form documented, prompt toileting programs/habit			Nursing Quality Improvement P The members of the Nursing QI will collect data on this issue an that information to the DON for and evaluation. 4. The Department Head will pr a report of the data collected an	Team d forward review resent d any action	
	A further review of t	he resident ' s clinical record			plans implemented to ensure su compliance at the monthly QI C which is chaired by the Adminis	ommittee	4/3/09

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Facility ID: WASHNURS

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PRINTED: 03/04/2009 FORM APPROVED OMB NO 0938-0391

	<u>KS FOR MEDICARE (</u>	& MEDICAID SERVICES					<u>. 0930-0391</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		ISTRUCTION	(X3) DATE SUI COMPLET	
		095022	B. WING			01/1	6/2009
NAME OF PF			:	TREET AD	DRESS, CITY, STATE, ZIP CODE		
WASHIN	GTON NURSING FACI	LITY			TH STREET SE NGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORREC EACH CORRECTIVE ACTION SHOULD EFERENCED TO THE APPROPRIATE) BE CROSS-	(X5) COMPLETION DATE
F 311	Continued From page	ge 68	F 3	11 483.	.25(a)(2) Activities of Dail	ly Living	· ·
		MDS, completed December 18, resident in 'Section H1- dder incontinent.					
	A care plan for "Inco 2008 lacked eviden	ontinence" dated December 24, ce that a prompted toileting/habit		11	Resident# F1		
		s initiated for Resident #27.		1.Ar	Incontinence Manageme	nt Program	3/6/09
	15, 2009 at 12:30 P	riew was conducted on January M with Employee ledged that the resident ' s		2. M sam	ledical records of residents le unit were reviewed to en upliance.		3/31/09
		d evidence that an ng program was initiated for ecord was reviewed January 16,		3.To The Nurs The	bileting status will be evalua "Bowel and Bladder Statu sing Quality Improvement I members of the Nursing Q	s" tool of the Program. QI Team	3/31/09
	14. Facility staff fail for Resident F1.	ed to initiate toileting program		that and	collect data on this issue a information to the DON for evaluation.	r review	
	"Resident Admission December 2, 2008. Bladder Assessmen resident was scored	It F1's record revealed a In Evaluation Form" completed Under the section " Bowel and It and Management " the as "12". The legend on the 7-14 Candidate for prompted ig."		a re plan com	The Department Head will port of the data collected a s implemented to ensure s pliance at the monthly QI (th is chaired by the Admin	nd any action sustained Committee	4/3/09
	December 24, 2008	continence of urine" was initiated . There was no evidence that leting program was initiated.					
	15, 2009 at 11:35 A #13, who acknowle	dged that no individualized as initiated for Resident F1. The					
	~.						

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Event ID: WPBP11

Facility ID: WASHNURS

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		AND HUMAN SERVICES	·			FORM	APPROVED 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		LE CONSTRUCTION	(X3) DATE SUR COMPLETE	VEY
		095022	B. WIN	G	·	01/16	5/2009
NAME OF PR					EET ADDRESS, CITY, STATE, ZIP CODE		
WASHING	STON NURSING FACIL	ITY			425 25TH STREET SE VASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIATE DE	E CROSS-	(X5) COMPLETION DATE
F 311	Continued From pag 15. Facility staff faile for Resident S5. A review of Residen Resident Admission October 25, 2008. U Bladder Assessmen resident was scored form documented, " retraining or individu There was no evider individualized trainin Resident S5. A face-to-face interv Employee #7 on Jan He/she acknowledge program was not init record was reviewed 16. Facility staff faile cleaning and trimmir On January 13, 2009 observed outside the Resident S6 's finge accumulated debris about his/her nails, F asked them to cut m hasn 't happened ye According to a quart completed November required extensive a hygiene.	ye 69 ed to develop a toileting program t S5's record revealed a " Evaluation Form " completed Under the section " Bowel and t and Management " the as " 19. " The legend on the 15-20 Possible candidate for ialized training. " the that a retraining or ig program was initiated for iew was conducted with huary 16, 2009 at 8:45 PM. ed that an incontinence training iated for Resident S5. The d January 16, 2009. ed to assist Resident S6 with ng of fingernails. P at 10:10 AM, Resident S6 was e dining room on the 2nd floor. er nails were thick, long and had under the nails. When queried Resident S6 stated, " I ' ve y fingernails many times. It		311	 483.25(a)(2) Activities of Daily 15. Resident #S5 1. An Incontinence Management was developed. 2. Medical records of residents of same unit were reviewed to ensure compliance. 3. Toileting status will be evaluated. The "Bowel and Bladder Status". Nursing Quality Improvement Protect The members of the Nursing QI will collect data on this issue and that information to the DON for reand evaluation. 4. The Department Head will prease a report of the data collected and plans implemented to ensure sust compliance at the monthly QI Cowhich is chaired by the Administ 16. Resident# S6 1. Facility staff cleaned and trimmed resident's fingernails. 2. Facility residents identified to be requiring extensive assistance w/ personal hygiene needs were assand needs attended to. 3. Inservice training was provided to staff responsible for providing personal hygiene. Fingernail cleanliness will be evaluated using the "Nursing Review" tool of the Nursing Quality Improvement Program. The members of the Nursing QI Tea will collect data on this issue and for that information to the DON for revie and evaluation. 4. The Department Head will preserve the nursing QI Tea will collect data on this issue and for that information to the DON for revie and evaluation. 4. The Department Head will preserve the nursing QI Tea will collect data on this issue and for that information to the DON for revie and evaluation. 4. The Department Head will preserve the other of the nursing QI Tea will collect data on this issue and for that information to the DON for revie and evaluation. 	Living Program n the ire ed using tool of the ogram. Team forward eview esent any action stained mmittee rrator sessed facility nal as Care mward w	3/6/09 3/31/09 3/31/09 4/3/09 1/14/09 1/13/09 3/13/09 3/31/09
					a report of the data collected and an plans implemented to ensure sustair compliance at the monthly QI Comm	ned	4/3/09

Event ID: WPBP11

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Facility ID: WASHNURS

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			•	OMB NO.	0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI			(X3) DATE SUR COMPLET	
			A. 001	LDING			
	1	095022	B. WIN	IG		01/1(6/2009
NAME OF PR				STR	EET ADDRESS, CITY, STATE, ZIP CODE		
					425 25TH STREET SE		
WASHIN	GTON NURSING FACI	LITY		V	VASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES FBE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIATE DEI	E CROSS-	(X5) COMPLETION DATE
F 311	Continued From page	ge 70	F	311	483.25(a)(2) Activities of Daily	Living	
	cleaning and trimmi	ng of fingernails.			17. Resident#S7	•	
					1. Facility staff cleaned and trimr	ned	1/14/09
	On January 15, 200	9 at 2:30 PM, Resident S7 was			Resident's fingernails,		
		e dining room on the 1st floor.			2. Facility residents identified to t	be	1/13/09
		er nails were jagged and had			requiring extensive assistance w		
	accumulated debris	under the nails. When queried			assessed and needs attended to	-	
	about his/her nails,	Resident S7 stated, " They look			3. Inservice training was provided to	facility	3/13/09
	pretty bad. "				staff responsible for providing persor		
					hygiene care for residents identified	as	
		nual MDS assessment			being totally dependent for personal		
		er 8, 2008, Resident S7 was			hygiene. Fingernail cleanliness	0	
		as requiring extensive			will be evaluated using the "Nursing Review" tool of the Nursing Quality	Care	
	assistance with pers	sonal hygiene.			Improvement Program.		
F 314	483.25(c) PRESSU	RE SORES			The members of the Nursing QI Tea	m	
SS=D					will collect data on this issue and for		
	Based on the comp	rehensive assessment of a			that information to the DON for revie	w	3/31/09
		must ensure that a resident who			and evaluation.		
	enters the facility wi	thout pressure sores does not			4. The Department Head will preser		
		pres unless the individual's			a report of the data collected and an		412100
		monstrates that they were			plans implemented to ensure sustair		4/3/09
		resident having pressure sores			compliance at the monthly QI Comm 483.25(c.) Pressure Sores	intee	
		treatment and services to			1. The staff member involved wa		
-		event infection and prevent new			-	-	1/31/09
	sores from developi	ny.			counseled and given 1:1 inservic 2. Nursing staff from other units	с.	1/21/08
					were given inservice training in prop	er wound	
		IT is not met as evidenced by:			techniques before and after	,	1/16/09
		n is not met as evidenced by.			each wound treatment.		
					3. Wound treatments will be observe		0.004.000
		ons for three (3) of six (6) wound			by ADONs, Clinical Mgrs, & Nursing	hainuss	3/31/09
		ons, it was determined that			supervisors to ensure that proper teo were used during the treatment. Date		
		: accurately code a pressure			through the Nursing Quality Improve		
		dents and follow clean e wound treatment for two (2)			Program's Treatment Observation Te		
	residents. Resident				Will be forwarded to the Director of N		
					and her QI team for evaluation.		
	The findings include	• · · ·			4. The Department Head will present		
		··· ·			a report of the data collected and any action plans implemented to ensure	•	
	1. Facility staff failer	t to follow clean technique			sustained compliance at the monthly		
		tment for Resident #20.			Quality Improvement Committee which		4/3/09
					is chaired by the Administrator		

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		& MEDICAID SERVICES			OMB NO	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SUF COMPLET	
		095022	B. WING		01/1	6/2009
	OVIDER OR SUPPLIER	LITY		REET ADDRESS, CITY, STATE, ZIP CODI 2425 25TH STREET SE WASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION SH REFERENCED TO THE APPROPRI	HOULD BE CROSS-	(X5) COMPLET DATE
F 314	Continued From pa	ge 71	F 314	4 483.25(c.) Pressure Sore	s (continued)	
	January 14, 2009 a ischial and sacral w	observation was conducted on tt 12:00 PM. The resident had an yound. Employee #23 completed		 Resident #27 The staff member invol counseled and given 1:1 in 	nservice.	1/31/0
		eatment and failed to wash gloves before beginning the acral wound.		 Nursing staff from other ur were given inservice training staging Wound treatments will be of 	in proper wound	3/31/0
	Employee #23 faile bedside table that we treatment equipment 2. Facility staff faile for Resident #27. A "Weekly Wound 29, 2008 coded an	e sacral wound treatment, d to clean the resident ' s was used to house wound nt. d to accurately stage a pressure I Progress Report " dated July initial observation of a Stage III e 1.5 cm x 4 cm x 0.1cm.		 by ADONs, Clinical Mgrs, & I supervisors to ensure that pri and proper staging was used through the Nursing Quality I Program's Treatment Obserview Will be forwarded to the Direct and her QI team for evaluation competencies. 4. The Department Head 	Nursing oper techniques . Data collected mprovement ration Tool ctor of Nurses on to ensure will present	3/31/0
	According to "Press and Prevention" by and Human Service thickness skin loss dermis. The ulcer i clinically as an abra Stage III: Full thickr or necrosis of subc down to but not thre ulcer presents clinic	sure Ulcers in Adults: Prediction the U.S. Department of Health es, page 1, "Stage II: Partial involving epidermis and/or s superficial and presents asion, blister or shallow crater. ness skin loss involving damage utaneous tissue that may extend bugh underlying fascia. The cally as a deep crater with or g of adjacent tissue."	· ·	a report of the data collect action plans implemented sustained compliance at th Quality Improvement Com is chaired by the Administ	to ensure ne monthly imittee which	4/3/0
		ence in the record that ge or necrosis of subcutaneous				
	approximately 1:15	bserved on January 15, 2009 at PM during a wound treatment to ulcer by Employee #27.				

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DEPART	MENT OF HEALTH	AND HUMAN SERVICES					: 03/04/2009 APPROVED
STATEMENT	S FOR MEDICARE	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIÅ IDENTIFICATION NUMBER:			PLE CONSTRUCTION	OMB NO (X3) DATE SUF COMPLET	
		095022	A. BUII B. WIN			0.4.44	
		000012				01/10	6/2009
	GTON NURSING FACIL	JITY		24	EET ADDRESS, CITY, STATE, ZIP CODE 425 25TH STREET SE VASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREF TAG	L IX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD E REFERENCED TO THE APPROPRIATE DE	E CROSS-	(X5) COMPLETION DATE
F 314	Continued From pag	ge 72	F	314	483.25(c.) Pressure Sores (cor	ntinued)	
	Employee #9 on Jar 4:20 PM. He/she ac should have been ic record was reviewed 3. Facility staff failed during a wound treat A wound treatment January 15, 2009 at placed a package of Isagel (hand cleans saline on a non-perr resident ' s bedside After completion of t #22 removed the so permeable barrier, p gauze, the bottle of bottle of Isagel direct stand. Employee #2 treatment waste, ret and placed the pack the bottle of Isagel a saline in the treatment	to follow clean technique tment for Resident S2. observation was conducted on 11:45 AM. Employee #22 f 4 x 4 gauze pads, bottle of er) and bottle of normal sterile neable barrier on top of the	•		 Resident S2 The staff involved was counse given a 1:1 inservice. Nursing staff from other units were given inservice training in techniques before and after each wound treatment. Wound treatments will be obs by ADONs, Clinical Mgrs, & Nur supervisors to ensure that prope were used during the treatment. through the Nursing Quality Imp Program's Treatment Observatio Will be forwarded to the Director and her QI team for evaluation. The Department Head will pr a report of the data collected an action plans implemented to ensist sustained compliance at the mo Quality Improvement Committee is chaired by the Administrator 	erved sing er technique Data colle rovement on Tool of Nurses esent d any sure nthly	3/31/09 es
F 323 SS=D	The facility must ensenvironment remain is possible; and eac	ITS AND SUPERVISION sure that the resident s as free of accident hazards as h resident receives adequate istance devices to prevent	F	323	483.25(h) Accidents and Supe	rvision	
					· · ·		

Facility ID: WASHNURS

If continuation sheet Page 73 of 121

483.25(h) Accidents and Supervision (continued)

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1. Extension Cords

1. Extension cords were removed upon discovery and replaced with a surge protector.

2. All residents' rooms were searched for the use of extension cords. No other instances were found.

1/16/09

1/16/09

 Extension cord use will be monitored by the Maintenance Quality Improvement Team. Any data collected on this issue will be forwarded to the Director of Maintenance for his review and evaluation.
 The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator

2. Wall Outlet Cover

1. Wall outlet cover were replaced upon 1/2 discovery.

2. All residents' rooms were searched for the missing outlet covers. No other instances were found.

3. Missing outlet covers will be monitored by the Maintenance Quality Improvement Team. Any data collected on this issue will be forwarded to the Director of Maintenance for his review and evaluation.

4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator 1/16/09

4/3/09

1/16/09

4/3/09

IMENT OF HEALTH	AND HUMAN SERVICES					APPROVED
RS FOR MEDICARE &					OMB NO.	0938-0391
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		•		(X3) DATE SUR COMPLETE	
	095022	B. WIN	IG		01/16	5/2009
			í i			
GTON NURSING FACIL	ITY					
(EACH DEFICIENCY MUST	BE PRECEDED BY FULL REGULATORY		і <u> </u>	PROVIDER'S PLAN OF CORRECTIN (EACH CORRECTIVE ACTION SHOULD B	E CROSS-	(X5) COMPLETION DATE
This REQUIREMEN Based on observation review, it was detern maintain a hazard fm by: extension cords electrical socket fact in a resident's room, unlocked and unatter in a side rail and me (1) medication cart. The findings include 1. Extension cords w residents' rooms: Room 233 plugged i approximately 2:25 I Room 205 plugged i 2:50 PM on January 2. A wall outlet cove first floor dining room 10:50 AM. 3. A rug with a non-s room 357 on Januar These findings were #11 and 29, 30 at th 4. Facility staff failed that were left unatter A. During a wound th January 14, 2009 at Employee #23 remo	T is not met as evidenced by: on, staff interview and record nined that facility staff failed to be environment as evidenced in residents' rooms, a missing e plate, a non-skid backed rug four (4) treatment carts left nded, Resident #19's foot stuck dication left unattended on one were observed in the following nto a multiple plug device at PM on January 13, 2009. nto a radio at approximately 13, 2009. r was observed missing in the n January 14, 2009 at skid backing was observed in y 13, 2009 at 11:05 AM. acknowledged by Employees e time of the observations. to lock four (4) treatment carts nded. reatment observation on 12:00 PM on unit 3 South, ved wound treatment items	F	323	 (continued) 3. Rug 1. The throw rug was removed to resident upon discovery. 2. All resident rooms were evalue the presence of a throw rug with non-skid backing. No other issue uncovered. 3. Housekeeping staff were insee on the need to report the presence of a throw rug without a non-skid backing staff and the housekeeping staff and the housekeeping staff and the housekeeping staff and the housekeeping of this issue will be done by the Housekeeping for her review and evaluation. 4. The Department Head will preareport of the data collected and action plans implemented to ensist sustained compliance at the more Quality Improvement Committee is chaired by the Administrator 4. Locking of treatment carts. A. 1. Treatment carts found unlock time of the survey were locked pupon discovery. 2. All treatment carts were asses for ability to be locked and being 	by the lated for lout a es were erviced ce of acking to eeping may be he data Director of lesent d any ure hthly which ed at the romptly ssed locked	1/16/09 1/31/09 4/3/09 1/16/09 1/31/09
	RS FOR MEDICARE & OF DEFICIENCIES F CORRECTION ROVIDER OR SUPPLIER GTON NURSING FACIL SUMMARY STA (EACH DEFICIENCY MUST OR LSC IDE Continued From pag This REQUIREMEN Based on observation review, it was detern maintain a hazard from by: extension cords electrical socket face in a resident's room, unlocked and unatter in a side rail and me (1) medication cart. The findings include 1. Extension cords we residents' rooms: Room 233 plugged i approximately 2:25 F Room 205 plugged i 2:50 PM on January 2. A wall outlet cover first floor dining room 10:50 AM. 3. A rug with a non-se room 357 on Januar These findings were #11 and 29, 30 at the 4. Facility staff failed that were left unatter A. During a wound tr January 14, 2009 at Employee #23 remo	F CORRECTION IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: 095022 ROVIDER OR SUPPLIER GTON NURSING FACILITY SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 73 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, it was determined that facility staff failed to maintain a hazard free environment as evidenced by: extension cords in residents' rooms, a missing electrical socket face plate, a non-skid backed rug in a resident's room, four (4) treatment carts left unlocked and unattended, Resident #19's foot stuck in a side rail and medication left unattended on one (1) medication cart. The findings include: 1. Extension cords were observed in the following residents' rooms: Room 233 plugged into a multiple plug device at approximately 2:25 PM on January 13, 2009. Room 205 plugged into a radio at approximately 2:50 PM on January 13, 2009. 2. A wall outlet cover was observed missing in the first floor dining room January 14, 2009 at	AS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA (X2) M OF DEFICIENCIES FOORECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) M A BUI 095022 (X2) M ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREF TAGE Continued From page 73 F This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, it was determined that facility staff failed to maintain a hazard free environment as evidenced by: extension cords in residents' rooms, a missing electrical socket face plate, a non-skid backed rug in a resident's room, four (4) treatment carts left unlocked and unattended, Resident #19's foot stuck in a side rail and medication left unattended on one (1) medication cart. The findings include: 1. Extension cords were observed in the following resident's rooms: Room 203 plugged into a multiple plug device at approximately 2:25 PM on January 13, 2009. Room 205 plugged into a radio at approximately 2:50 PM on January 13, 2009. 2. A wall outlet cover was observed missing in the first floor dining room January 14, 2009 at 10:50 AM. 3. A rug with a non-skid backing was observed in room 357 on January 13, 2009 at 11:05 AM. These findings were acknowledged by Employees #11 and 29, 30 at the time of the observations. 4. Facility staff failed to lock four (4) treatment carts that were left unattended. A. During a wound treatment observation on Janu	35 FOR MEDICARE & MEDICAID SERVICES (X2) MULTIL OF DEFICIENCIES FORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIL 095022 B. WING	RS FOR MEDICARE & MEDICAID SERVICES OF DEFLEXCES OPECT OPECT OPECT OPECT OPECT OPECT REACH DEFLORMENT STATEMENT OF DEFLICENCIES (EACH DEFLORMENT BE PRECIDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 73 Continued From page 73 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, it was determined that facility staff failed to maintain a hazard free any on-skid backed rug in a resident's room, four (4) treatment carts left unicked and unattended, Resident #19 s foot stuck in a side rail and medication left unattended on one (1) medication cart. The findings include: 1. Extension cords were observed in the following resident's room; stail and medication left unattended on one (1) medication cart. 1. Extension cords were observed in the following resident's room; 13, 2009. 2. A wall outlet cover was observed missing in the first floor dining room January 14, 2009 at 10:50 AM. 3. A rug with a non-skid backing was observed in room 357 on Janu	MENT OF HEALTH AND HUMAN SERVICES FORM SFOR MEDICARE & MEDICARE SECTION SERVICES OWE NO. or descrictions (x1) PROVERSUPPLENCIA. DEWTIFICATION NUMBER (x2) MULTIPLE CONSTRUCTION A BULDNOG (x3) MUC OWDER OR SUPPLER STREET ADDRESS, GITY, STRE. 29 CODE 2425 2514 STREET SE GOTON NURSING FACILITY STREET ADDRESS, GITY, STRE. 29 CODE 2425 2514 STREET SE EACH DERICATE SET OF DEPICENCES DEPICIPLENCES MASHINGTON, DC 20020 EACH DERICATE CODE DEPICENCES DEPICIPLENCE TO THE APPROPRIATE DEFICIENCY OR LSC IDENTIFYING MERCHILLTONY OR LSC IDENTIFYING MERCHILLTONY TAG PEOWDER SPLAN OF CORRECTION PEOWDER PLAN OF CORRECTION INFORMATION DO C 20020 This REQUIREMENT is not met as evidenced by: the anazyta and medication left facility staff failed to maintain a hazard free environment as evidenced by: extension cords in resident #195 foot stuck in a side rail and medication left unattended on one (1) medication cart. F 323 483.26(h) Accidents and Supervision (2) All resident rooms: The data supproximately 22.5 PM on January 13, 2009. Room 233 plugged into a mutipe plug evice at that for adming room January 14

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Facility ID: WASHNURS

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		AND HUMAN SERVICES				FORM	APPROVED
		& MEDICAID SERVICES					0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SUF COMPLET	
		095022	B. WIN	IG		01/10	5/2009
NAME OF PR				STR	EET ADDRESS, CITY, STATE, ZIP CODE		
WASHING	GTON NURSING FACIL	.ITY			425 25TH STREET SE		
				V	VASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD BI REFERENCED TO THE APPROPRIATE DE	E CROSS-	(X5) COMPLETION DATE
F 323	resident 's room. E treatment cart again resident 's room and treatment cart was le When the wound tre- resident 's door was were observed in the the treatment cart. Items contained in th cart included tubes of ointment, Urea 40% wound dressing oint Valerate 0.2% ointm The treatment cart w presence of Employ- wound treatment wa B. During a wound treat cart. Employee #22 towards the wall by the hallway on 1 North a The treatment cart w unattended. After the completed, the reside (1) resident was sitti treatment cart. The top drawer of the tubes of Collagen hy ointment. The treatment cart w	mployee #23 positioned the st the wall in the hallway by the d closed the door. The eft unlocked and unattended. atment was completed, the s opened and two (2) residents e hallway in close proximity to the top drawer of the treatment of Santyl ointment, Bacitracin cream, Collagen hydrogel ment and Hydrocortisone tent. vas observed unlocked in the ee #23 immediately after the is completed. reatment observation on 11:45 AM. Employee #22 atment items from the treatment turned the cart drawers the resident 's room in the and closed the resident 's door. vas left unlocked and he wound treatment was lent 's door was opened. One ing in a wheelchair next to the e treatment cart contained vdrogel wound dressing	F	323	 (continued) 4. Locking of treatment carts is 3. Inservice training was given to staff about the importance of ma sure that treatment carts are lock when not in use for safety reason Monitoring of the locking of treat carts will be done through the Nu Quality Improvement Team and "Treatment Observation" tool. R of their data collection will be brot the Director of Nurses for her revevaluation. 4. The Department Head will preare a report of the data collected and action plans implemented to ensisustained compliance at the mor Quality Improvement Committee is chaired by the Administrator B. 1. Treatment carts found unlock time of the survey were locked pupon discovery. 2. All treatment carts were asse for ability to be locked and being when in use of being stored. No issues were found 3. Inservice training was given to staff about the importance of ma sure that treatment carts are lock when not in use for safety reason Monitoring of the locking of treat carts will be done through the Nu Quality Improvement Team and "Treatment Observation" tool. R of their data collection will be brocking of treat carts will be done through the Nu Quality Improvement Team and "Treatment Observation" tool. R of their data collection will be brocking of treat carts will be done through the Nu Quality Improvement Team and "Treatment Observation" tool. R 	(continued) o facility king ked ns. ment ursing their esults ought to view and esent d any ure nthly which ed at the romptly ssed locked o other o facility king ked ns. ment ursing their esults ought to	3/31/09 4/3/09 1/16/09 1/31/09 3/31/09
					the Director of Nurses for her revealuation.	view and	

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Event ID: WPBP11

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		AND HUMAN SERVICES				FORM	: 03/04/2009 APPROVED
STATEMENT	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) ML A. BUIL			(X3) DATE SUF COMPLET	
		095022	B. WING	3		01/10	5/2009
NAME OF PR		· · · ·			EET ADDRESS, CITY, STATE, ZIP CODE 425 25TH STREET SE		
WASHING	STON NURSING FACIL	JITY			ASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD B REFERENCED TO THE APPROPRIATE DE	E CROSS-	(X5) COMPLETION DATE
F 323	C. During a wound t January 15, 2009 at removed wound trea cart. Employee # 27 towards the door of hallway on 3 North. opened. Resident # away from the entry was pulled. The trea and unattended. Sev walking up and dow dinning room. The contents of the following wound dre Bacitracin, Collagen cream. The treatment cart w unattended in the pr immediately after the completed. Employee treatment cart in the A-face-to-face interv Employee# 27 on Ja approximately 2:45 ft the treatment cart w D. During a tour of th at approximately 10: Employee #10, it wa left the treatment cart would be a source of the front of room 310, in Several residents woo	reatment observation on 1:15 PM, Employee #27 atment items from the treatment 7 turned the cart 's drawers the resident 's room in the The resident 's door was left 27 's bed was by the window door and the privacy curtain tment cart was left unlocked veral residents were observed in the hallway returning from the top drawer included the ssing ointments: Accuzyme, hydrogel Santyl, and Urea 40% vas observed unlocked and esence of Employee #27 e wound treatment was the #27 eventually secured the clean utility room. iew was conducted with inuary 15, 2009 at PM. He/she acknowledged that as not locked. the facility on January 16, 2009 35 AM, in the presence of s observed that Employee #30 rt unlocked and unattended in the hallway on 3 South. ere observed walking up and turning from the dinning room	F 3	323	 483.25(h) Accidents and Super (continued) B. (continued) 4. The Department Head will presend a report of the data collected and an action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee whiles chaired by the Administrator C. 1. Treatment carts found unlock time of the survey were locked pupon discovery. 2. All treatment carts were assere for ability to be locked and being when in use of being stored. Not issues were found 3. Inservice training was given to fact staff about the importance of making sure that treatment carts are locked when not in use for safety reasons. Monitoring of the locking of treatmer carts will be done through the Nursin Quality Improvement Team and their "Treatment Observation" tool. Result of their data collection will be brough the Director of Nurses for her review evaluation. 4. The Department Head will presend a report of the data collected and an action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee whiles chaired by the Administrator D. 1. Treatment carts found unlock time of the survey were locked pupon discovery. 2. All treatment carts found unlock time of the survey were locked pupon discovery. 3. All treatment carts were assered for ability to be locked and being when in use of being stored. Notice were assered for ability to be locked and being when in use of being stored. Notice were assered for ability to be locked and being when in use of being stored. Notice were found asserts were found asserts were found asserts were assered for ability to be locked and being when in use of being stored. Notice were found asserts for ability to be locked and being when in use of being stored. Notices were found asserts we	nt ly y ich led at the romptly ssed locked o other cility o th lts nt to y ich ed at the romptly ssed locked o other cility and nt ly y ich	4/3/09 1/16/09 1/31/09 3/31/09 4/3/09 1/16/09 1/31/09

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		AND HUMAN SERVICES				FORM	03/04/2009 APPROVED 0938-0391
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		PLE CONSTRUCTION G	(X3) DATE SUF COMPLETI	RVEY
		095022	B. WIN	G		01/16	5/2009
NAME OF PR	OVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE		_
WASHING	STON NURSING FACIL	ITY			2425 25TH STREET SE WASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIATE DEL	E CROSS-	(X5) COMPLETION DATE
F 323	following wound dre lactate, Ketoconazo Accuzyme, Bacitraci Urea 40% cream an A face-to-face interv Employees #10 and that the treatment ca unattended with the 5. Facility staff failed supervision for Residen nurse's note dated D AM, "Resident's foot rail" The resident was he 2008 through Janua thrombosis. A telephone order da PM, unsigned by the for 1/2 side rails to a Resident #19 was of 7:45 AM in bed with position. A face-to-f with the resident at t When asked if he/sh	top drawer included the ssing ointments: Ammonium e shampoo, Hydrocortisone, n, Collagen hydrogel, Santyl,	F :	323	 483.25(h) Accidents and Super (continued) D. 3. Inservice training was given to fact staff about the importance of making sure that treatment carts are locked when not in use for safety reasons. Monitoring of the locking of treatment carts will be done through the Nursir Quality Improvement Team and their "Treatment Observation" tool. Result of their data collection will be brough the Director of Nurses for her review evaluation. 4. The Department Head will preser a report of the data collected and an action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee while is chaired by the Administrator 5. Resident #19 1. The resident is currently using low bed with half rails. 2. Other residents who may have for half rails were evaluated. No issues were found. 3. Inservice training will be given facility staff regarding making fre rounds and checking all residents will be done through the Nursing Quality Improvement Team. Results of their data collection will be for half rails will be done through the Nursing Parts during the Monitoring of the side rail incidents will be done through the Nursing Quality Improvement Team. Results of their data collection will be brough the Director of Nurses for her review evaluation. 4. The Department Head will preser a report of the data collected and an action plans implement team. Results of their data collection will be brough the Director of Nurses for her review evaluation. 	sility t t ng r lts and at y dch g a e an order other to the quent s during tention e rounds s tto and	3/31/09 4/3/09 3/20/09 3/31/09 3/13/09
	6. Facility staff left m	edication unattended on the			action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee whi is chaired by the Administrator	,	4/3/09

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		MEDICAID SERVICES					APPROVED . 0938-0391
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUIL			(X3) DATE SUF COMPLET	RVEY
		095022	B. WIN	IG		01/1	6/2009
NAME OF PR					EET ADDRESS, CITY, STATE, ZIP CODE		
WASHING	GTON NURSING FACIL	ITY			425 25TH STREET SE VASHINGTON, DC 20020	·	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIATE DEF	CROSS-	(X5) COMPLETION DATE
F 323	medication cart . On January 12, 200 during the medication medication unattend front of Resident JH to the resident. The on the medication ca 20mg, Isosorbid Din 25mg, Digoxin 0.25r Docusate 100mg wh resident's room. The sight of Employee # A face-to-face interv of this observation w	9, at approximately 9:56 AM on pass, Employee #23 left led on the medication cart in 7's room while he/she attended following medications remained art Multivitamin/Iron, Lisinopril itrate 20mg, Hydrochlothiazide ng, Caredilol 25mg and then Employee #23 entered the e medication cart was out of the	F	323	 483.25(h) Accidents and Supervision (continued) 6. Unlocked Med Cart 1. Med carts found unlocked at t time of the survey were locked produpon discovery. 2. All med carts were assessed for ability to be locked and being I when in use of being stored. No issues were found 3. Inservice training was given to facilistaff about the importance of making sure that med carts are locked when not in use for safety reasons. Monitoring of the locking of med carts will be done through the Nursing Quality Improvement Team and their "Med Pass" tool. Results of their data collection will be brought to the Direct 	he omptly locked other lity g	1/16/09 1/31/09 3/31/09
F 325 SS=D	the facility must ensi (1) Maintains accept status, such as body unless the resident's that this is not possi (2) Receives a thera nutritional problem. This REQUIREMEN Based on record rev	's comprehensive assessment, ure that a resident - table parameters of nutritional weight and protein levels, clinical condition demonstrates ble; and peutic diet when there is a T is not met as evidenced by: iew and staff interview for one sidents it was determined, that	F	325	Nurses for her review and evaluation 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator 483.25(i) Nutrition Resident #6 1. The resident has been reweight is being closely monitored by the dietician and the Risk Manageme for Weight Loss. The resident will evaluated soon at Johns Hopkins rule out the possibility that he has Mysthenia Gravis. 2. All residents with significant we are being presented to the Risk Management Committee for Weig Loss to ensure that a reweigh has taken place and that approaches	t ned and nt team I be to ight loss	4/3/09 3/31/09 3/31/09

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DEPART	MENT OF HEALTH	AND HUMAN SERVICES				APPROVED
CENTER	S FOR MEDICARE	& MEDICAID SERVICES	1			0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILE	LTIPLE CONSTRUCTION	(X3) DATE SU COMPLE	
		095022	B. WING	;	01/1	6/2009
NAME OF PR				STREET ADDRESS, CITY, STATE, ZIP CO		
WASHING	WASHINGTON NURSING FACILITY			2425 25TH STREET SE WASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTION REFERENCED TO THE APPRO	SHOULD BE CROSS-	(X5) COMPLETION DATE
F 325	Resident # 6 ' s sign The findings include A review of Resider a "Resident Weigh revealed the followi 10/5/08 Weight = 1 12/2/08 Weight = 1 No weight was reco and Height Record. a weight of 156 & 3 nurse ' s note date PM. There was no resident was ever re 156 and 3/4lb which weight loss of 17% was no further docu on the record regard A review of the facil and Heights " Polic nine, item " c " rev Check the previous a change of + or - 5 or 10% in 180 days reweighed within 24 The facility failed to weight change. Re greater than 10% bi record that the resid hours. A face-to-face intern Employee #39 at ap January 14, 2009. he/she was unawar weight loss until hea his/her readmission	nificant weight loss. a: t # 6 ' s clinical record revealed t and Height Record" which ng documentation: 90 pounds 59 pounds 59 pounds orded on the "Resident Weight " for November 2008. However /4lb (pounds) was noted in a 4 November 25, 2008 at 10:30 evidence on the record that the eweighed to verify the weight of n represented a significant from October 5, 2008. There umentation and or interventions ding the weight of 156 and 3/4lb. lity ' s policy " Nursing Weights by #1403070A.000, Page two of ealed the following statement: " weight for changes. If there is 5% in 30 days, 7.5% in 90 days , schedule resident to be	F 3	 483.25(i) Nutrition Resident #6 place for any resident wit weight loss. The facility Weight polinserviced with staff to enveights are taken and reproperly and reweighs or guidelines mandated. The Management Committee follows every resident wit weight loss to ensure all approaches are carried of the Director of Nurse Risk Management Commit Loss and will report any stindings to the Administration the Quality Improvement 	icy will be re- sure that corded cur within the le Risk for weight loss h significant appropriate ut. s chairs the littee for Weight significant tor monthly at	3/31/09

Facility ID: WASH

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		AND HUMAN SERVICES				/I APPROV). 0938-03
TATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI	PLE CONSTRUCTION	(X3) DATE SU COMPLE	RVEY
		095022	B. WING		01/1	6/2009
NAME OF PR			ST	REET ADDRESS, CITY, STATE, ZIP CODE		0/2009
WASHING	GTON NURSING FAC	ILITY		2425 25TH STREET SE WASHINGTON, DC 20020		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	' 	PROVIDER'S PLAN OF COR	RECTION	(X5)
PREFIX		ST BE PRECEDED BY FULL REGULATORY SENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO REFERENCED TO THE APPROPRIA		(X5) COMPLETI DATE
F 325	Continued From pa	age 79	F 325			
	weight loss. I also experiencing difficu to dental problems regular to mechani	ssessed him/her I recognized the determined that he/she was ulty chewing and swallowing due . I changed his/her diet from cal soft and added three cans of The record was reviewed on			•	
F 329 SS=D	483.25(I) UNNECE	SSARY DRUGS	F 329	483.25(I) Unnecessary Dru	gs	
	unnecessary drugs drug when used in duplicate therapy); without adequate r indications for its u consequences whi	ug regimen must be free from s. An unnecessary drug is any excessive dose (including or for excessive duration; or nonitoring; or without adequate se; or in the presence of adverse ch indicate the dose should be inued; or any combinations of the		·		
	resident, the facility have not used antii these drugs unless necessary to treat and documented in who use antipsych- reductions, and be	ehensive assessment of a y must ensure that residents who psychotic drugs are not given antipsychotic drug therapy is a specific condition as diagnosed the clinical record; and residents otic drugs receive gradual dose havioral interventions, unless cated, in an effort to discontinue				
		NT is not met as evidenced by:				
		eview and staff interview for five esidents, it was determined				

CENTEF	<u>RS FOR MEDICARE</u>	& MEDICAID SERVICES				OMB NO.	<u>. 0938-0391</u>
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL			(X3) DATE SUF COMPLET	
		095022	B. WIN	G	· · · · · · · · · · · · · · · · · · ·	01/16	5/2009
				STR	EET ADDRESS, CITY, STATE, ZIP CODE		
	GTON NURSING FACI	LITY		2425 25TH STREET SE			
				V	VASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD B REFERENCED TO THE APPROPRIATE DE	E CROSS-	(X5) COMPLETION DATE
F 329	Continued From page	je 80	F	329	483.25(I) Unnecessary Drugs		
	monitor for the use ((1) resident, monitor resident, and adequ medication side effe	ed to: document evidence and of Ambien for insomnia for one Dilantin levels for one (1) ately monitor behaviors and octs for three (3) residents otic medications. Residents #1			 (continued) 1. Resident #1 1. Medical record will reflect mo for the indication for use, insomr the administration of Ambien. T 	nia, with	3/31/09
	The findings include	:			routine order for an over-the-cou medication. 2. All other residents who have	Inter	5/5//09
	Psychoactive Drug pages 1 and 2, "Ps AtypicalSeroquel Under "Psychoactiv Sheet Antipsycho	e Drug Monitoring Reference tic - Must know diagnosis to			 for the routine use of Ambien 10 insomnia will be evaluated with r added whenever necessary. Facility staff were given inser regarding documenting evidence monitoring for the use of Ambier 	mg for nonitoring vice e and	3/31/09
	i.e. Dementia diagno non drug interventio behaviors and sumr	-			Consultant Pharmacist will assis monitoring Ambien 10mg. Docu of issues will be forwarded to the Director of Nurses.	t in mentation e	4/2/03
	monitor for the use of Resident #1.	l to document evidence and of Ambien for insomnia for			 The Department Head will pro- a report of the data collected and action plans implemented to ensistained compliance at the mon- sustained compliance at the mon- 	d any ure hthly	
		signed and dated December 16, ien 10 mg 1 PO QHS [one (1) our of sleep].			Quality Improvement Committee is chaired by the Administrator	which	4/3/09
	the following ' Doctor "December 16, 2008	lent ' s clinical record revealed or's Progress Notes': 3: Attending: Resident has been 10 mg po QHS because of					
	(MAR) for the month January 2009, Resid	dication Administration Record s of December 2008 and dent #1 was administered 9. QHS for insomnia'', on					
						•	

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							APPROVED
		& MEDICAID SERVICES					0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUIL		PLE CONSTRUCTION	(X3) DATE SUF COMPLETI	
		095022	B. WIN	G	·	01/1	5/2009
NAME OF PR	OVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE		
WASHING	STON NURSING FACI	LITY			425 25TH STREET SE VASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY INTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE	BE CROSS-	(X5) COMPLETION DATE
					483.25(I) Unnecessary Drugs	(continued)	
F 329	Continued From page	je 81	F	329			
	December 17 throug	h December 31, 2008 and			2. Resident #5		
		5, 2009 as evidenced by the			1. Psychiatrist consult will be o		
	initials on the MAR of	on the aforementioned dates.			for this resident requesting to e		
					the resident for the continued u		3/31/09
		he resident's 'Nurse's Notes',			Seroquel. With its continued u	,	
		Notes' and a December 16, ned 'Physician History and			nursing staff will initiate Behavio		
		cumented evidence for			Flow Sheet to document any e	pisodes	
	monitoring for the us				of negative behaviors. 2. For any other resident on S	oroguol who	
					has not been evaluated continu		
	A face-to-face interv	view was conducted with			staff will request a consultation		3/31/09
		nuary 16, 2009 at approximately			Psychiatrist. With its continued		5/5//03
		cknowledged that the resident's			nursing staff will initiate Behavio		
		d documented evidence for			Flow Sheet to document any e	-	
		se of Ambien for insomnia. The			of negative behaviors		
	record was reviewed	January 16, 2009.			3. Compliance will be monitore	ed 🦂	
	2 Eacility staff failer	to adequately monitor the use			through the Nursing Services (Quality	3/31/09
Í	of Seroquel for Resi				Improvement Program's tool for	r	
					"Psychoactive Drug Review."		
	A review of Residen	t #5's record revealed			The Nursing QI Team will forwa		
		gned by the physician on July 4,			findings to the Director of Nurs	ing for her	
		roquel 25 mg twice daily and			review and evaluation.		
	Seroquel 400 mg at	bedtime" for Bipolar disease.			 The Department Head will p a report of the data collected a 		
	According to the "In	itial Psychiatric Evaluation"			action plans implemented to er		
		1, 2008, the psychiatrist			sustained compliance at the m		
		Seroquelas ordered."			Quality Improvement Committee		4/3/09
	.,				is chaired by the Administrator		
		lent's record revealed that the			· · · ·		
		low Sheet" for December 2008			3. Resident #10		
		ailed to identify the target			1. Psychiatrist consult will be c		
		cation side effects to monitor for			for this resident requesting to e		
	Resident #5.				the resident for the continued u	-	3/31/09
	A face-to-face interv	iew was conducted with			Seroquel. With its continued u		
		nuary 12, 2009 at 3:45 PM.			nursing staff will initiate Behavio	•	
					Flow Sheet to document any e of negative behaviors.	lisoues	
					or negative beliaviors.		
ODM CMS 255	·						

acility ID: WASHNURS

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDI	TIPLE CONSTRUCTION	(X3) DATE SUF COMPLET	
		095022	B. WING		- 01/1	6/2009
AME OF PR			s	TREET ADDRESS, CITY, STATE, ZIP CO	· · · · · · · · · · · · · · · · · · ·	<u></u>
WASHING	STON NURSING FAC	ILITY [.]		2425 25TH STREET SE WASHINGTON, DC 20020		
(10)15			 	PROVIDER'S PLAN OF		(25)
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	ST BE PRECEDED BY FULL REGULATORY DENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION REFERENCED TO THE APPRO	SHOULD BE CROSS-	(X5) COMPLETIC DATE
F 329	Continued From pa	age 82	F 32	9 483.25(I) Unnecessary	Drugs (continued)	
		ged that the behavior monitoring		3. Resident #10		
		er 2008 and January 2009 were		2. For any other residen		
	blank. The record	was reviewed January 12, 2009.		has not been evaluated of staff will request a consu		3/31/0
	3. Facility staff faile	ed to adequately monitor the use		Psychiatrist. With its cor		5/51/
	of Seroquel for Re			nursing staff will initiate E		1
				Flow Sheet to document	any episodes	1
		nt #10's record revealed a a lated November 22, 2008,		of negative behaviors	opitorod	1
	"Seroquel 50 mg d			3. Compliance will be maintenance will be main		3/31/
		• .		Improvement Program's		0/01/
		nitoring Flow Sheet" for		"Psychoactive Drug Revi		1
		cember 2008 and January 2009 behaviors and medication side		The Nursing QI Team wi		1
	-	ored were not documented on the		findings to the Director or review and evaluation.	f Nursing for her	1
	sheets.			4. The Department Head	d will present	1
	A face to face into	view was conducted with		a report of the data colle		1
		d 16. Both employees stated that		action plans implemented		•
	Resident #10 remo	oves his/her clothes daily and has		sustained compliance at		41010
	to be re-dressed at	t least twice during the day shift.		Quality Improvement Col is chaired by the Adminis		4/3/0
	A face to face inter	view was conducted with		4. Resident #11		1
		January 14, 2009 at 3:30 PM.		1. Physician reviewed th	ne total plan of	л. Г
	He/she acknowled	ged that the behavior monitoring		care on this resident to p		
		for November and December 2009 and that Resident #10		of the resident's dilantin 2. All the medial records		3/31/0
		othes several times a day. The		physician were reviewed		1
		ed January 14, 2009.	•	evidence of other reside		3/31/0
	1 The physician fo	iled to followed up with his/her		take dilantin.	A '	
		onthly Dilantin levels for Resident		3. Physician Services m held to review the physic		3/31/(
	#11.			responsibility in addressi		0.01/(
	A physician's and	deted Merch 10, 2000 and		resident issues. Monitor	ing of inclusion	
		dated March 19, 2008 and ician on May 1, 2008, directed:		of these issues in the phy		212410
			*	progress notes will be do Clinical Managers who w		3/31/0
				any concerns to the Direct		

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PRINTED: 03/04/2009 FORM APPROVED

<u>CENTER</u>	<u>IS FOR MEDICARE (</u>	& MEDICAID SERVICES				<u>OMB NO.</u>	<u>0938-0391</u>
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL		LE CONSTRUCTION	(X3) DATE SUF COMPLET	
		095022	B. WIN	G		01/1€	6/2009
NAME OF PR				STR	EET ADDRESS, CITY, STATE, ZIP CODE		
WASHING	STON NURSING FACIL	LITY			425 25TH STREET SE VASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIATE DEP	CROSS-	(X5) COMPLETION DATE
F 329	Continued From page	ne 83	F	329	483.25(I) Unnecessary Drugs (continued)	
	"Phenytoin100m mg) by mouth twice 12/05/07," "Dilantin level every According to the res	gDilantin2 capsules (200 daily for seizures. Ori: (Origin) monthorig 09/13/2007." ident's MAR for the months of the resident was administered		525	 4. Resident #11 (continued) 4. The Department Head will prear report of the data collected and action plans implemented to ensure sustained compliance at the mon Quality Improvement Committee is chaired by the Administrator 	esent I any ure ithly	4/3/09
	Dilantin as evidence during the aforemen Monthly Dilantin leve resident's record for	ed by the initials for Dilantin tioned months. els were not available in the the aforementioned months.					
	Resident #11's clinic and July 3, 2008 lac	sician's progress notes in cal record dated May 2, June 3, ked evidence that the physician nt ' s monthly Dilantin laboratory			 Resident #13 Psychiatrist consult will be ord for this resident requesting to eva the resident for the continued use 	aluate	3/31/09
	up with his/her orde	nce that the physician followed r to monitor the resident's hly for the aforementioned			Seroquel and Klonopin. With its use, the nursing staff will initiate Monitoring Flow Sheet to docume episodes of negative behaviors 2. For any other resident on Ser	Behavior nt any	
	Employee #10 on Ja approximately 11:30 that the resident's cl that the physician fo monitor the resident	e-face interview was conducted with e #10 on January 14, 2009 at nately 11:30 AM. He/She acknowledged resident's clinical record lacked evidence obysician followed up with his/her order to he resident's monthly Dilantin levels for the			and Klonopin who have not been evaluated for its continued use, staff will request a consultation from the Psychiatris 3. Compliance will be monitored through the Nursing Services Quality Improvement Program's tool for		3/31/09
	reviewed January 145. Facility staff failed	to adequately monitor the use			"Psychoactive Drug Review." The Nursing QI Team will forward findings to the Director of Nursing review and evaluation.		3/31/09
		nopin for Resident ler dated October 9, 2008 50 mg po (orally) twice daily			4. The Department Head will pre- a report of the data collected and action plans implemented to ensu- sustained compliance at the mon Committee which is chaired by the	any ure thly QI	4/3/09
					Administrator.		

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DEPART	MENT OF HEALTH	AND HUMAN SERVICES					APPROVED
	S FOR MEDICARE	MEDICAID SERVICES				OMB NO	<u>. 0938-0391</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI			(X3) DATE SUP COMPLET	
		095022	B. WIN	IG		01/10	5/2009
NAME OF PR					EET ADDRESS, CITY, STATE, ZIP CODE		
WASHING	GTON NURSING FACI	JTY			425 25TH STREET SE /ASHINGTON, DC 20020		
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY		ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIATE DE	E CROSS-	(X5) COMPLETION DATE
F 329	Continued From pages for agitated behavio for agitation."	ge 84 rs and Klonopin 1 mg po daily	F	329		 	
	November, 2008 an Target behaviors an monitored were not "Behavior Monitoring	itoring Flow Sheet" for d January 2009 were blank. d medication side effects to be documented on the sheets. The g Flow Sheets" for October and Ild not be located at the time of byee #5.					
	Employee #5 on Jar He/she acknowledg sheets were blank a behaviors and medi	iew was conducted with nuary 13, 2009 at 3:45 PM. ed that the behavior monitoring nd some missing and that target cation side effects were not ord was reviewed on January					
F 332 SS=D		sure that it is free of medication	F	332	483.25(m)(1) Medication Errors A. Resident JH1 1. Employee involved in the error omission during medication pass were counseled and inserviced. The staff member was observed	ors of	
	Based on observation	T is not met as evidenced by: on, record review and staff ermined that the medication			QA nurses from Remedi SeniorC for the proper administration and documentation during Med Pass 2. All nurses were observed by QA nurses from Remedi SeniorC	Care I the	3/31/09
	passes. The findings include On January 12, 13 a	% in 2 (two) of 13 medication : and 14, 2008 medication pass e (5) of six (6) nursing units. 92			for the proper administration and documentation during Med Pass Baseline competencies were est 3. Proper Medication administra be monitored by the Nursing QI the use of the "Med Pass" tool in	ablished. tion will Feam and	3/31/09
		bbserved with five (5) non-			Nursing QI Program. Results of their monitoring will be given to the Director of Nurses for her review evaluation.		3/31/09

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B WING 095022 01/16/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2425 25TH STREET SE WASHINGTON NURSING FACILITY WASHINGTON, DC 20020 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (EACH CORRECTIVE ACTION SHOULD BE CROSS-PREFIX PRÉFIX OR LSC IDENTIFYING INFORMATION) REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE TAG TAG F 332 Continued From page 85 F 332 483.25(m)(1) Medication Errors The non-significant errors were as follows: (continued) A. Resident JH! (continued) 4. The Department Head will present A. Resident JH1 was observed receiving a report of the data collected and any medications on January 13, 2009 at 11:40 AM. After reconciling the Physicians Orders Sheet action plans implemented to ensure (POS) signed and dated on January 10, 2009 with sustained compliance at the monthly the Medication Administration Record (MAR) for Quality Improvement Committee which 4/3/09 January 2009, it was discovered that Simvastin 20 is chaired by the Administrator mg was omitted during the medication pass. B. Resident JH2 1. Employee involved in the errors of B. Resident JH2 was observed receiving omission during medication pass medications on January 12, 2009 at 10:50 AM. were counseled and inserviced. After reconciling the Physicians Orders Sheet The staff member was observed by the (POS) signed and dated on December 18, 2008 and QA nurses from Remedi SeniorCare 3/31/09 an Interim order signed and dated December 16. for the proper administration and 2008 with the MAR for January 2009, it was documentation during Med Pass. discovered that Alphagan 0.15% ophthalmic drops. 2. All nurses were observed by the Cospt ophthalmic drops, Cardiazem ER180mg and QA nurses from Remedi SeniorCare Ranitidine 150 mg tablets were omitted during the for the proper administration and 3/31/09 medication pass. documentation during Med Pass. F 368 Baseline competencies were established. F 368 483.35(f) FREQUENCY OF MEALS 3. Proper Medication administration will SS=E be monitored by the Nursing QI Team and Each resident receives and the facility provides at least three meals daily, at regular times comparable the use of the "Med Pass" tool in the to normal mealtimes in the community. Nursing QI Program. Results of their monitoring will be given to the 3/31/09 There must be no more than 14 hours between a Director of Nurses for her review and substantial evening meal and breakfast the evaluation. following day, except as provided below. 4. The Department Head will present a report of the data collected and any The facility must offer snacks at bedtime daily. action plans implemented to ensure sustained compliance at the monthly When a nourishing snack is provided at bedtime, up Quality Improvement Committee which 4/3/09 to 16 hours may elapse between a substantial is chaired by the Administrator evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
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CENTER	<u>IS FOR MEDICARE 8</u>	& MEDICAID SERVICES				OMB NO.	0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL			(X3) DATE SURVEY COMPLETED	
			B. WIN				
		095022	0. 11			01/10	5/2009
NAME OF PR	OVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE		
WASHING	GTON NURSING FACIL	_ITY			425 25TH STREET SE VASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY INTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD B REFERENCED TO THE APPROPRIATE DE	E CROSS-	(X5) COMPLETION DATE
F 368	Continued From pag	ge 86 T is not met as evidenced by:	F	368	1. The amount of snacks provid each unit has been increased to snack for each non-tube fed resi	afford a dent.	1/31/09
	(4) of six (6) nursing	ons and staff interview, for four units, it was determined that consistently offer bedtime nts.			2. The adequacy and provision will be added as a permanent ag item on the Menu Planning Com and the Residents' Council to en residents' satisfaction with the fa	enda mittee sure	3/31/09
		erview was conducted on			 snack program. Inservice will be provided to t nursing staff on the importance of and offering nourishments and s 	of passing nacks to	3/31/09
		om 3:00 PM until 4:30 PM. at the staff did not consistently 00 PM.			all residents. Monitoring of the s program will be done by the Nuti Services QI Team. Results of th monitoring efforts will be forward	itional eir	3/31/09
		made on January 14, 2009 from M on all nursing units regarding acks as follows:			Directors of Nutritional Services Nursing for their review and eval 4. 4. The Department Heads wil	and uation. I present	
	packages of cracker	o of potato chips, several rs, and 25 bagged snacks for Init census was 57 residents eiving tube feedings.		•	a report of the data collected and action plans implemented to ens sustained compliance at the mor Quality Improvement Committee is chaired by the Administrator.	ure http://www.action.com/action/actio	4/3/09
	crackers, several pa crackers and graham snacks for specific re	s of cookies, 2 packages of ckages of peanut butter n crackers and 28 bagged esidents. Unit census was 58 dents receiving tube feedings.					
		cake, packages of potato chips, h several bagged snacks for					
	cookies, 10 package packages of pretzels	vided included 4 packages of es of graham crackers, 2 s, 2 packages of potato chips, 2 ig, 28 bagged snacks for					

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	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING		(X3) DATE SURVEY COMPLETED 01/16/2009	
		095022	B. WING			
	OVIDER OR SUPPLIER	LITY	- 24	ET ADDRESS, CITY, STATE, ZIP CODE 25 25TH STREET SE ASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES I BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SHO REFERENCED TO THE APPROPRIA	ULD BE CROSS-	(X5) COMPLETION DATE
F 368	with 9 residents rec 3 North: snacks pro- cookies, 10 package packages of Ritz cra- packages of potato specific residents. L with 4 residents rec 3 South: No snacks specific residents. L with 3 residents rec Staff interviews with conducted on Janua through 4:35 PM reg snacks for the resid 1 North: Interview w conducted at 4:15 P the bagged snacks usually wants a sna know who wants. " 1 South: Interview w conducted at 4:25 P have to offer snacks want a snack. " 2 North: Interview w conducted at 4:10 P snack and the bagg on the cart and go d	Init census was 60 residents eiving tube feedings. vided included 2 packages of es of graham crackers, 12 ackers, 2 containers of Jello, 2 chips and 19 bagged snacks for Init census was 57 residents eiving tube feedings. and 25 bagged snacks for Init census was 57 residents eiving tube feedings. Certified Nurse Aides were ary 15, 2009 from 3:30 PM garding procedure of providing	F 368			
		Employee #34 was conducted at				

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

CENTER	S FOR MEDICARE	& MEDICAID SERVICES				OMB NO	. 0938-0391
	AN OF CORRECTION IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SUF COMPLET			
			A. BUI	LDING	·	· ·	
		095022	B. WIN	IG		01/1	6/2009
NAME OF PF		•		STR	EET ADDRESS, CITY, STATE, ZIP CODE		
WASHIN	GTON NURSING FACIL	TY		2	425 25TH STREET SE		
				N	VASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES THE PRECEDED BY FULL REGULATORY INTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD BI REFERENCED TO THE APPROPRIATE DE	E CROSS-	(X5) COMPLETION DATE
F 368	Continued From page	je 88	F	368			
	bagged snacks first wants a snack. "	and then go and ask if anyone					
	conducted at 3:30 P the cart and put all t and juice, usually at	ith Employee #34 was M. He/she stated, "We use he snacks on the cart with water bout 8:15 or 8:20 at night. We and then give anyone else a it."					
	3:30 PM. He/ she st snacks but we don't someone doesn't wa use it for another res	mployee #35 was conducted at ated, "We always get bagged always get the extra snacks. If ant their bagged snack, we can sident. If we have snacks and ve them what ever we have."					· · · ·
	consistently offered	ed that bedtime snacks were not. to residents. Additionally, no e snacks were available on unit 14, 2009.			483.35 (i) Sanitary Conditions		
F 371 SS=E		Y CONDITIONS m sources approved or ory by Federal, State or local	F	371	 Food found undated was take storage and discarded. All food in the walk-in and rea refrigerators and the dry storage 	en out of ich-in areas	1/16/09 1/16/09
		listribute and serve food under			were reviewed to ensure proper 3. Nutritional Services staff was regarding the need to date all pe and canned goods upon delivery facility. Monitoring of this practic be done by the members of the Nutritional Services Quality Impo	inserviced rishable to the e will	3/31/09
	Based on observation	IT is not met as evidenced by: ons during the survey period, it t dietary services were not			Nutritional Services Quality Impro Committee. who will collect data on this criteria and forward their recommendations to the Director Nutritional Services for his review evaluation.	informatior • of	I .

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 095022 01/16/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2425 25TH STREET SE WASHINGTON NURSING FACILITY WASHINGTON DC 20020 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION łD (X5) COMPLETION DATE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-OR LSC IDENTIFYING INFORMATION) REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG TAG F 371 Continued From page 89 F 371 483.35 (i) Sanitary Conditions (continued) adequate to ensure that foods were served in a safe 4. The Department Head will present and sanitary manner as evidenced by, foods observed undated in the walk-in refrigerator, reacha report of the data collected and any in refrigerator and the dry storage area; soiled dome action plans implemented to ensure covers, ice machine, ceiling tiles, spice rack and sustained compliance at the monthly food carts; damaged ceiling tile in the dry storage Quality Improvement Committee which 4/3/09 area; and serving utensils were observed wet; foods is chaired by the Administrator were observed being plated with the incorrect ladle [scoop size] during the tray line service; and a pan Β. of vegetables placed on the floor tray line service. Soiled Interior of the Ice Machine These findings were acknowledged by Employees 1. The interior of the ice machine was #14 and 41 at the time of the observations. cleaned upon discovery. 1/16/09 2. There are no other ice machines in the The findings include: kitchen area 1/16/09 Nutritional Services staff was inserviced A. The following foods were observed undated in regarding the need to routinely clean the the walk-in refrigerator, reach-in refrigerator and the interior of the ice machine. Monitoring of dry storage area: this practice will be done by the members 3/31/09 of the Nutritional Services Quality Two (2) bundles of withered lettuce Improvement Committee, who will collect One (1) box of withered kale data on this criteria and forward their One (1) case of strawberries with a green and white substance on the berries and side of the cartons information recommendations to the Director of Nutritional Services for his One (1) pan of lemon pudding undated Two (2) of four (4) cartons of packed parmesan review and evaluation. cheese undated 4. The Department Head will present Three (3) of three (3) cans of gelatin undated a report of the data collected and any Two (2) of seven (7) containers of pudding were action plans implemented to ensure unclearly dated [January 2009], facility staff unable sustained compliance at the monthly to determine if the date was January 9, 2009 or Quality Improvement Committee which 4/3/09 January 2009 is chaired by the Administrator B. The following were observed soiled and/or damaged in the main kitchen: One (1) of one (1) ice machine interior surface was observed soiled in the main kitchen

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING		DATE SURVEY COMPLETED
		095022	B. WING		01/16/2009
	ROVIDER OR SUPPLIER	ILITY	24	EET ADDRESS, CITY, STATE, ZIP CODE 425 25TH STREET SE VASHINGTON, DC 20020	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES ST BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CR REFERENCED TO THE APPROPRIATE DEFICI	
F 371 F 386 SS=D	Ceiling tiles were s One (1) damaged of One (1) of one (1) s 24 of 51 food carts One (1) full size pa observed wet and v Seven (7) of 41 dor and were store for C. During tray line 2009 at 1:40 PM or during the tray line 12:40 PM on the 3r observed plating th with the incorrect la spinach, mechanica The ladle sizes wer January 14, 2009 a D. During the tray li 2009 at 1:44 PM or Employee #40 was vegetables [covere placing it on the flo the food warmer. A Employee #40 ackr stated that the pan down. Approximate removed from the v 483.40(b) PHYSICI The physician must program of care, in treatments, at each of this section; write	oiled in the chemical room ceiling tile in the dry storage area spice rack was soiled or of serving utensils were was stored for reuse me covers were observe soiled reuse observations on January 12, in the 1st floor dining room and service on January 13, 2009 at d floor, dietary staff was e following foods for residents adle [scoop size]: Season al soft pork and rice re verified with Employee #14 on at approximately 4:00 PM. ine observation on January 12, in the 1st floor dining room, observed removing a loaf pan of d with foil] from the warmer and or and then putting it back into t the time of the finding nowledged what happened and was hot and he/she had to put it ely five minutes later the pan was varmer by Employee #41. AN VISITS t review the resident's total cluding medications and i visit required by paragraph (c) e, sign, and date progress notes	F 371	 483.35 (i) Sanitary Conditions (continued) B. Continued Ceiling Tiles 1. Soiled and damaged ceiling tiles noted at the time of the survey were replaced upon discovery. need for replacement and no other changes were necessary. 3. Monitoring of the ceiling tiles will be done by the members of the Nutritional Services Quality Improvement Committee. who will colled data on this criteria and forward their information recommendations to the Director of Nutritional Services for his review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator Spice Rack The Spice Rack was cleaned upon discovery. 2. There are no other spice racks in the kitchen. 3. Monitoring of the spice rack will be done by the members of the Nutritional Services Quality Improvement Committee. who will colled data on this criteria and forward their information recommendations to the Director of Nutritional Services Guality Improvement Committee. who will colled data on this criteria and forward their information recommendations to the Director of Nutritional Services for his review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly	4/3/09 1/16/09 1/16/09 3/31/09
	exception of influen polysaccharide vac	gn and date all orders with the iza and pneumococcal cines, which may be nysician-approved facility		Quality Improvement Committee wh is chaired by the Administrator	

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(continued) Page 91A of 121 B. Continued Food Carts 1. Food Carts were cleaned upon 1/16/09 discovery. 2. All food carts were evaluated for cleanliness and no further action was needed. 1/16/09 3. Monitoring of the food carts will be done by the members 3/31/09 of the Nutritional Services Quality Improvement Committee, who will collect data on this criteria and forward their information recommendations to the Director of Nutritional Services for his review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which 4/3/09 is chaired by the Administrator Wet Serving Utensils 1. Serving utensils were removed from service, re-washed and properly dried. 1/19/09 2. All serving utensils were evaluated for proper drying and no further action was needed. 1/16/09 3. Monitoring of the utensils will be done by the members 3/31/09 of the Nutritional Services Quality Improvement Committee, who will collect data on this criteria and forward their information recommendations to the Director of Nutritional Services for his review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which 4/3/09 is chaired by the Administrator

483.35 (i) Sanitary Conditions

483.35 (i) Sanitary Conditions (continued) Page 91B of 121

B. Continued

1. Dome lid covers noted to be soiled at the time of the survey were removed from service and re-washed. 1/16/09 2. All dome lid covers were evaluated for the need for re-washing and no further action was needed. 1/16/09 3. . Monitoring of the dome lid covers will be done by the members 3/31/09 of the Nutritional Services Quality Improvement Committee, who will collect data on this criteria and forward their information recommendations to the Director of Nutritional Services for his review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which 4/3/09 is chaired by the Administrator C. Ladle Size 1. The employee involved with the use of the wrong sized ladle was counseled and inserviced. 1/16/09 2. All servers were inserviced on the size of ladles. 3/31/09 3. . Monitoring of the ladles will be done by the members 3/31/09 of the Nutritional Services Quality Improvement Committee, who will collect data on this criteria and forward their information recommendations to the Director of Nutritional Services for his review and evaluation. 4. The Department Head will present a report of the data collected and any

a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator

4/3/09

483.35 (i) Sanitary Conditions (continued) Page 91C of 121

B. Continued

Loaf Pan of Vegetables 1. Employee involved in this incident was corrected, counseled and inserviced.

2. All servers were monitored to ensure that proper technique is used in handling food.

3. Monitoring of food handling will be done by the members of the Nutritional Services Quality Improvement Committee. who will collect data on this criteria and forward their information recommendations to the Director of Nutritional Services for his review and evaluation.

4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator

4/3/09

1/16/09

3/31/09

3/31/09

DEPART	MENT OF HEALTH	AND HUMAN SERVICES): 03/04/2009 I APPROVED
	S FOR MEDICARE	& MEDICAID SERVICES					0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		095022	B. WIN	IG		01/1	6/2009
NAME OF PR		·		STR	EET ADDRESS, CITY, STATE, ZIP CODE		
WASHING	GTON NURSING FACIL	LITY			425 25TH STREET SE VASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES I BE PRECEDED BY FULL REGULATORY INTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD E REFERENCED TO THE APPROPRIATE DI	E CROSS-	(X5) COMPLETION DATE
F 386	Continued From pag	ge 91	F	386	483.40(b) Physician Visits		
	policy after an asses	ssment for contraindications.					
					1. Resident #5		
	This REQUIREMEN	T is not met as evidenced by:			 Physician reviewed the total care on this resident to provide of the resident's falls and episod 	evidence	
	(4) of 30 sampled re	view and staff interview for four esidents, it was determined that			agitated behaviors. 2. All the medial records of this		3/31/09
	Residents #5, 6, 7, a	to review the total plan of care. and 8.			physician were reviewed to prov evidence of other residents who have had falls and episodes of		3/31/09
	The findings include				agitated behaviors. 3. Physician Services meeting v	Nas	
	1. The physician fail care for Resident #5	ed to review the total plan of			held to review the physicians' responsibility in addressing spec resident issues. Monitoring of ir	cific	3/31/09
	A review of Residen following nurses' no	t #5's record revealed the otes:			of these issues in the physician progress notes will be done by t	he	3/31/09
	sitting on the floor				Clinical Managers who will forwa any concerns to the Director of I 4. The Department Head will pr	Nurses.	
		3:00 PM: "Monthly summary - confrontation with roommate			a report of the data collected an		
	and threatened [him confrontation with a	/her]also had a verbal nother patient on [another unit] ab [him/her] and called 911 to			action plans implemented to ens sustained compliance at the mo Quality Improvement Committee is chaired by the Administrator	nthly	4/3/09
	physician wrote prog and November 20, 2	t #5's record revealed that the gress notes dated September 25 2008. There was no evidence in of the above cited fall or behaviors.					
	Employee #5 on Jar He/she acknowledge address the above in	iew was conducted wit nuary 12, 2009 at 3:45 PM. ed that the physician did not ncidents in the physician's e record was reviewed January			· · ·		
			•				

Event ID: WPBP11 Facility ID: WASHNURS

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	03/04/2009 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION UMBER:		(X2) MUL A. BUILD		(X3) DATE SUI COMPLET	RVEY	
		095022	B. WING		01/16/2009	
NAME OF PROVIDER OR SUPPLIER WASHINGTON NURSING FACILITY		5	STREET ADDRESS, CITY, STATE, ZIP CODE 2425 25TH STREET SE WASHINGTON, DC 20020			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETION DATE
F 386	 The physician fail care for Resident #6 Dilantin level. A review of the clinic revealed that on Aug Dilantin level of 5.2 i um/ml) and diagnoss The lab report was s August 21, 2008. For record revealed doc Progress Notes " wi dated August 21, 200 Will give him/her a lo extra each day for 5 Level on 8/27/08." No lab report was no 27, 2008 but the rec September 19, 2009 ug/ml and another re with a Dilantin level not have any seizure Dilantin level. The record revealed attending physician November 25, Dece 2008. The attending the resident's Dilantit the treatment plan in levels. A face-to-face interv Employee # 6 at app January 14, 2009. T that the attending ph the resident's sub-tt record was reviewed 	ed to address the total plan of to maintain a therapeutic cal record for Resident #6 gust 20, 2008 the resident had a ug/ml (normal 10 ug/ml to 20 es which include Seizures. signed by the physician on urther review of the clinical umentation in the "Doctor's hich revealed the following note 08, "Labs Dilantin level 5:2. bading dose of Dilantin 300mg [five] days and repeat Dilantin oted on the record for August ord revealed a lab report dated with a Dilantin level of 4.5 eport dated October 8, 2008 of 9.2 ug/ml. The resident did es despite the sub therapeutic documentation from the for October 4, October 14, mber 23, and December 30, physician failed to address to n levels and/or document that included sub-therapeutic Dilantin iew was conducted with proximately 10:00 AM on he employee acknowledged hysician failed to follow up on herapeutic Dilantin level. The d on January 13, 2009. ed to address the total plan of	F 38	 483.40(b) Physician Visits (co. 2. Resident #6 1. Physician reviewed the total care on this resident to provide of the resident's dilantin level. 2. All the medial records of this physician were reviewed to pro evidence of other residents wh take dilantin. 3. Physician Services meeting held to review the physicians' responsibility in addressing speresident issues. Monitoring of i of these issues in the physician progress notes will be done by Clinical Managers who will forw any concerns to the Director of 4. The Department Head will p a report of the data collected an action plans implemented to ensustained compliance at the med Quality Improvement Committer is chaired by the Administrator 	plan of evidence vide o was cific nclusion the vard Nurses. resent nd any sure onthly	3/31/09 3/31/09 3/31/09 3/31/09 4/3/09

Facility ID: WASHNURS

If continuation sheet Page 93 of 121

		AND HUMAN SERVICES				FORM	APPROVED
		& MEDICAID SERVICES	<u> </u>				. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		095022	B. WING			01/16/2009	
NAME OF PR				STRE	EET ADDRESS, CITY, STATE, ZIP CODE		
WASHINGTON NURSING FACILITY				25 25TH STREET SE			
SUMMARY STATEMENT OF DEFICIENCIES			VV	ASHINGTON, DC 20020			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE C TAG REFERENCED TO THE APPROPRIATE DEFIC			E CROSS-	(X5) COMPLETION DATE
F 386	Continued From page	ge 93	F 3	886	483.40(b) Physician Visits (cor	itinued)	
	progress note dated # (pounds) Down 9.	t #7's record revealed a dietary October 31, 2008, "Weight 138 8% in 30 days. Significant			 Resident #7 Physician reviewed the total pcare on this resident to provide ecological and the second s	evidence	
	weight loss is uninte				of the resident's weight loss and lab 2. All the medial records of this physician were reviewed to prov		3/31/09
	 A physician's progress note dated November 4 and December 16, 2008 failed to address the resident's weight loss. A laboratory report dated October 31, 2008 revealed the following: Hemoglobin 9.2 [normal 11.6-15.1 gm/dl] and Hematocrit 27.9 [normal 34.0 - 45.0 %]. 				evidence of other residents who have had falls and episodes of agitated behaviors.		3/31/09
					 Physician Services meeting w held to review the physicians' responsibility in addressing spect resident issues. Monitoring of in of these issues in the physician 	ific	3/31/09
	revealed the followin Hematocrit 26.7.	date December 10, 2008 ng: Hemoglobin 8:5 and			progress notes will be done by the Clinical Managers who will forwar any concerns to the Director of N 4. The Department Head will pre-	rd Iurses.	3/31/09
	However, there was indicated in the Dec	signed by the physician. no evidence that the physician ember 16, 2008 note what was for the decreasing Hemoglobin			a report of the data collected and action plans implemented to ens sustained compliance at the mor Quality Improvement Committee is chaired by the Administrator	l any ure hthly	4/3/09
	conducted on Janua acknowledged that t	iew with Employee #6 was ary 13, 2009 at 2:25 PM. He/she he physician failed to address es. The record was reviewed		<			
	4. The physician fail care for Resident #8	ed to review the total plan of	·		 Resident #8 Physician reviewed the total provident of total provident of the total provident of t	blan of	
	following interim ord	· .			care on this resident to provide e of the resident's cardiology consult. 2. All the medial records of this	vidence	3/31/09
	November 27, 2008 need of anticoagula	: "Cardiology consult: confirm tion."			physician were reviewed to provievidence of other residents who have had orders for cardiology c		3/31/09

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Facility ID: WASHNURS

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PRINTED: 03/04/2009 FORM APPROVED OMB NO 0938-0391

	S FUR MEDIUARE	X WEDICAID SERVICES	-			<u>. 0938-0391</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		COMPLE	
		095022	B. WING	G	01/1	<u>6/</u> 2009
NAME OF PF	OVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE	
WASHING	GTON NURSING FACIL	ITY			425 25TH STREET SE /ASHINGTON, DC 20020	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIJ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS- REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 386	Continued From page	je 94	F 3	386	483.40(b) Physician Visits (continued)	
		t #8's record revealed that the gress notes on January 8 and			3. Physician Services meeting was held to review the physicians' responsibility in addressing specific resident issues. Monitoring of inclusion	3/31/09
	The aforementioned physician's progress notes lacked evidence that he/she followed up with the aforementioned order for a cardiologist consult. A face-to-face interview was conducted with Employee #12 on January 16, 2009 at 11:00 AM. He/she acknowledged that the resident's clinical record lacked evidence that the physician followed up with his/her order for a cardiologist consult. The record was reviewed January 16, 2009.				of these issues in the physician progress notes will be done by the Clinical Managers who will forward any concerns to the Director of Nurses.	3/31/09
					4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator	4/3/09
F 412	483.55(b) DENTAL	SERVICES - NF	F 4	12	483.55(b) Dental Services	
SS=D	outside resource, in this part, routine (to State plan); and eme the needs of each re assist the resident in arranging for transpo	nust provide or obtain from an accordance with §483.75(h) of the extent covered under the ergency dental services to meet sident; must, if necessary, making appointments; and by ortation to and from the dentist's mptly refer residents with lost or o a dentist.			 Resident #7 1. This resident received her annual dental screen. 2. An audit was done for all residents of the facility to ensure that an annual dental screen was done. Correction were made whenever necessary. 3. The unit clerks will perform monthly quantitative audits noting the date of the 	1/31/09 3/31/09
	This REQUIREMEN	T is not met as evidenced by:			last dental screening. Their findings will be communicated to the consultant dentist. The Clinical Managers will monitor the timeliness of annual dental screens and communicate their	3/31/09
	(1) of 30 sampled re	iew and staff interview for one sidents, it was determined that obtain an annual routine screen			findings to the DON. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly QI Committee which is chaired by the Administrator.	4/3/09
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FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WPBP11

Facility ID: WASHNURS

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	0: 03/04/2009 APPROVED . 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII			(X3) DATE SU	(X3) DATE SURVEY COMPLETED	
		095022	B. WIN	G	<u>-</u>	01/1	6/2009	
	NAME OF PROVIDER OR SUPPLIER WASHINGTON NURSING FACILITY SUMMARY STATEMENT OF DEFICIENCIES			2	EET ADDRESS, CITY, STATE, ZIP CODE 425 25TH STREET SE VASHINGTON, DC 20020	<u> </u>	_	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD E REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETION DATE	
F 412	screen dated Decen evidence that an an completed for 2008. A face-to-face interv Employee #6 on Jar He/she stated, "We	t #7's record revealed a dental nber 20, 2007. There was no nual dental screen was	F	412			-	
F 425 SS=E	483.60(a),(b) PHAR The facility must pro- drugs and biological under an agreement part. The facility mat to administer drugs under the general su A facility must provid (including procedure acquiring, receiving, of all drugs and biological each resident. The facility must em- licensed pharmacist	MACY SERVICES wide routine and emergency s to its residents, or obtain them t described in §483.75(h) of this ay permit unlicensed personnel if State law permits, but only upervision of a licensed nurse. de pharmaceutical services es that assure the accurate dispensing, and administering ogicals) to meet the needs of ploy or obtain the services of a who provides consultation on ovision of pharmacy services in		425	483.60(a)(b) Pharmacy Servic	PS		
	This REQUIREMEN	T is not met as evidenced by:						
	interview, it was det	on, record review and staff ermined that the facility staff document administration of						

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Facility ID: WASHNURS

If continuation sheet Page 96 of 121

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	03/04/2009 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
	095022		B. WIN	G		01/16	5/2009
NAME OF PR	OVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE		
WASHING	STON NURSING FACIL	ITY			425 25TH STREET SE VASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	id PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIATE DEFI	CROSS-	(X5) COMPLETION DATE
F 425	controlled substance Administration Reco multi-dose vials, to r the medication carts administer medicatio residents. JH1, JH13 The findings include 1. The facility staff fa the administration of November and Dece JH15 and JH16. A. On January 16, 2 during a review of R revealed a physician 2008 that directed, "Oxycodone/APAP t tablets by mouth eve The November 2008 indicated that Oxyco administered in Nove entered in the allotte The " Controlled Dro Oxycodone 5-325 m controlled substance 2008. There was no 2008 MAR that the C administered on Nove B. On January 16, 2 during a review of R	es on the Medication rd (MAR), to date and initial emove expired medication from and refrigerator and failed to ons in a timely manner to two (2) 5, JH16 and JH20. ailed to consistently document controlled substances on the ember 2008 MARs for Residents 009, at approximately 9:30 AM, esident JH15 's records 1 's order dated November 24, ab 5-325mg, Take two (2) ery 6 hours as needed for pain. " MAR was reviewed and done 5-325 mg tablet was not ember, there were no initials	F	425	 483.60(a)(b) Pharmacy Services 1A. Resident # JH 15 1. Employees involved in the error documentation for the administration documentation for the administration caycodone were counseled and inserviced. Each was observed by QA nurses from Remedi SeniorCa for the proper administration and documentation during Med Pass. 2. All nurses were observed by the QA nurses from Remedi SeniorCa for the proper administration and documentation during Med Pass. 2. All nurses were observed by the QA nurses from Remedi SeniorCa for the proper administration and documentation during Med Pass. Baseline competencies were esta 3. Controlled substance documer will be monitored by the Clinical M throughout the month. The results of their monitoring will be given to Director of Nurses for her review a evaluation. 4. The Department Head will press a report of the data collected and a plans implemented to ensure sust compliance at the monthly QI Con which is chaired by the Administration and set the monthly of the data collected and a plans implemented to ensure sust compliance at the monthly QI Con which is chaired by the Administration and set the monthly QI Con which is chaired by the Administration and the consultation at the monthly QI Consultation at the monthly	ors of ion of y are blished. htation langer s the and sent any action ained nmittee	3/31/09 3/31/09 3/31/09 4/3/09
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Facility ID: WASHNURS

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<u> </u>	RS FOR MEDICARE	& MEDICAID SERVICES				OMB NO	<u>. 0938-0391</u>
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII			(X3) DATE SUI COMPLET	
		095022	B. WIN	IG	· · · · · · · · · · · · · · · · · · ·	01/1	6/2009
NAME OF PF	ROVIDER OR SUPPLIER	-		STR	EET ADDRESS, CITY, STATE, ZIP CODE		
WASHIN	GTON NURSING FACI	LITY		1	425 25TH STREET SE VASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES F BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD B REFERENCED TO THE APPROPRIATE DE	E CROSS-	(X5) COMPLETION DATE
F 425	24, 2008 that directe " Lorazepam 1mg ta every 8 hours as ne pressure < 90/60 fal The November 2008	ed , ablet, take 1 tablet by mouth eded for agitation, hold if blood	F	425	(continued) 1B. Resident #JH 16 1 Employees involved in the err documentation for the administra Lorazepam were counseled and	ors of ation of	
	administered in Nov entered in the allotte evidence that the re The "Controlled Dr	ember, there were no initials ed areas. There was no sident received the medication. ug Record " indicated the			inserviced. Each was observed QA nurses from Remedi Senior for the proper administration and documentation during Med Pass 2. All nurses were observed by QA nurses from Remedi Senior	Care I s. the	3/31/09
	controlled substance 12, 2008. A face-to-face interv after the review on t	let was removed from the e drawer on November 3 and view was conducted immediately he resident's records with 54. They acknowledged that the			for the proper administration and documentation during Med Pass Baseline competencies were est 3. Controlled substance docume will be monitored by the Clinical throughout the month. The resu	ablished. entation Manger Its	3/31/09
	MARs did not indica controlled substance Controlled substance Residents JH15 and on January 16, 2009	te with signatures that the e was administered and the e record did not indicate that to d JH16. The record was review			 of their monitoring will be given t Director of Nurses for her review evaluation. 4. The Department Head will provide a report of the data collected and plans implemented to ensure succompliance at the monthly QI Co which is chaired by the Administ 	and esent any action stained ommittee	3/31/09 4/3/09
	of two (2) of six (6) t				 Multi-dose Vials Opened Multi-dose vials foun to be dated or initialed at the time survey were destroyed upon disc All multi-dose vials were inspito to insure proper documentation i No other issues were found. 	e of the covery. ected	1/16/09 1/16/09

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WPBP11

Facility ID: WASHNURS

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	riple construction	(X3) DATE SUF COMPLET	
		095022	B. WING		01/16/2009	
NAME OF PF			s'	TREET ADDRESS, CITY, STATE, ZIP CODE		
WASHIN	GTON NURSING FACIL	ITY		2425 25TH STREET SE WASHINGTON, DC 20020	-	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE	BE CROSS-	(X5) COMPLETION DATE
F 425	 (2) Pneumococcal v Heparin 10,000 unit, 3 North Lorazepam Injection 3. The facility staff f medications from the According to the ma vial of Tuberculin PF in use for 30 days m On January 14, 2000 during the inspection North the following r in the medication ca Buspirone 10 mg, 30 5/28/2008 Risperdal 1 mg, 50 t Multivitamin, 50 table Loperamide 2 mg, 5 Alprazolam 0.25 mg Fluvirin 5 ml injection Tubersol 5 TU vial - 2 South observed or Diphenhydramine 25 Loperamide 2 mg ca Tylenol 325 mg table A face-to-face interv #8 and 54 on Januar 	accine 1ml vials 10ml vial mg/ ml 10 ml vial ailed to remove expired e medication cart. nufacturer's specifications, "A 2D which has been entered and nust be discarded." B at approximately 3:30 PM n of the medication area on 3 nedications were found expired rt and refrigerator. 0 tablets, expiation date ablets, 2/15/2008 ets, 2/15/2008 capsules, 9/13/2008 s, 8/6/2008 , 9 tablets, 5/30/2008 n, 1 vial, 6/30/2008 n, 1 vial, 6/30/2008 opened, 1 vial, 1/3/2009 n January 16, 2009 at 9:00 AM 5 mg capsules, 10/08 psules, 12/28/08 ets, 10/07 iew was conduct with Employee ry 14, 2008, after the carts were acknowledge that the above	F 42	 5 483.60(a)(b) Pharmacy Serviti (continued) 2. Multi-dose Vials (continued) 3. Multi-dose vial documentati will be monitored by the Clinica throughout the month. The rest of their monitoring will be giver Director of Nurses for her revise evaluation. 4. The Department Head will p a report of the data collected a plans implemented to ensure as compliance at the monthly QI (which is chaired by the Admin 3. Expired Medication 1. Expired Medication 1. Expired medication found in medication area of 3 North and at the time of the survey were of per policy 2. All medication areas were in for the presence of expired medication dispositi will be monitored by the Clinica throughout the month. The rest of their monitoring will be giver Director of Nurses for her revise evaluation. 4. The Department Head will p a report of the data collected a plans implemented to ensure s compliance at the month. The rest of their monitoring will be giver Director of Nurses for her revise evaluation. 4. The Department Head will p a report of the data collected a plans implemented to ensure s compliance at the monthly QI (which is chaired by the Admin) 	ed) on al Manger sults in to the ew and oresent ind any action sustained Committee istrator in the d 2 South disposed mspected eds and ion al Manger sults in to the ew and oresent ind any action sustained Committee	3/31/09 4/3/09 1/31/09 3/31/09 4/3/09

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

PRINTED:	03/04/2009
FORM A	APPROVED
OMB NO	0938-0391

CENTER	SFOR MEDICARE	MEDICAID SERVICES				<u>OMB NO.</u>	<u>. 0938-0391</u>
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		095022	B. WING		·	01/16/2009-	
NAME OF PR	OVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE		
WASHING	GTON NURSING FACIL	ITY		24	425 25TH STREET SE		
117101111		····		N	VASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIATE DE	E CROSS-	(X5) COMPLETION DATE
F 425	Continued From page	je 99	F	425	483.60(a)(b) Pharmacy Service	s	
	inspection.	· .			(continued)		
	timely manner for Re On January 13, 200	I to administer medications in a esidents JH1 and JH20. 9 at approximately 10:30 AM	idents JH1 and JH20. 1 Employees involved in the errors of notification of the missing keys and the transmission of the transmission of the missing keys and the transmission of the missing keys and the transmission of transmission of the transmission of transmission of the transmission of transmissio		nd the tra	1/31/09	
	not be located to un 1 North.	nedication pass the keys could lock the medication cart on Unit	·		Strength and Novolog insulin wa counseled and inserviced on the the interim box. A procedure to ensure the consis	use of stent	
A face-to-face interview was cond Employee #55 on January 13, 20 He/she stated, " At about eight fo morning, I realized that I didn't ' t [Night shift Employee #56] was ca		anuary 13, 2009 at 10:30 AM. about eight forty-five this hat I didn't ' t have the keys.			provision of on-site replacement keys for all med carts was put in by the Administrator. 2. All nurses were observed by t QA nurses from Remedi SeniorC	place the	
	pharmacy at nine the key to come from ph	-	·		for the proper and timely adminis documentation during Med Pass Baseline competencies were est	stration and ablished.	3/31/09
		ary 2009 MAR revealed that not receive the morning medication.			3. the timeliness of medication passes will be monitored by the Clinical Mangers throughout the month. The results of their monitoring will be given to the		3/31/09
	JH5 dated Novembe	ysician ' s order for Resident er 21, 2008, " Tylenol Extra les by mouth three times a day "	•		Director of Nurses for her review evaluation. 4. The Department Head will pre a report of the data collected and	esent any action	4/0/00
	The facility had determined that the resident would receive the medication at 8:00 AM, 12:00 PM and 6:00 PM. The 8:00 AM dose was omitted because the medication cart keys were not available to unlock the medication cart and provide access to the medication.				plans implemented to ensure sustained compliance at the monthly QI Committee which is chaired by the Administrator		4/3/09
		ysician ' s order for Resident er 18, 2008, " Novolog 3 units e times with meals. "					

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: WASHNURS

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OF DEFICIENCIES CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 095022	(X2) MU A. BUIL			(X3) DATE SUF	
	095022			·	(X3) DATE SURVEY COMPLETED	
	095022		G		01/16	5/2009
			24	EET ADDRESS, CITY, STATE, ZIP CODE 425 25TH STREET SE VASHINGTON, DC 20020		
(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIATE DE	CROSS-	(X5) COMPLETION DATE
The facility had detereceive the medication receive the medication 5:30 PM. The 8:30 the medication cart unlock the medication the medication. A face-to-face interve Employee #55 on Ja He/she stated, " I we insulin and the Tyler A review of the cont that the dosage of T JH1 and the type of JH20 were not inclue A pharmacy represe cart keys at approximation physicians for the ad scheduled to receive were contacted and to adjust the administres medications through residents. No untoward effects above cited resident	rmined that the resident would on at 8:30 AM, 1:30 PM and AM dose was omitted because keys were not available to on cart and provide access to iew was conducted with anuary 13, 2009 at 10:30 AM. rent to the interim box for the nol. " ents of the interim box revealed ylenol required for Resident insulin required for Resident ded in the interim box. entative delivered the medication mately 11:30 AM. The dditional 14 residents who were e medications at 10:00 AM, telephone orders were received stration of additional iout the day and monitor the were observed for any of the s as a result of the adjustment	F 4	125			
The drug regimen of reviewed at least on pharmacist. The pharmacist mus attending physician,	each resident must be ce a month by a licensed at report any irregularities to the and the director of nursing, and	F 4	128	483.60(c.) Drug Regimen Revie		
	The facility had detereceive the medication receive the medication 5:30 PM. The 8:30 of the medication cart I unlock the medication the medication. A face-to-face interve Employee #55 on Ja He/she stated, "I we insulin and the Tyler A review of the contribution that the dosage of T JH1 and the type of JH20 were not include A pharmacy represe cart keys at approximal physicians for the ad scheduled to receive were contacted and to adjust the administ medications through residents. No untoward effects above cited resident of their medications. 483.60(c) DRUG RE The drug regimen of reviewed at least on pharmacist. The pharmacist mus-	The facility had determined that the resident would receive the medication at 8:30 AM, 1:30 PM and 5:30 PM. The 8:30 AM dose was omitted because the medication cart keys were not available to unlock the medication cart and provide access to the medication. A face-to-face interview was conducted with Employee #55 on January 13, 2009 at 10:30 AM. He/she stated, "I went to the interim box for the insulin and the Tylenol. " A review of the contents of the interim box revealed that the dosage of Tylenol required for Resident JH1 and the type of insulin required for Resident JH20 were not included in the interim box. A pharmacy representative delivered the medication cart keys at approximately 11:30 AM. The physicians for the additional 14 residents who were scheduled to receive medications at 10:00 AM, were contacted and telephone orders were received to adjust the administration of additional medications throughout the day and monitor the residents. No untoward effects were observed for any of the above cited residents as a result of the adjustment of their medications. 483.60(c) DRUG REGIMEN REVIEW The drug regimen of each resident must be reviewed at least once a month by a licensed	The facility had determined that the resident would receive the medication at 8:30 AM, 1:30 PM and 5:30 PM. The 8:30 AM dose was omitted because the medication cart keys were not available to unlock the medication cart and provide access to the medication. A face-to-face interview was conducted with Employee #55 on January 13, 2009 at 10:30 AM. He/she stated, " I went to the interim box for the insulin and the Tylenol. " A review of the contents of the interim box revealed that the dosage of Tylenol required for Resident JH1 and the type of insulin required for Resident JH20 were not included in the interim box. A pharmacy representative delivered the medication cart keys at approximately 11:30 AM. The physicians for the additional 14 residents who were scheduled to receive medications at 10:00 AM, were contacted and telephone orders were received to adjust the administration of additional medications throughout the day and monitor the residents. No untoward effects were observed for any of the above cited residents as a result of the adjustment of their medications. 483.60(c) DRUG REGIMEN REVIEW The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and	The facility had determined that the resident would receive the medication at 8:30 AM, 1:30 PM and 5:30 PM. The 8:30 AM dose was omitted because the medication cart keys were not available to unlock the medication cart and provide access to the medication.A face-to-face interview was conducted with Employee #55 on January 13, 2009 at 10:30 AM. He/she stated, " I went to the interim box for the insulin and the Tylenol. "A review of the contents of the interim box revealed that the dosage of Tylenol required for Resident JH20 were not included in the interim box.A pharmacy representative delivered the medication cart keys at approximately 11:30 AM. The physicians for the additional 14 residents who were scheduled to receive medications at 10:00 AM, were contacted and telephone orders were received to adjust the administration of additional medications throughout the day and monitor the residents.No untoward effects were observed for any of the above cited residents as a result of the adjustment of their medications.483.60(c) DRUG REGIMEN REVIEWF 428The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.The pharmacist must report any irregularities to the attending physician, and the director of nursing, and	The facility had determined that the resident would receive the medication at 8:30 AM, 1:30 PM and 5:30 PM. The 8:30 AM dose was omitted because the medication cart keys were not available to unlock the medication cart and provide access to the medication.A face-to-face interview was conducted with Employee #55 on January 13, 2009 at 10:30 AM. He/she stated, "I went to the interim box for the insulin and the Tylenol."A review of the contents of the interim box revealed that the dosage of Tylenol required for Resident JH1 and the type of insulin required for Resident JH2 owere not included in the interim box.A pharmacy representative delivered the medication cart keys at approximately 11:30 AM. The physicians for the additional 14 residents who were scheduled to receive medications at 10:00 AM, were contacted and telephone orders were received to adjust the administration of additional medications throughout the day and monitor the residents.No untoward effects were observed for any of the above cited resident as a result of the adjustment of their medications.483.60(c) DRUG REGIMEN REVIEWF 428483.60(c) DRUG REGIMEN REVIEWF 428483.60(c) DRUG REGIMEN REVIEWF 428Afturg regimen of each resident must be reviewed at least once a month by a licensed pharmacist.The pharmacist must report any irregularities to the attending physician, and the director of nursing, and	The facility had determined that the resident would receive the medication at 8:30 AM, 1:30 PM and 5:30 PM. The 8:30 AM does was omitted because the medication cart keys were not available to unlock the medication cart and provide access to the medication.A face-to-face interview was conducted with Employee #55 on January 13, 2009 at 10:30 AM. He/she stated, "I went to the interim box for the insulin and the Tylenol."A review of the contents of the interim box for the insulin and the Tylenol."A review of the contents of the interim box.A parmacy representative delivered for Resident JH20 were not included in the interim box.A pharmacy representative delivered the medication cart keys at approximately 11:30 AM. The physicians for the additional 14 residents who were scheduled to receive medications at 10:00 AM, were contacted and telephone orders were received to adjust the administration of additional medications.No untoward effects were observed for any of the above cited residents as a result of the adjustment of their medications.483.60(c) DRUG REGIMEN REVIEWThe drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.The pharmacist must report any irregularities to the attending physician, and the director of nursing, and

Facility ID: WASHNURS

If continuation sheet Page 101 of 121

		AND HUMAN SERVICES				FORM	APPROVED
STATEMENT	OF DEFICIENCIES	X MEDICAID SERVICES	(X2) MULTIPLE CONSTRUCTION			OMB NO. 0938-039 (X3) DATE SURVEY	
AND PLAN OF	CORRECTION		A. BUILDING		G	COMPLETE	ED
		095022	B. WIN	IG		01/16/2009	
NAME OF PR				STR	EET ADDRESS, CITY, STATE, ZIP CODE	•	
WASHING	GTON NURSING FACIL	.ITY			425 25TH STREET SE		
_				V	PROVIDER'S PLAN OF CORRECT!	<u></u>	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	A EMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIATE DE	E CROSS-	(X5) COMPLETION DATE
F 428	Continued From pag	je 101	F	428	483.60 (c.) Drug Regimen Revi (continued) 1A. Resident #5 1. Consultant Pharmacist was m of the oversight.		3/6/09
		T is not met as evidenced by:			2. Other charts were checked to the monthly Drug Regimen Revie completed. No further notificatio	ew was n to the	3/9/09
	(2) of 30 sampled re the pharmacist failed dose reduction for a	view and staff interview for two sidents, it was determined that d to: recommend attempting a ntipsychotics for two (2) w one (1) resident's medication			Consultant Pharmacist was nece 3. Monitoring of the Consultant Pharmacists notes will be added monthly audit tool completed by Unit Clerks. Discrepancies will b	to the the	4/1/09
	monthly. Residents in The findings include 1. The pharmacist fa dose reduction for R Seroquel for five (5) of the Drug Regimer	#5 and 13. ailed to recommend attempting a tesident #5 who was prescribed months and complete a review n for one (1) month. ailed to review Resident #5's			brought to the attention of the Co Pharmacist immediately upon dis by the Director of Nurses. 4. The Department Head will pre a report of the data collected and action plans implemented to ens sustained compliance at the mor Committee which is chaired by th Administrator.	onsultant scovery. esent d any ure nthly QI	4/3/09
	pharmacist reviewed July 29, August 28, 3 December 24, 2008, the pharmacist revie for November 2008. A face-to-face interv conducted on Janua acknowledged that t	iew with Employee #5 was ry 12, 2009 at 3:45 PM. He/she he pharmacist did not review ations for November 2008. The	2		 1B. Resident #5 1. Psychiatrist consult will be ord for this resident requesting to eva the resident for a gradual dose re of her Seroquel. 2. For any other resident on Ser has not been evaluated for a gra dose reduction, staff will request consultation from the Psychiatris 3. Compliance will be monitored through the Nursing Services Qu Improvement Program's tool for "Psychoactive Drug Review." The Nursing QI Team will forward findings to the Director of Nursing review and evaluation. 	aluate eduction oquel who dual a t. ality d their	3/31/09 3/31/09

Event ID: WPBP11

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

PRINTED: 03/04/2009 FORM APPROVED OMB NO 0938-0391

095022 NAME OF PROVIDER OR SUPPLIER WASHINGTON NURSING FACILITY (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 428 Continued From page 102 B. Review of Resident #5 's record revealed that admission orders, signed by the physician on July 4 2008, directed, " Seroquel 25 mg twice daily; Seroquel 400 mg at bedtime." A review of the " Chronological Record of Medication Regimen Review " revealed that the pharmacist reviewed the resident 's medication on July 29, August 28, September 29, October 27 and December 24, 2008. The pharmacist did not review the resident 's medication in November 2008. There was no evidence that the pharmacist recommended attempting a gradual dose reduction for Resident #5 's Seroquel. A face-to-face interview was conducted with Employee #5 on January 12, 2009 at 3:45 PM. He/she acknowledged that the pharmacist failed to		REET ADDRESS, CITY, STATE, ZIP CODE	01/16	
WASHINGTON NURSING FACILITY (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 428 Continued From page 102 B. Review of Resident #5 's record revealed that admission orders, signed by the physician on July 4 2008, directed, "Seroquel 25 mg twice daily; Seroquel 400 mg at bedtime." A review of the "Chronological Record of Medication Regimen Review" revealed that the pharmacist reviewed the resident 's medication on July 29, August 28, September 29, October 27 and December 24, 2008. The pharmacist did not review the resident 's medication in November 2008. There was no evidence that the pharmacist recommended attempting a gradual dose reduction for Resident #5 's Seroquel. A face-to-face interview was conducted with Employee #5 on January 12, 2009 at 3:45 PM.		REET ADDRESS, CITY, STATE, ZIP CODE		5/2009
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 428 Continued From page 102 B. Review of Resident #5 's record revealed that admission orders, signed by the physician on July 4 2008, directed, "Seroquel 25 mg twice daily; Seroquel 400 mg at bedtime." A review of the "Chronological Record of Medication Regimen Review" revealed that the pharmacist reviewed the resident 's medication on July 29, August 28, September 29, October 27 and December 24, 2008. The pharmacist did not review the resident 's medication in November 2008. There was no evidence that the pharmacist recommended attempting a gradual dose reduction for Resident #5 's Seroquel. A face-to-face interview was conducted with Employee #5 on January 12, 2009 at 3:45 PM.		2425 25TH STREET SE WASHINGTON, DC 20020		
 B. Review of Resident #5 's record revealed that admission orders, signed by the physician on July 2008, directed, "Seroquel 25 mg twice daily; Seroquel 400 mg at bedtime." A review of the "Chronological Record of Medication Regimen Review "revealed that the pharmacist reviewed the resident 's medication on July 29, August 28, September 29, October 27 and December 24, 2008. The pharmacist did not review the resident 's medication in November 2008. There was no evidence that the pharmacist recommended attempting a gradual dose reduction for Resident #5 's Seroquel. A face-to-face interview was conducted with Employee #5 on January 12, 2009 at 3:45 PM. 	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOUL REFERENCED TO THE APPROPRIATE	D BE CROSS-	(X5) COMPLETION DATE
 Preview of Resident #13's record revealed the psychiatrist's order dated October 9, 2008, "Seroquel 50 mg po twice daily for agitated behaviors, Klonopin 1 mg po daily for agitation." There was no "Behavior Flow Sheet" located by Employee #5 at the time of this review for October and December 2008. The November 2008. "Behavior Flow Sheet" was blank. 	4, v i	 483.60 (c.) Drug Regimen Re (continued) 1B. Resident #5 (continued) 4. The Department Head will a report of the data collected a action plans implemented to a sustained compliance at the re Committee which is chaired b Administrator. 2. Resident #13 Psychiatrist consult will be for this resident requesting to the resident for a gradual dos of her Seroquel. For any other resident on S has not been evaluated for a dose reduction, staff will require consultation from the Psychia 3. Compliance will be monito through the Nursing Services Improvement Program's tool f "Psychoactive Drug Review." The Nursing QI Team will forvi findings to the Director of Nur review and evaluation. The Department Head will a report of the data collected a action plans implemented to e sustained compliance at the re Committee which is chaired b Administrator. 	present and any ensure nonthly QI y the ordered evaluate e reduction Seroquel who gradual est a trist. red Quality or vard their sing for her present and any ensure nonthly QI	4/3/09 3/31/09 3/31/09 4/3/09
The pharmacist reviewed the resident's				
				•

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WPBP11

Facility ID: WASHNURS

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	D: 03/04/2009 A APPROVED D: 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		.095022	B. WIN	G		01/1	6/2009
	OVIDER OR SUPPLIER	JITY		24	EET ADDRESS, CITY, STATE, ZIP CODE 425 25TH STREET SE /ASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD I REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETION DATE
F 428	December 18, 2008 recommend a gradu Klonopin and Seroq A face-to-face interv conducted on Janua acknowledged that t	ober 19, November 19, and The pharmacist failed to al dose reduction for the use of uel for Resident #13. riew with Employee #5 was ary 13, 2009 at 3:45 PM. He/she he a gradual dose reduction led by the pharmacist. The	F 4	128			
F 431 SS=D	483.60(b), (d), (e) P The facility must em licensed pharmacist records of receipt ar drugs in sufficient do reconciliation; and d in order and that an	HARMACY SERVICES ploy or obtain the services of a who establishes a system of nd disposition of all controlled etail to enable an accurate etermines that drug records are account of all controlled drugs eriodically reconciled.	F 4	1 31	483.60(b), (d), (e) Pharmacy S	ervices	
	labeled in accordance professional principl accessory and cauti expiration date when In accordance with a facility must store al compartments unde and permit only auth access to the keys. The facility must pro- permanently affixed controlled drugs liste	Is used in the facility must be ce with currently accepted es, and include the appropriate onary instructions, and the n applicable. State and Federal laws, the drugs and biologicals in locked r proper temperature controls, orized personnel to have vide separately locked, compartments for storage of ed in Schedule II of the g Abuse Prevention and					

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		AND HUMAN SERVICES				FORM	APPROVED
			(20) 14			OMB NO. 0938-0391 (X3) DATE SURVEY	
	OF DEFICIENCIES CORRECTION		A. BUIL		PLE CONSTRUCTION	COMPLETED	
. •		095022	. B. WING			01/16/2009	
NAME OF PR		· · · · · · · · · · · · · · · · · · ·		STR	EET ADDRESS, CITY, STATE, ZIP CODE		
WASHING	STON NURSING FACIL	ITY	2425 25TH STREET SE WSHINGTON, DC 20020				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD B REFERENCED TO THE APPROPRIATE DE	E CROSS-	(X5) COMPLETION DATE
TAG F 431	Continued From page Control Act of 1976 abuse, except when package drug distrik quantity stored is mi be readily detected. This REQUIREMEN Based on observation interview, it was deter failed to properly stored temperature controls in the medication can The findings include 1. 22 DCMR 3227.8 for storage of medic temperature betwee forty-six degrees (46 refrigerator shall be that is easily readab working condition. " On January 15, 200 during the inspection the 3 North medication read 24 F. According to the mo reports for 2008, the	ge 104 and other drugs subject to the facility uses single unit oution systems in which the nimal and a missing dose can T is not met as evidenced by: on, record review and staff ermined that the facility staff ore medication under proper is and stored Xalatan unopened rt. , "Each refrigerator that is used ations shall operate at a n thirty-six degrees (36) and B) Fahrenheit (F); each equipped with a thermometer le, accurate and in proper 9, at approximately 10:20 AM, n of the medication refrigerators, on refrigerator 's temperature nthly unit pharmacy inspection e temperature of the 3 North		431	 483.60(b), (d), (e) Pharmacy Set 1. Noted refrigerator temperature retaken at the time of the survey found to be in range. 2. All medication refrigerators we checked for the correct temperation corrections were needed. 3. Medication refrigerators are comonthly by the Consultant Pharmonthly by the Maintenance QI routinely by the nursing staff. Fl in temperature are brought to the attention of the Director of Maint for review and evaluation. 4. The Department Head will provide a report of the data collected and action plans implemented to ensist sustained compliance at the more Committee which is chaired by the Administrator. 2. 1. Xalatan eye drops found imposit of the improper storage of Xalatat drops and no corrections were in 3. Inservice training regarding pristorage of Xalatan eye drops was provided to the staff. 	ervices es were and ere ture and thecked macist, Team and uctuations enance esent d any ure nthly QI he roperly were cked an eye ecessary.	1/16/09 1/16/09 4/3/09 1/16/09 1/16/09
	35 F. A face-to-face interv of the observation w	nber was 28 F and December riew was conducted at the time rith Employee #29. He/she e refrigerator was out			Compliance will be monitored through the Nursing Services Qu Improvement Program's tool for Pass." The Nursing QI Team will forward their findings to the Director of Nursing for her review evaluation.	"Med	3/31/09

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 03/04/2009 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		095022	B. WIN	B. WING		01/10	6/2009
	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
WASHING	GTON NURSING FACIL	JTY		WASHINGTON, DC 20020			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD B REFERENCED TO THE APPROPRIATE DE	E CROSS-	(X5) COMPLETION DATE
F 431		ge 105 iately adjusted the refrigerator	F	431	483.60(b), (d), (e) Pharmacy Se (continued)	ervices	
	to the correct tempe	rature. rved stored unopened in the			 The Department Head will provide a report of the data collected and action plans implemented to ensure sustained compliance at the model. 	d any sure	4/3/09
	on January 16, 2009 medication cart on 2				Committee which is chaired by t Administrator.		
	"Store unopened bo F to 46 F."	nufacturer's recommendation, ttle (s) under refrigeration at 36					
	of the observation w	iew was conducted at the time ith Employees #8 and 54. Both he unopened Xalatan should the refrigerator.			483.65(a) Infection Control 1. Resident #11 1. Employee involved was couns provided inservice with return	seled and	
F 441 SS=D	483.65(a) INFECTIO		F	441	2. Wound treatment observation	was done	3/6/09
	control program des sanitary, and comfor prevent the develop disease and infectio infection control prog				with nursing staff to ensure their 3/31/09 with infection control and wound 3. Inservice training regarding pr handwashing while in the proces wound care treatments was prov	care. oper ss of doing vided to	
	facility, decides wha should be applied to	s, and prevents infections in the t procedures, such as isolation an individual resident; and f incidents and corrective ections.			the staff. Compliance will be more through the Nursing Services Qu Improvement Program's tool for Control." The Nursing QI Team will forward their findings to the Director of Nursing for her evaluation	uality "Infection	3/31/09
		T is not met as evidenced by:			4. The Department Head will pro a report of the data collected and action plans implemented to ens	esent d any ure	4/3/09
		on and record review for two (2) ents, it was determined that wash hands after			sustained compliance at the more Committee which is chaired by the Administrator.		

Facility ID: WASHNURS

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		AND HUMAN SERVICES & MEDICAID SERVICES			· · ·	FORM	: 03/04/2009 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		095022	B. WING			01/10	6/2009
	ROVIDER OR SUPPLIER	LITY	.	2	REET ADDRESS, CITY, STATE, ZIP CODE 2425 25TH STREET SE VASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES I BE PRECEDED BY FULL REGULATORY INTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD B REFERENCED TO THE APPROPRIATE DE	E CROSS-	(X5) COMPLETION DATE
F 441	reaching into a pock wound care treatme clean a soiled mattre Residents #11 and 2 The findings include 1. Facility staff failed reaching into his/het with a wound care the Employee #26 was treatment to Reside approximately 11:30 the resident and exp to do. He/she washe covered with a barri supplies on the table Employee #11 react took out keys and lo failed to wash his/het the wound care treat the treatment cart. A-face-to-face interv Employee# 26 on Ja approximately 10:30 he/she failed to was keys from his/her po 2. Facility staff failed mattress after remonsoaked with the com	 ket before proceeding with a ent for one (1) resident, and ess for one (1) resident. 27. a: b to wash his/her hands after r pocket and before proceeding reatment for Resident #11. observed during a wound care nt #11 on January 14, 2009 at 0 AM. He/she introduced self to blained what he/she was going ed hands, cleaned the table and er before putting the treatment e. b hed into his/her pant's pocket, beked the treatment cart. He/she er hands before proceeding with trment procedure after locking 	F	441	 483.65(a) Infection Control (co. 2. Resident #27 1. Employee involved was cours provided inservice. 2. There are no other residents facility with both a colostomy and require wound care. 3. Inservice training regarding print Infection Control under the cited circumstances was provided to the staff. This practice will be moni- through the Nursing Services Quart Improvement Program's tool for Control." The Nursing QI Tearn will forward their findings to the Director of Nursing for her review evaluation. 4. The Department Head will print a report of the data collected and action plans implemented to ensist sustained compliance at the mo Committee which is chaired by the Administrator. 	seled and in the d who roper he tored uality "Infection w and esent d any sure nthly QI	3/6/09 3/6/09 3/31/09 4/3/09

Event ID: WPBP11

Facility ID: WASHNURS

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		AND HUMAN SERVICES				FORM	: 03/04/2009 APPROVED
CENTER	S FOR MEDICARE	& MEDICAID SERVICES				OMB NO	<u>. 0938-0391</u>
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		095022	B. WIN	G		01/1	6/2009
NAME OF PR				STR	EET ADDRESS, CITY, STATE, ZIP CODE		
WASHING	STON NURSING FACIL	LITY		2	425 25TH STREET SE VASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIATE DE	E CROSS-	(X5) COMPLETION DATE
F 441	treatment on Januar Employee #27. The were observed soile of the resident's colo completed the resid Employee #29 took clean the resident. E of a fitted and flat sh on the mattress and and flat sheets) to m failed to clean the st clean bed linens to n A face-to-face interv Employee #29 on Ja approximately 2:35 the stained mattress	bbserved during a wound by 15, 2009 at 1:15 AM by resident's body and bed linens d and soaked with the contents botomy bag. After Employee #27 ent's wound care treatment, over from Employee #27 to Employee #29 stripped the bed neets, picked up some crumbs applied clean linens (a fitted nake the bed. Employee #29 rained mattress before applying make the bed.	F	441			
	INFECTION The facility must req after each direct res handwashing is indi- practice. This REQUIREMEN Based on observation and medication pass staff failed to: use gl resident plates when checking ladles size	ENTING SPREAD OF uire staff to wash their hands ident contact for which cated by accepted professional T is not met as evidenced by: ons during the tray line service s, it was determined that facility oved hands to place noodles on n plating food; use gloves when as; consistently use gloves when ature and to wash hands after	F	444	 483.65(b)(3) Preventing Spread Infection 1. Tray Line Service A. The Noodle 1. The employee was corrected plate was discarded. 2. All servers were monitored to proper serving and infection cont technique. 3. Inservice was done on the pro of gloves and serving utensils wh handling food and taking tempera Compliance will be monitored thr Nutritional Services Quality Impre Program's tool for "Infection Con QI team will forward their findings 	and the o ensure trol oper use nen atures. rough the ovement trol." The	1/13/09 1/16/09 3/31/09

Facility ID: WASHNURS

If continuation sheet Page 108 of 121

DEPART	MENT OF HEALTH	AND HUMAN SERVICES					APPROVED
	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO.	0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING		·		
		095022	B. WING			01/16/2009	
NAME OF PR				STR	EET ADDRESS, CITY, STATE, ZIP CODE		
WASHING	STON NURSING FACIL	ITY					
				<u></u>	ASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIZ TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIATE DEP	CROSS-	(X5) COMPLETION DATE
F 444	Continued From pag resident JH19 and b to Resident JH4. Th the presence of Em The findings include 1. During tray line of 2009 at 1:40 PM in t following was observed A. Employee #42 wa noodles on resident utensil. B. Dietary staff was sizes with ungloved 2. During tray line o 2009 at 12:40 PM th was observed using testing the temperat Salisbury steak, med carrots, mashed pot Employee #42 insert gloved hand and cle ungloved hand. The above mentione by Employee #14 ar	ye 108 efore administering medications e observations were made in ployees #14, 41 and 51. oservations on January 12, he 1st floor dining room, the ved: as observed placing loose plates with gloved hand not a observed checking the ladle hands. bservations on January 13, e 3rd floor dining services staff one (1) gloved hand when ures for the mechanical soft chanical soft chicken, gravy, atoes and baked potatoes. ted the thermometer with the aned the thermometer with the aned the thermometer with the and findings were acknowledged ad 41.		144	 483.65(b)(3) Preventing Spread Infection (continued) 1. Tray Line Service A. The Noodle (continued) review and evaluation. 4. The Department Head will present a report of the data collected and an action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee whit Is chaired by the Administrator B. Ladle 1. The ladle was taken out of set upon discovery. 2. All servers were monitored to proper serving and infection contitechnique. 3. Inservice was done on the pro- of gloves and serving utensils wh handling food and taking temperation Compliance will be monitored the Nutritional Services Quality Impro- Program's tool for "Infection Conting Director of Nutritional Services for 4. The Department Head will present a report of the data collected and an action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee whit Is chaired by the Administrator 2. The thermometer 1. The thermometer in question of the data collected and an action plans implemented to ensure 	I of I	3/31/09 4/3/09 1/12/09 1/16/09 3/31/09 4/3/09
	during the morning r administered medica failed to wash or sar	9, at approximately 11:30 AM nedication pass, Employee #51 ations to Resident JH19. He/she nitize his/her hands before nistering medications			cleaned using an alcohol pad and gloved hand. 2. All servers were monitored to proper serving and infection cont technique.	ensure	1/13/09

Facility ID: WASHNURS

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483.65(b)(3) Preventing Spread of Infection (continued)

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The Thermometer (continued)
 Inservice was done on the proper use of gloves and serving utensils when handling food and taking temperatures. Compliance will be monitored through the Nutritional Services Quality Improvement Program's tool for "Infection Control." The QI team will forward their findings to the Director of Nutritional Services for his
 The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which Is chaired by the Administrator

3.Resident #JH!

1. The employee was counseled upon discovery.

2. Med Pass observations were done on all the nurses by the QA nurses of the contract pharmacy. Staff who did not follow proper technique were corrected on the spot with follow-up observations done by the Inservice Coordinator of the facility. Competencies were established for all nurses in Med Pass techniques. 3. The Nursing Quality Improvement Team will collect data on the Med Pass technique using the "MAR Review" tool in the Nursing QI Program. They will report their findings to the Director of Nurses. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which Is chaired by the Administrator

4/3/09

3/31/09

1/16/09

3/31/09

3/31/09

4/3/09

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SU COMPLET	RVEY
		095022	B. WIN	IG		01/1	6/2009
	OVIDER OR SUPPLIER			2	EET ADDRESS, CITY, STATE, ZIP CODE 425 25TH STREET SE		
					VASHINGTON, DC 20020	_	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	ATEMENT OF DEFICIENCIES F BE PRECEDED BY FULL REGULATORY INTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD B REFERENCED TO THE APPROPRIATE DE	E CROSS-	(X5) COMPLETION DATE
F 444	Continued From page	ge 109	F	444			
	to Resident JH4.						
	after the observation concurred that no ha occurred after passi	view was conducted immediately n with Employee #51. He/she and-washing or sanitizing ng medication to Resident JH19 g and passing medications to					
F 454	483.70 PHYSICAL I	ENVIRONMENT	F	454	483.70 Physical Environment Resident Room Doors		
SS=D	equipped, and main	designed, constructed, tained to protect the health and personnel and the public.			 New door closures were insta the doors of rooms 110 and 202 All resident room doors were to ensure that they had a positiv 	checked	1/16/09
		IT is not met as evidenced by:			and none were held opened by a other means than the door closu 3. The Maintenance Quality Improv	ire.	1/16/09
	rooms during the en January 12 and 13, facility staff failed to evidenced by propp The environmental t 12, 2009 from 3:06 2009 from 9:25 AM	our was conducted on January PM to 4:10 PM, January 13, to 4:20 PM and January 14,			Team will collect data through their Program on the door closures. The findings will be reported to the Director of Maitenance for his review and evaluation. 4. The Department Head will prese a report of the data collected and ar action plans implemented to ensure sustained compliance at the monthly	QI nt . ıy	3/31/09
	Employees #11, 29,	25 PM in the presence of and 30. The findings were e time of the observations.			Quality Improvement Committee wh Is chaired by the Administrator.	ich	4/3/09
	The findings include	:					
	observed that the er	South and 2 South, it was htry door to the resident ' s were propped open with a					
		were made in the presence of nd 30 who acknowledged					
		. <i>.</i>					

Facility ID: WASHNURS

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

PRINTED: 03/04/2009 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI	TIPLE CONSTRUCT	TION	(X3) DATE SUI COMPLET	
		095022	B. WING		·	01/1	6/2009
	ROVIDER OR SUPPLIER	LITY	s	IREET ADDRESS, 2425 25TH STR WASHINGTO		·	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES I BE PRECEDED BY FULL REGULATORY INTIFYING INFORMATION)	ID PREFIX TAG	(EACH CO	ROVIDER'S PLAN OF CORREC DRRECTIVE ACTION SHOULD CED TO THE APPROPRIATE	BE CROSS-	(X5) COMPLETION DATE
F 454 F 456 SS=F	483.70(c)(2) SPACE The facility must ma electrical, and patien operating condition. This REQUIREMEN Based on observation determined that the essential mechanica equipment in safe o by: a damaged gard machine sink, the di temperature, damage Conditioning (HVAC water temperatures (F) to 110 F in reside temperatures betwe for the laundry wash The environmental to 12, 2009 from 3:06 II 2009 from 9:25 AM 2009 8:15 AM to 4:22 Employees #11, 29, acknowledged at the The findings include 1. One (1) of two (2) observed damaged	me of the observation. E AND EQUIPMENT intain all essential mechanical, int care equipment in safe IT is not met as evidenced by: on and staff interview, it was facility did not maintain all al, electrical, and patient care perating condition as evidenced bage disposal, dishwashing ishwashing machine wash ged Heating Ventilation and Air c) units and pulley hook and between 95 degrees Fahrenheit en 130 - 155 degrees F needed a cycles. our was conducted on January PM to 4:10 PM, January 13, to 4:20 PM and January 14, 25 PM in the presence of and 30. The findings were e time of the observations.	F 45	 Garbag The gatime of the 2. The services valuated determined The As Services valuated determined The As Services valuated determined The As Services valuated value of the Nutritional Program. The Director review and The Determined The Director action plan sustained Sink at 1. The hair was repaired All sinks for any simil were found The As Services with kitchen equility lim use of the E Nutritional S Program. Since of action plans sustained c Quality limp 	sistant Director of Nutril ill monitor the on-going sipment status through Environment section of Services Quality Impro She will report her findi r of Nutritional Services evaluation. Dartment Head will pres the data collected and s implemented to ensu compliance at the mont provement Committee v	aged at placed. sals was ment was ent. utritional bing ugh the n of the provement indings to ices for his present ind any nsure ionthly ee which the sink k. aluated none tional the the vement ngs to s for his sent any re hly	4/3/09 4/3/09 3/31/09 4/3/09 1/31/09 2/28/09 3/31/09 3/31/09
					by the Administrator.		

FORM CMS-2567(02-99) Previous Versions Obsolete

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Facility ID: WASHNURS

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-		AND HUMAN SERVICES & MEDICAID SERVICES			FOR	MAPPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU		(X3) DATE SU COMPLE	JRVEY
	· · · · · · · · · · · · · · · · · · ·	095022	B. WING		01/1	6/2009
	OVIDER OR SUPPLIER	.ITY		STREET ADDRESS, CITY, STATE, ZIP CODE 2425 25TH STREET SE WASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION SH REFERENCED TO THE APPROPRI	OULD BE CROSS-	(X5) COMPLETION DATE
F 456	Continued From pag crack/gap.		F 4	 56 483.70 (c.)(2) Space and E 3. Wash Cycle 1. Heating elements and boos were evaluated for proper ope 	ster heater	
		emperature reached 148 F on 2009 during the dishwashing n.		adjustments were made when necessary.2. Temperatures of the wash	cycle	3/31/09
	136, 206, 304 and 1 5. The right pulley [r	units were observed in rooms N resident lounge area. esident rehabilitation gym		 will be routinely monitored by a Nutritional Services Superviso continued compliance. 3. The Assistant Director of N Services will monitor the on-go 	rs to ensure utritional ping	3/31/09
	observed to have a l 6. Facility staff failed between 95 degrees	l to maintain water temperatures Fahrenheit (F) to 110 F in		kitchen equipment status throu use of the Environment section Nutritional Services Quality Im Program. She will report her f the Director of Nutritional Serv	n of the provement indings to	3/31/09
	without having to us of warm water. Res During the testing of	esidents to have personal care e personal care wipes instead idents F7, F12, F14 and F19. the resident room water nuary 13 and 14, 2009 the water is were as follows		review and evaluation. 4. The Department Head will a report of the data collected a action plans implemented to e sustained compliance at the m Quality Improvement Committed Is chaired by the Administration	and any nsure nonthly ee which	4/3/09
		ratures on January 13, 2009		 Damaged HVAC Units HVAC units noted to be dat time of the survey were correct immediately upon discovery. All HVAC units in resident to 	ted	1/16/09
. [121 77.2 F 137 84.4 F 141 79.3 F 159 82.8 F			and lounge areas were evalua ensure that they were in good 3. The Maintenance Quality In Program monitors the function	ted to condition. provement ing and	1/31/09
	Employee #29 on Ja He/she stated, " The	iew was conducted with muary 13, 2009 at 10:07 AM. e main boiler for the floors [that		repair of the HVAC units. The QI Team will collect data on th report their findings to the Dire evaluation. 4. The Department Head will p	is issue and ctor for his	3/31/09
	and the laundry boile have three (3) boiler	t rooms] is down. The kitchen ers are okay. We [the facility] s. I spoke with the [name of they are on the way		a report of the data collected of temperatures and any action plans implemented to en sustained compliance at the m Quality Improvement Committed is chaired by the Administration	on water nsure lonthly ee which	

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Facility ID: WASHNURS

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DEPART	MENT OF HEALTH	AND HUMAN SERVICES					: 03/04/2009 APPROVED
	S FOR MEDICARE	& MEDICAID SERVICES					0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		PLE CONSTRUCTION	(X3) DATE SUR COMPLETE	
		095022	B. WIN	IG		01/16	5/2009
NAME OF PR	ROVIDER OR SUPPLIER	·		STF	REET ADDRESS, CITY, STATE, ZIP CODE		
	GTON NURSING FACIL	ITY		2	2425 25TH STREET SE		
WASHIN				V	WASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATORY INTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD B REFERENCED TO THE APPROPRIATE DE	E CROSS-	(X5) COMPLETION DATE
F 456	Continued From page		F	456	483.70 (c.)(2) Space and Equip	ment	
	to repair the problem	n.			5. Pulley in the Rehabilitation	Gvm	
	A face-to-face interv	view was conducted with			1. The pulley was repaired upor		
		nuary 13, 2009 at 10:20 AM.			discovery.		1/16/09
		e maintenance department he water temperature problem.			2. All the pulleys were evaluated need for repair .	d for the	1/16/09
		es. The CNA [Certified Nurse			3. The Maintenance Quality Imp	rovement	1/10/09
	Aide] 's on all floors	s is being notified to use the			Program monitors the functioning		
	wipes. "				repair Rehab equipment. The Ma		
	Additional resident r	oom temperatures were as			QI Team will collect data on this		3/31/09
	follows:				report their findings to the Direct evaluation.		3/31/09
					4. The Department Head will pre	esent	
	between 10:43 AM t	eratures on January 13, 2009 to 11:54 AM			a report of the data collected on	water	
	304 78.4 F				temperatures and any		4/3/09
	305 86.1 F				action plans implemented to ens sustained compliance at the more		
	310 73.8 F 313 62.3 F				Quality Improvement Committee		
	313 62.3 F				is chaired by the Administrator.		
	317 66.6 F						
	324 59.0 F						
	333 66.6 F 338 77.7 F				6. Water Temperatures		
	341 77.4 F				1. Water temperatures were atte		
	342 76.1 F				immediately upon discovery. Fac		
	347 65.2 F 354 74.8 F				contractor, Capital Boilers, was capital and hot water temperature		
	357 66.6 F				restored within a matter of hours		1/14/09
	359 79.9 F				both days noted. Disaster Plan v	-	
	Room Water tempe	aratures on January 14, 2000			implemented which included the	1	
	between 8:15 AM to	eratures on January 14, 2009 9:15 AM	[personal care wipes and warmin in the microwave oven.	ig water	
	126 82.0 F				2. Water temperatures were che	ecked	
	205 84.7 F				continuously both as the water e	exited the	1/14/09
	219 85.1 F 231 85.1 F				boilers and as the hot water flow		
	240 89.1 F				of the faucets in the residents' ro appropriate temperatures were r		
	257 84.4 F					etumeu.	
ĺ							
		balata Evant ID: WDBD1					

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Facility ID: WASHNURS

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		PLE CONSTRUCTION	(X3) DATE SUR COMPLETE	VEY
		095022	B. WIN	IG	·	01/16	5/2009
	OVIDER OR SUPPLIER	ודץ		2	EET ADDRESS, CITY, STATE, ZIP CODE 425 25TH STREET SE VASHINGTON, DC 20020		
(X4) ID PREFIX TAG	· (EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIATE DE	E CROSS-	(X5) COMPLETION DATE
F 456	305 91.0 F Beauty shop - 85.6 F A face-to-face interv 14, 2009 at 8:15 AM stated, " The water boiler that provides of have the company of the boiler. When the [the facility] implement warmed for the reside A review of the work revealed, "Boiler air leak in piping ver recommended instal A face-to-face interv 14, 2009 at 8:37 AM stated, " The water yesterday. I haven " know when. " A face-to-face interv 14, 2009 at 8:45 AM stated, " The water dressed. The water wipes. People can't water is cold." A face-to-face interv 14, 2009 at 4:10 PM stated, " I couldn't I had to reschedule 10:00 AM. The water	iew was conducted on January with Employee #29. He/she temperatures are down. The water to the residents is down. I oming back out today to repair e water temperature is down we ent the wipes that can be dents to use for personal care. " corder dated January 14, 2009 #3 [services the resident areas] ht; these [this] is the second time	F -	456	 483.70 (c.)(2) Space and Equip (continued) 6. Water Temperatures (contin 3. The Maintenance Department water temperatures through its Quality Improvement Program and monitors the functioning of the fat boilers through its Preventative Mance Program and routine maint done by its contractor. Nothing of Maintenance or its contractor condone would have prevented the from going down on these two dat 4. The Department Head will pre a report of the data collected on temperatures and any action plans implemented to ens sustained compliance at the mor Quality Improvement Committee is chaired by the Administrator. 	nued) t monitors nd ncility's Mainten- enance either uld have boilers ays. sent water ure nthly	3/31/09

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	•	AND HUMAN SERVICES				FORM	03/04/2009 APPROVED
STATEMENT	RS FOR MEDICARE	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL		PLE CONSTRUCTION (X3)	MB NO. DATE SUR COMPLETE	
		095022	B. WIN	G		01/16	/2009
-	OVIDER OR SUPPLIER			2	REET ADDRESS, CITY, STATE, ZIP CODE 2425 25TH STREET SE VASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	ATEMENT OF DEFICIENCIES I BE PRECEDED BY FULL REGULATORY INTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CRC REFERENCED TO THE APPROPRIATE DEFICIEI		(X5) COMPLETION DATE
F 456	Continued From page	ge 114	F 4	456			
	14, 2009 at 4:25 PM	view was conducted on January I with Resident F14. He/she is cold, it's cold now. I don't wash my arms. "					
	of the laundry it was temperature for thre machines did not re activate the enzyme	2009 at 12:06 PM during a tour observed that the water e (3) of three (3) washing ach 130 degrees F in order to is needed to sanitize and/or ucts from facility linen.					
	The temperatures w 97.1 99.1 77.7	ere as follows:	· .	-			
	dated January 9, 20 [name] These produ bath and their temp degrees. Destainer (bleach):	dor name] letter to the facility 08 revealed, "Detergents: incts are used during the wash- erature range is 130-140 This product is used during the ' temperature range is from 140-	·		 483.70(g) Dining and Resident Act Residents are seated in the third floor dining room so that they are giv sufficient space. Residents in all dining rooms are are seated so that they are given sufficient space. Restorative Nursing will be assign the responsibility of ensuring that pro- 	ven	3/31/09 3/31/09
		re made and acknowledged in ployees #11 and 29.			space is afforded to each resident in dining rooms. The Nursing Supervis will oversee this process to ensure th	the sors	3/31/09
F 464 SS=D	The facility must pro designated for resid These rooms must I ventilated, with non-	ND RESIDENT ACTIVITIES wide one or more rooms ent dining and activities. be well lighted; be well smoking areas identified; be d; and have sufficient space to tivities.	F 4	464		port es. t er	4/3/09

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Facility ID: WASHNURS

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DEPART	MENT OF HEALTH	AND HUMAN SERVICES					: 03/04/2009 APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES					0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		PLE CONSTRUCTION	(X3) DATE SUF COMPLET	
		095022	B. WIN	IG _		01/1	6/2009
NAME OF PR		<u> </u>		STI	REET ADDRESS, CITY, STATE, ZIP CODE		
	GTON NURSING FACI				2425 25TH STREET SE		
WASHING	STON NURSING FACI			۱	WASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES I BE PRECEDED BY FULL REGULATORY INTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIATE DE	E CROSS-	(X5) COMPLETION DATE
F 464	Continued From pag	ge 115	F	464			
		IT is not met as evidenced by:					
	was determined that provide sufficient sp residents dining in t	on during the survey period, it t the facility staff failed to ace for 11 supplemental he rear right section of the 3rd esidents F20, F21, F22, F23, F28, F29 and F30.					
	The findings include	:					
	the above cited resid right section of the 3 steam tables]. Table residents: one (1) in blocked the walk way which was backed a	9 at approximately 12:40 PM, dents were observed in the rear of floor dining room [near the e One residents seated two (2) an electric wheelchair which ay and one (1) in a gerichair against the wall. Table Two idents in regular arm chairs.			483.75(b) Administration		
		three (3) residents: one (1) in a			Resident #7		
	0	s next to the resident in the			1. This resident received her ann		1/7/09
	(2) residents seated	seated at Table One; and two in wheel chairs. Table Four idents: one(1) in a merry walker, chairs.			 An audit was done for all resid the facility to ensure that an annu dental screen was done. Correc made whenever necessary. The unit clerks will perform metals 	ual tion were	3/31/09
	walker and the elect side ways in order to	d in the geri chairs, merry ric wheel chair were positioned b eat at the table, which blocked cked sufficient space in this			quantitative audits noting the data last dental screening. Their findi be communicated to the consulta	e of the ngs will ant	2/21/00
	area.	cked sufficient space in this			dentist. The Clinical Managers w monitor the timeliness of annual screens and communicate their findings to the DON.		3/31/09
F 492 SS=D	483.75(b) ADMINIS		F۰	492	4. The Department Head will pre a report of the data collected and	any action	10.00
	compliance with all a	erate and provide services in applicable Federal, State, and ns, and codes, and with			plans implemented to ensure sus compliance at the monthly QI Co which is chaired by the Administ	mmittee	4/3/09
				· ·	- <u>l </u>		

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Facility ID: WASHNURS

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		AND HUMAN SERVICES			· · · · · · · · · · · · · · · · · · ·	FORM	: 03/04/2009 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		095022	B. WIN	IG		01/1	6/2009
	ROVIDER OR SUPPLIER	LITY		2	REET ADDRESS, CITY, STATE, ZIP CODE 425 25TH STREET SE VASHINGTON, DC 20020	· · ·	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD I REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETION DATE
F 492	Continued From pag accepted profession apply to profession facility. This REQUIREMEN Based on record rev (1) of 30 sampled ret the physician failed and physical for Res #7. The findings include According to 22DCN shall have a compre and evaluation of his every twelve (12) more resident ' s medical A review of Residen last history and phys December 12, 2007 A face-to-face interv Employee #6 on Jar He/she acknowledge	ge 116 hal standards and principles that ils providing services in such a T is not met as evidenced by: riew and staff interview for one sidents, it was determined that to complete an annual history sident 		492			
F 514 SS=D	in December 2008. January 13, 2009. 483.75(I)(1) CLINIC/ The facility must ma	The record was reviewed	F	514	483.75(I)(1) Clinical Records	· .	
	standards and pract	ices that are complete; ted; readily accessible; and			: :		

Event ID: WPBP11

Facility ID: WASHNURS

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DEPART	MENT OF HEALTH	AND HUMAN SERVICES				APPROVED
CENTER	S FOR MEDICARE	& MEDICAID SERVICES			OMB NO	<u>. 0938-0391</u>
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MUL A. BUILD		(X3) DATE SUI COMPLET	
	_	095022	B. WING		01/1	6/2009
NAME OF PR	OVIDER OR SUPPLIER		s	STREET ADDRESS, CITY, STATE, ZIP CODE		
WASHING	GTON NURSING FACI	LITY		2425 25TH STREET SE WASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	ATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOUL REFERENCED TO THE APPROPRIATE	D BE CROSS-	(X5) COMPLETION DATE
F 514	information to identi resident's assessme services provided; t screening conducte notes. This REQUIREMEN Based on record ref (2) of 30 sampled re supplemental reside facility staff failed to record was readily a organized, and failed tracking form in the resident, and failed medication for one and JH18. The findings include 1. A review of Reside (MDS) completed N the resident was co weight:96 pounds	must contain sufficient must contain sufficient ify the resident; a record of the ents; the plan of care and he results of any preadmission d by the State; and progress IT is not met as evidenced by: view and staff interview for two esidents and one (1) ent, it was determined that o ensure that the monthly weight accessible and systematically ed to include the discharge closed record for one (1) to correctly transcribe a (1) resident. Resident #1, 30, e: dent #1's Minimum Data Set lovember 11, 2008 reveled that ded in: " Section K2: Height and , Section K3: Weight Change: 5) percent or more in the last 30	F 5	 483.75(I)(1) Clinical Records Resident #1 The weights for this resider found and made accessible up discovery. Unit clerks reviewed all the charts to ensure that the mont record was readily accessible organized. The Nursing Quality Improve Team will collect data on the redocumentation of weights usin "Weight Change Review" tool Nursing QI Program. They witheir findings to the Director of 4. The Department Head will pareport of the data collected of temperatures and any action plans implemented to ensustained compliance at the mont of the data collected of the sustained compliance at the mont of the data collected of the sustained compliance at the mont of the data collected of the sustained compliance at the mont of the data collected of the sustained compliance at the mont of the data collected of the sustained compliance at the mont of the data collected of the sustained compliance at the mont of the data collected of the sustained compliance at the mont of the data collected of the sustained compliance at the mont of the data collected of the sustained compliance at the mont of the data collected of the data collected of the data collected of the data collected of the sustained compliance at the mont of the data collected of the sustained compliance at the mont of the data collected of the sustained compliance at the mont of the data collected of the data coll	nt were bon resident's hly weight and well vement outine in the in the il report Nurses. present on water nsure nonthly ee which	1/16/09 3/31/09 3/31/09 4/3/09
	A review of the July Order revealed an o "Weigh every mont					
	A review of the resi revealed the followi	dent's Dietary Progress Notes ng:				
	"May 14, 2008 Ann	uual assessment completed"				
FORM CMS-256	57(02-99) Previous Versions C	Dbsolete Event ID: WP8P11		Facility ID: WASHNURS If con	tinuation sheet Pa	age 118 of 121

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		AND HUMAN SERVICES				FORM): 03/04/2009 APPROVED . 0938-0391
STATEMENT OF DEFK AND PLAN OF CORRE		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) ML A. BUIL			(X3) DATE SUI COMPLET	
		095022	B. WIN	G		01/1	6/2009
NAME OF PROVIDER		ITY		24	EET ADDRESS, CITY, STATE, ZIP CODE 425 25TH STREET SE VASHINGTON, DC 20020		
(X4) ID PREFIX (EACH TAG	I DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETION DATE
"Aug Curre " "Oct poun loss The r from clinic weigh Acco Reco weigh Octol Nove Dece Janua The v Septe and H	ent weight: 105 ober 31, 2008: ds decrease 8. " esident's weigh the dietary pro- al record lacke- nt record lacke- nt record was s rding to the "Re rd" form for 20 nt as follows: oper 2008 9 mber 2008 9	ADS/Quarterly Reviewed Today: pounds [increase 7% x 1 month weight check, current: 96 1% x 1 month significant weight at was not easily accessible gress notes and the resident's d evidence that the resident's ystematically organized. esident Weight and Height 08 documented the resident's 8 pounds 97 pounds 88 pounds. 1, May, June, July and re not on the "Resident Weight form and were not easily	F	514	483.75(I)(1) Clinical Records	(continued)	
A fac Empl 11:30 weigl "Resi revie resid 2008 A fac	oyee #6 on Jar AM. He /she ant for April to So ident Weight ar wed the resident ent's weights fr from other multiple-to-face interv	iew was conducted with nuary 16, 2009 at approximately acknowledged that the resident's eptember were not listed on the nd Height Record." Employee #6 nt's record and compiled the om April through September tiple sources in the record. iew was conducted with anuary 16, 2008 at					
ORM CMS-2567(02-99)		bsolete Event ID: WPBP11			cility ID: WASHNURS If conti	nuation sheet P	

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	03/04/2009 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		CONSTRUCTION	(X3) DATE SUR COMPLET	VEY
		095022	B. WIN	IG		01/16	5/2009
NAME OF PR	OVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE		
WASHING	GTON NURSING FACI	_ITY			425 25TH STREET SE		
				V	VASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES DE PRECEDED BY FULL REGULATORY INTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD B REFERENCED TO THE APPROPRIATE DE	E CROSS-	(X5) COMPLETION DATE
F 514	Continued From page	ge 119	F	514	483.75(I)(1) Clinical Records (c	continued)	
	approximately 11:30 the Dietary Progress resident's weight was systematically organ resident's clinical re- resident's weight for was not readily acce Facility staff failed to monthly weight reco systematically organ record. The record w 2. Facility staff faile Tracking "form for R A review of Residen resident was discha on august 28, 2008. was not present in the A face-to-face interv Employee #2 on Jan He/she acknowledg " form should have to was reviewed Janua 3. Facility staff failed correctly on the Med for JH18. A review of the resid physician 's order s 31, 2008, directed, po [by mouth], qd [d	AM. He/she acknowledged that s Notes lacked evidence that the is readily accessible and nized. He/she reviewed the cord and acknowledged that the the month of September 2008 essible. The resident's clinical vas reviewed January 16, 2009. It include the "Discharge esident #30. The "Discharge Tracking" form the record. The was conducted with muary 15, 2009 at 2:30 PM. ed that the "Discharge Tracking peen on the record. The record			 Resident #30 The discharge tracking form v found and made part of the med The medical records of all residence of the med value of the presence of the presence	was ical record. sidents ere of the ctions ment charge ogram. the DON. sent water ure othly which ewed as ed was re that oscription.	1/31/09 3/31/09 4/3/09
			-				

Event ID: WPBP11

Facility ID: WASHNURS

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		AND HUMAN SERVICES					APPROVED
		& MEDICAID SERVICES	1				0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI			(X3) DATE SUP COMPLET	
		095022	B. WING	i		01/10	5/2009
	ROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE		
WASHING	GTON NURSING FACIL				ASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETION DATE
F 514	Continued From page	ge 120	F 5	14	483.75(I)(1) Clinical Records	continued)	
	determined that the transcribed onto the instead of Nifedipine The blister pack loca	ated in the cart was observed as			Resident #JH18 3. The Nursing Quality Improve Team will collect data on the tra of physician orders using the tools in the Nursing QI Program	Inscription	3/31/09
	2008 MAR, the resident daily.	d according to the January dent received the medication riew was conducted at the time			They will report their findings to 4. The Department Head will pr a report of the data collected or temperatures and any action plane implemented to on	esent water	4/3/09
	of this observation w acknowledged that t	vith Employee #54. He/she the above cited order was tly on the MAR. The record was			action plans implemented to en sustained compliance at the mo Quality Improvement Committe is chaired by the Administrator	onthly	
			<u>.</u>				
		•					
		· · · · · · · · · · · · · · · · · · ·			· · · ·		
							· .
FORM CMS-256	67(02-99) Previous Versions O	bsolete Event ID: WPBP11	1	Fac	ility ID: WASHNURS If contin	nuation sheet Pa	age 121 of 121