Revised 8/14/06

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

PRINTED: 07/28/2006
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095022	A. BUILDING _____ B. WING _____	R 07/19/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON NURSING FACILITY	2426 26TH STREET SE WASHINGTON, DC 20020

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 309}	Continued From page 10 drawn. A face-to-face interview with the Clinical Manager was conducted on July 19, 2006 at 1:50 PM. He/she acknowledged that the blood test was not done. The blood test was done on July 19, 2006 and the results were within the physician's specified parameters. The record was reviewed July 19, 2006.	{F 309}		
{F 314} SS=D	483.25(c) PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by : Based on observation, record review and staff interview, for one (1) of 18 sampled residents, it was determined that facility staff failed assess and obtain a treatment order for three (3) open areas on the resident's right buttocks. Resident # 1. The findings include: During a treatment observation on July 19, 2006 at 11:32 AM for the left buttocks, it was observed that the staff nurse administered a treatment to	{F 314}	**483.25© PRESSURE SORES** Resident #1 1. The treatment order was obtained immediately upon discovery that one was not present. The nurse involved in this treatment was counseled regarding treatment without an order. 7/19/06 2. Inservicing was done with the licensed nursing staff to emphasize that treatments must be ordered by a physician and that skin assessments and documentation of the assessment is done in an appropriate and timely manner. 8/1/06 3. The Clinical Mangers and Assistant Clinical Managers on each unit will monitor their residents' treatment orders to ensure that physician orders are present for each treatment that is performed. They will report their findings to the Director of Nurses. 8/4/06 4. The Director of Nurses will oversee the monitoring. The results of her monitoring, along with any action plans for improvement will be integrated into the quality improvement program. 8/4/06	

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{F 314}	Continued From page 11 three (3) open areas on the right buttocks. A review of Resident #1's "Physician's Telephone Order Sheet" dated July 17, 2006 read "Clean open area on left buttock ... NS (normal saline) ... Seasorb dressing and 4X4 tape Q day (every day) till healed". There was no treatment order for the right buttock. Additionally, the July 2006 " Treatment Administration Record" lacked evidence of an order to treat the three (3) open areas to the right buttocks. A review of the facility's "Weekly Wound Progress Report", physician's and nurses' progress notes revealed that there was no assessment identifying the three (3) open areas to the resident's right buttocks; therefore, it could not be determine that the treatment administered was appropriate. A face-to-face interview was conducted with the staff nurse on July 19, 2006 at 12:26 PM. The staff nurse acknowledged that he/she treated three (3) open areas to the resident's right buttocks without a physician's order. He/she stated, " The areas have been opened for about one week." The record was reviewed July 19, 2006.	{F 314}		
{F 323} SS=E	483.25(h)(1) ACCIDENTS The facility must ensure that the resident environment remains as free of accident hazards as is possible. This REQUIREMENT is not met as evidenced by	{F 323}		

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{F 323}	Continued From page 12 Based on observations during the survey period, it was determined that facility staff failed to provide safety for the residents from environmental hazards as evidenced by: an unsecured toilet and front covers of over bed lamps, damaged floor tiles, an unsteady table and water left running in two (2) tub rooms. These observations were made in the presence of the Directors of Maintenance and Housekeeping and/ or nursing staff. The findings include: 1. Toilets were not secured to the floor in the 1 South shower room and rooms 142, 146, and 153 in four (4) of eight (8) observations between 10:20 AM and 1:00 PM on July 19, 2006. 2. Over bed lamp covers were not secured to the lamp frames in rooms 114, 144 and 154 in three (3) of nine (9) observations between 10:20 AM and 1:30 PM on July 19, 2006. 3. Floor tiles were damaged in the 1 South dining room and 3 North pantry area in two (2) of two (2) observations between 12:00 PM and 1:00 PM on July 19, 2006. 4. A table in the dining room on the second floor was supported by another table. When the supporting table was examined, the first table fell to the floor in one (1) of one (1) observation at approximately 3:20 PM on July 19, 2006. 5. Water was observed running in the tub rooms unattended on units 2N and 3S during the tour of the facility at approximately 9:40 AM on July 19, 2006.	{F 323}	**483.25(h)(1) ACCIDENTS** Toilets, Overbed lamp covers, floor tiles, table in 2nd floor dining room, running water 1. Issues cited at the time of the survey have been addressed and corrected. The toilet was secured, the overbed lamps were secured to the walls, damaged floor tile was replaced, diningroom table was removed, and the water was turned off tightly. 2. Toilets, overbed lamps, floor tiles, broken tables and running water throughout the facility have been evaluated so that maintenance can address their repair. 3. The Director of Maintenance and his staff will monitor these issues ensure their repair has been sustained. 4. The Director of Maintenance will oversee the monitoring. The results of his monitoring, along with any action plans for improvement will be integrated into the quality improvement program.	8/4/06 8/4/06 8/4/06 8/4/06

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{F 323}	Continued From page 13 Items #1, 2 and 3 were repeated deficiencies from the recertification survey completed May 19, 2006. The plan of correction indicated these items would be repaired and/or corrected on May 19, 2006.	{F 323}	**483.25(h)(2) ACCIDENTS** 1. The Customer Service Representative who was tardy arriving at her post in the kiosk was counseled regarding notification of the facility of any tardiness. 2. The facility security guard will man the kiosk at 7:00 AM on any day that the Customer Service Representative is tardy. 3. The 11-7 Nursing House Supervisor will assist in the monitoring of the kiosk at 7 AM. S/he will report the findings of the monitoring to the Assistant Administrator. 4. The Assistant Administrator will oversee the monitoring. The results of his monitoring, along with any action plans for improvement, will be integrated into the quality improvement program.	7/19/06 7/30/06 8/4/06 8/4/06
{F 324} SS=D	483.25(h)(2) ACCIDENTS The facility must ensure that each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by : Based on observation and staff interview, it was determined that facility staff failed to provide staffing in the kiosk located at the front of the building. The findings include: On July 19, 2006, it was observed that the Customer Service Representative (CSR) arrived at the kiosk located at the entrance of the facility at 7:17 AM. A face-to-face interview was conducted on July 19, 2006 at 7:30 AM with the CSR at the front desk. He/she stated that the other CSRs that were scheduled to work that day were running late. According to the plan of correction for the incident investigation completed May 1, 2006, "A Customer Service Representative (CSR) will be in	{F 324}		

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{F 324}	Continued From page 14 the kiosk at 7:00 AM." The facility failed to follow their plan of correction.	{F 324}	**483.35 I)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE** Open Doors and flies 1. The front and rear door of the Nutritional Service Department was closed immediately upon discovery. 2. Inservice was done with the Nutritional Services staff to ensure their understanding for the need to keep the doors closed and to maintain a pest-free environment. Bay City Pest Management, the facility's longstanding pest control company, was called in to do an additional review of the kitchen. No flies or other pests were found. The air screen at the back door was repaired and is now operable allowing for pest protection when the door is opened during deliveries times. 3. The Nutritional Services Assistant Director and supervisors will monitor the doors in the kitchen and for the presence of any pests. They will report their findings to the Director of Nutritional Services. 4. The Director of Nutritional Services will oversee the monitoring. The results of his monitoring, along with any action plans for improvement will be integrated into the quality improvement program. Kitchen Floor 1. Repairs to the cited areas of the kitchen floor were completed. The areas have been smoothed and painted to allow for an easily cleanable surface. 2. All areas of the floor throughout the kitchen have been evaluated so that maintenance can address their repair. 3. The Director of Maintenance and his staff will monitor these issues ensure their repair has been sustained. 4. The Director of Maintenance will oversee the monitoring. The results of his monitoring, along with any action plans for improvement will be integrated into the quality improvement program.	7/19/06 8/2/06 8/4/06 8/4/06 8/4/06 8/4/06 8/4/06
{F 371} SS=D	483.35(i)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by : Based on observations on July 19, 2006, it was determined that the facility failed to maintain safe and sanitary conditions as evidenced by: open front and back doors to the main kitchen, flies in the kitchen and damaged floors. The findings include: 1. The front and back doors to the main kitchen was observed in the open position at 7:20 AM on July 19, 2006. 2. Flies were observed in the food preparation and tray line areas at 7:20 AM on July 19, 2006. 3. Floors throughout the main kitchen were observed cracked and in disrepair. This was a repeat deficiency from the recertification survey completed May 19, 2006. According to the plan of correction, floor repairs were to be completed by July 9, 2006.	{F 371}		

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{F 441} SS=D	483.65(a) INFECTION CONTROL The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections. This REQUIREMENT is not met as evidenced by : Based on observations during the survey period, facility staff failed to provide a safe, sanitary and comfortable environment as evidenced by: soiled shower chair seats, shower stretcher, and protective floor mat. These findings were observed in the presence of the Directors of Maintenance, Housekeeping and Nursing Staff. The findings include: 1. Soiled shower chairs were observed in the 1 North and 1 South shower rooms on July 19, 2006 between 10:20 AM and 11:30 AM in two (2) of two (2) observations. 2. A shower stretcher was observed soiled with a brown substance in the shower room on unit 2N at approximately 9:30 AM on July 19, 2006 3. Soiled and uncovered bedside mat was observed in room 106 during the survey in one (1) of one (1) observation at 1:11 PM on July 19, 2006.	{F 441}	**483.65(a) INFECTION CONTROL** Shower chairs, shower stretcher, and bedside mats 1. All areas cited at the time of the survey have been addressed and infection control maintained. Shower chairs were cleaned, shower stretchers were cleaned and the bedside mat was cleaned. 2. Inservices were done with all levels of nursing staff reviewing the principals and practice of infection control including the proper and timely cleaning of the cited areas. 3. The Charge nurses and Clinical Management Staff on the units will monitor these issues to ensure their cleanliness has been sustained. They will report their findings to the Director of Nurses. 4. The Director of Nurses will oversee the monitoring. The results of her monitoring, along with any action plans for improvement will be integrated into the quality improvement program.	8/1/06 8/1/06 8/4/06 8/4/06

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{F 456} SS=B	483.70(c)(2) SPACE AND EQUIPMENT The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by : Based on observations during the survey period, facility staff failed to maintain amplification devices on public telephones. These observations were made in the presence of the Directors of Maintenance, Housekeeping and Nursing Staff. The findings include: Amplification devices of public telephones failed to operate when tested on 1 South, 1 North and 2 North in three (3) of three (3) observations from 10:30 AM to 4:30 PM on July 19, 2006.	{F 456}	**483.70(c)(2) SPACE AND EQUIPMENT** 1. Verizon was called for a service call to correct the pay phone amplifiers cited at the time of the survey. 2. All pay phone amplifiers were checked and repairs were done as needed. All pay phones on the resident units having working amplification devices. 3. Monitoring of the devices will be done by the maintenance staff to ensure their repair is sustained. The results of their monitoring will be forwarded to the Director of Maintenance. 4. The Director of Maintenance will oversee the monitoring. The results of his monitoring, along with any action plans for improvement will be integrated into the quality improvement program.	8/1/06 8/1/06 8/4/06 8/4/06
F 469 SS=F	483.70(h)(4) PHYSICAL ENVIRONMENT- PEST CONTROL The facility must maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by : Based on observations on July 19, 2006, it was determined that flies and gnats were observed throughout the facility. The findings include:	F 469	**483.70(h)(4) PEST CONTROL** 1. Bay City Pest Management, the facility's long-standing pest control company, did a review of the cited areas. Their recommendations were followed and any cited flies/gnats were eliminated. 2. Bay City Pest Management evaluated other areas of the facility which had the potential for the presence of flies/gnats. Their recommendations were followed and any flies/gnats were eliminated. 3. Bay City Pest Management Company has a schedule for their extermination services where the facility is visited 48 times per year to ensure that the presence of pests does not occur. The results of their monitoring will be maintained by the Directors of Housekeeping and	8/2/06 8/2/06 8/2/06

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F 469	Continued From page 17 Flies and gnats were observed in the following areas: Flies in the main kitchen at 7:20 AM. Flies by the 3rd floor elevator at 8:30 AM. Flies and gnats by the 1st floor elevator at 8:40 AM. Fly near room 317 at 9:30 AM. Fly by room 146 at 10:05 AM. Fly by the 2nd floor elevator at 10:30 AM. Gnats by the nurse's station at 1:10 PM. Fly near room 358 at 2:20 PM.	F 469	Maintenance. 4. The Assistant Administrator will oversee the monitoring. The results of his monitoring, along with any action plans for improvement will be integrated into the quality improvement program.	8/4/06
{F 490} SS=F	483.75 ADMINISTRATION A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by : Based on observations, record reviews and staff interviews, it was determined that the Administrator failed to integrate, coordinate and monitor the facility's practice related to resident's care.	{F 490}	**483.75 ADMINISTRATION** 1. See responses to 483.15, F253, 483.25, F323, F324, 483.35, F371, 483.65, F 441, 483.70, F469. 2. See responses to 483.15, F241, 483.20, F279, 483.25, F309, F314.	8/4/06 8/4/06

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{F 490}	Continued From page 18 The findings include: 1. The Administrator failed to ensure that housekeeping and maintenance services were maintained in a safe and sanitary manner. Cross reference 483.15, Quality of Life, F 253; 483.25, Quality of Care, F323 and F324; 483.35 Dietary Services, F 371; 483.65 Infection Control, F 441, and 483.70, Physical Environment, F 469. 2. The Administrator failed to integrate residents' care and provide or arrange services to meet professional standards of quality. Cross reference 483.15 Quality of Life, F241; 483.20 Resident Assessment, F279; 483.25 Quality of Care, F309 and F314.	{F 490}		
{F 493} SS=F	483.75(d)(1)-(2) GOVERNING BODY The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and the governing body appoints the administrator who is licensed by the State where licensing is required; and responsible for the management of the facility This REQUIREMENT is not met as evidenced by : Based on observations, record reviews and staff interviews, it was determined that the Administrator failed to integrate, coordinate and monitor the facility's practice related to resident ' s	{F 493}	483.75(d) GOVERNING BODY 1.See responses to 483.15, F253, 483.25, F323, F324, 483.35, F371, 483.65, F441, 483.70, F469. 2. See responses to 483.15, F241, 483.20, F279, 483.25, F309 and F314.	8/4/06 8/4/06

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{F 493}	Continued From page 19 care. The findings include: 1. The Governing Body failed to ensure that housekeeping and maintenance services were maintained in a safe and sanitary manner. Cross reference 483.15, Quality of Life, F 253; 483.25, Quality of Care, F323 and F324; 483.35 Dietary Services, F 371; 483.65 Infection Control, F 441, and 483.70, Physical Environment, F 469. 2. The Governing Body failed to integrate residents' care and provide or arrange services to meet professional standards of quality. Cross reference 483.15 Quality of Life, F241; 483.20 Resident Assessment, F279; 483.25 Quality of Care, F309 and F314.	{F 493}		
{F 514} SS=D	483.75(l)(1) CLINICAL RECORDS The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by :	{F 514}	**483.75(l)(1) CLINICAL RECORDS** Resident #W2 1. The charge nurse did document via a written statement but failed to transfer the information to the resident's medical record. A late entry of the incident was done. 2. Medical charts of residents having the potential to be affected were reviewed and corrections were made when necessary. The licensed nursing staff was inserviced on the regulatory and legal aspects of documentation. 3 The Clinical Mangers and Assistant Clinical Managers on each unit will monitor the documentation when there is an allegation of resident abuse. They will ensure that proper documentation is available in the medical record. The results of their monitoring will be forwarded to the Director of Nurses. 4. The Director of Nurses will oversee the monitoring. The results of her monitoring, along with any action plans for improvement will be integrated into the quality improvement program.	7/19/06 8/4/06 8/1/06 8/4/06 8/4/06

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{F 514}	Continued From page 20 Based on record review and staff and resident interviews, it was determined that facility staff failed to document an alleged staff-to-resident abuse incident in the nurses' notes. Resident W2 . The findings include: A face-to-face interview was conducted with Resident W2 on July 19, 2006 at approximately 4: 00 PM. He/She stated, " [CNA] hit me. [CNA] tried to hit me on the face and I stopped him/her with my hand. [CNA] made contact with my hand. This was about 2 or 3 weeks ago. " An entry in the nurses ' notes dated July 17, 2006 at 11:40 AM revealed the following: " Writer spoke with [Psychiatrist] regarding resident being agitated and also informed him/her about resident behavior last Sunday ... DON (Director of Nursing) also left a message for resident ' s social worker ... " The social service progress notes included the following: " July 17, 2006 @ 12:15 noon, Statement from [Resident] RE: 7/16/06 incident. ...I was standing outside hallway of Rm 357 and he/she punched at me - was blocked by my left forearm ... " The nurses ' notes failed to include reference to the incident of alleged resident abuse on July 16, 2006. The record was reviewed on July 19, 2006.	{F 514}		