STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	06/22/2007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An annual recertification survey was conducted June 18 through 22, 2007. The following deficiencies were based on observations, record reviews and staff interviews. The sample included 30 residents based on a census of 237 residents on the first day of survey, and three (3) supplemental residents.	F 000	**The Washington Center for Aging Services makes its best efforts to operate in substantial compliance with both Federal and state Law. Submission of this Plan of Correction(POC) does not constitute an admission or agreement by any party, its officers, directors, employees or agents as the truth of the facts alleged or the validity of the conditions set forth alleged or the validity of the conditions set forth on the Statement of Deficiencies. This plan of Correction (POC) is prepared and /or executed solely because it is required by federal and state Law.**	
F 164 SS=D	483.10(e), 483.75(l)(4) PRIVACY AND CONFIDENTIALITY The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.	F 164	**F164 Privacy and Confidentiality** 1. Resident 4 hospital grown was pulled down to cover the buttocks. 2. All residents were evaluated and no other resident was affected by this practice. 3. A meeting was held with staff to remind them if resident is uncovered to re-cover the resident to ensure privacy. 4. Monitoring the resident's rights, including privacy, is a part of the quality program and is presented at QI Meeting.	6/27/07

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Williston E. A. Page	Administrator	9-18-07

...y deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ...er safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days ...owing 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 ...s following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ...gram participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	06/22/2007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 164	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation of one (1) of four (4) wound treatment observations, it was determined that facility staff failed to cover Resident #4 to prevent unnecessary exposure of the body. The findings include: A wound treatment observation to Resident #4's left lateral foot under the small toe was conducted on June 19, 2007 at 1:10 PM. Upon entering the room, Employee #13 stated that the resident had just been transferred into bed. The resident was laying on his/her right side wearing a hospital gown. The resident's buttocks and lower extremities were uncovered. Employee #13 entered with a basket of wound treatment items, placed the basket on the bedside table and spoke briefly to the resident. Employee #13 then pulled the hospital gown over the resident's buttocks.	F 164		
F 246 SS=D	483.15(e)(1) ACCOMODATION OF NEEDS A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by:	F 246	**F -246 Accommodations of Needs** 1 Call Bells in rooms 201B, 218B, 219A, 307B, 313B, 314B and 319B were immediately placed in reach of the residents. 2 The other resident's rooms were checked and the other call bells were noted to be within reach of the residents. No other residents were affected by this practice. 3 The nursing staff was re-instructed of this requirement and will be instructed to check call bell placement during each round. 4 Monitoring of call bells for proper placement is conducted by nursing management. This information is presented at QI Meeting.	6/27/07

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	06/22/2007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 246	Continued From page 2 Based on observations during the initial tour for two (2) of nine (9) resident units, it was determined that facility staff failed to position call bells within reach of residents. Observations were made in the presence of facility nursing staff. The findings include: The initial tour of the two (2) units was conducted on June 18, 2007 from 8:40 AM until 10:50 AM. The following call bells were observed out of reach of residents: 2 Blue rooms: 201B, 218B, and 219A. 3 Blue rooms: 307B, 313B, 314B and 319B. Employee #15 [3 Blue] and Employee #16 [2 Blue] acknowledged the above cited deficiencies at the time of the observations.	F 246		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations during the survey period, it was determined that housekeeping and maintenances services were not adequate to ensure that the facility was maintained in a safe and sanitary manner as evidenced by: soiled grates in the rear of washers in the laundry room, a wall in the therapy room, pantry counter tops and sinks, compressor fan covers and the refrigerator unit cover, cleaning equipment and other items were stored on the floor, under the sink and under the ice machine, a hole in the wall,	F 253	**F-253 Housekeeping/ Maintenance** 1. The soiled grates in the rear of washers in the laundry room, a wall in the therapy room, pantry counter tops and sinks, compressor fan covers and the refrigerator unit cover, cleaning equipment and other items that were stored on the floor, under the ice machine, the hole in the wall, the base board that were missing under the refrigerator were reviewed by Environmental Services Manager and were corrected as indicated. All cleaning equipment and paper supplies that were stored under sinks have been removed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	06/22/2007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253	Continued From page 3 the baseboard was missing under the refrigerator and marred floors. The findings include: 1. The top surfaces of metal grates in the rear of washers were soiled in the laundry room with accumulated lint and debris in one (1) of one (1) observation of a grate at approximately 12:15 PM on June 18, 2007 and June 19, 2007 at 3:30 PM in the presence of Employee #20. 2. A brown substance measuring 3 inches by 4 inches was noted on the wall of the occupational therapy room behind the triceps press machine on June 20, 2007 at 9:25 AM in the presence of Employee #24. 3. Counter tops and sinks were observed soiled with stains and debris as follows: 3 Green Pantry -The sink and pantry counter top was soiled with water stains and debris at 8:20 AM on June 20, 2007 observed in the presence of Employee #11. 2 Green Pantry - The sink and pantry counter top was soiled with water stains and debris at 8:30 AM on June 20, 2007 in the presence of Employee #10. The sink in the physical therapy room was soiled with stains and debris in one (1) of two (2) sinks observed on June 20, 2007 at 9:15 AM in the presence of Employee #24. 4. Compressor fan covers and the outer surface of the refrigeration unit were soiled with accumulated dust and debris in the walk in	F 253	2. Environmental Services and Engineering Management Team inspected all soiled grates in the rear of washers in the laundry room, the wall surfaces in the therapy room, pantry counter tops and under the sinks, compressor fan covers, and location of cleaning equipment, and floor and surfaces under the sink and ice machine. The areas were repaired, cleaned or items stored as needed. 3. Environmental Management team re-educated staff on proper cleaning procedures and preventive maintenance program. 4. Monitoring the environment is a part of the Environmental Services and Engineering program. Findings are presented at the QI meetings.	7/20/07

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	06/22/2007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253	Continued From page 4 produce refrigerator in one (1) of two (2) fan covers observed at 9:00 AM on June 18, 2007 in the presence of Employee #26. 5. Cleaning equipment was stored on floor surfaces in the janitorial closet, cart wash room and food preparation areas of the main kitchen in three (3) of three (3) areas observed between 8:39 AM and 11:00 AM on June 18, 2007 in the presence of Employee #26. 6. Nine (9) pantries were observed, one (1) on each unit in the facility. The following items were observed stored on the floor and under the sink and ice machine in the following areas: 1 Green - A box of Styrofoam water pitchers was observed stored in a cabinet under the ice machine at 9:00 AM on June 20, 2007 in the presence of Employee #9. 3 Blue - One (1) box of disposable diapers was stored on the floor and three (3) boxes of disposable diapers were stored on/in the sink of the supply closet. Cleaning items and rolls of clear plastic tape were stored under the sink in the trash room on the same unit in two (2) of two (2) sinks observed between 8:40 AM and 9:20 AM on June 18, 2007 in the presence of Employee #15. 1 Blue - 10 rolls of paper towels, a cookie sheet and serving bowl were observed under the sink in the pantry on June 18, 2007 at 10:45 AM in the presence of Employee # 3. 7. A hole in the wall was observed behind the door to the supply closet on 3 Blue on June 18, 2007 at 8:40 AM in the presence of Employee	F 253		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	06/22/2007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253	Continued From page 5 #15. The size and shape of the hole matched the size and shape of the door handle. 8. The baseboard under the refrigerator in the 2 Green pantry was missing observed on June 20, 2007 at 8:45 AM in the presence of Employee #10. 9. The floor in the 1 Orange dining room was observed to be marred and scarred on June 19 2007 at 12:30 PM observed in the presence of Employee #20. The identified employees acknowledged the deficient practice at the time of the observations.	F 253		
F 257 SS=D	483.15(h)(6) ENVIRONMENT- TEMPERATURE The facility must provide comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 - 81° F This REQUIREMENT is not met as evidenced by: Based on observations during the survey, it was determined that ambient air temperatures were above 81 degrees Fahrenheit (F). The findings include: On June 19, 2007 between 11:00 AM and 12:30 PM the follow temperatures were recorded: 3 Orange nursing station: 84 degrees F. 2 Orange nursing station: 84 degrees F. 1 Green nursing station: 86 degrees F. 2 Green, Room 280: 88 degrees F.	F 257	**F 257 Environment/ Temperature** 1. The air conditioning was adjusted on the nursing units; however nursing staff verbalized comfort with the temperature setting. The resident in room 280 expressed to Nursing and Engineering staff that she preferred not to have her air-conditioning unit turned on and is comfortable with her room temperature. 2. The temperature in the resident's room 280 and common areas were checked, and were noted to meet a comfortable safe temperature range. No residents were affected by this practice. 3. The Engineering Department will monitor the ambient temperature at the nursing station. 4. Monitng the air temperature is a part of the Engineering program and is presented at the QI meetings.	6/19/07

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	06/22/2007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 257	Continued From page 6 Employee #23 acknowledged the elevated temperatures at the time of the observations. Residents residing on the above cited units did not complain of being hot or uncomfortable.	F 257		
F 278 SS=D	483.20(g) - (j) RESIDENT ASSESSMENT The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record reviews for two (2) of 30 sampled residents and one (1)	F 278	**F278 Resident Assessment** 1. The MDS for resident #23 was corrected to indicate accurate staging. The current MDS for resident 24 and S1 are correct. Unable to retrospectively correct. 2. All MDSs submitted within the last 30 days have been reviewed for accuracy. No other resident affected by this practice. 3. The clinical team was in-serviced on the accuracy of MDS coding and staging of pressure sores. 4. The MDS Coordinator & Dietitian will monitor this aspect and report findings at the QI Meetings.	7/15/07

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	06/22/2007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 257	Continued From page 6 Employee #23 acknowledged the elevated temperatures at the time of the observations. Residents residing on the above cited units did not complain of being hot or uncomfortable.	F 257		
F 278 SS=D	483.20(g) - (j) RESIDENT ASSESSMENT The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record reviews for two (2) of 30 sampled residents and one (1)	F 278	**F278 Resident Assessment** 1. The MDS for resident #23 was corrected to indicate accurate staging. The current MDS for resident 24 and S1 are correct. Unable to retrospectively correct. 2. All MDSs submitted within the last 30 days have been reviewed for accuracy. No other resident affected by this practice. 3. The clinical team was in-serviced on the accuracy of MDS coding. 4. The MDS Coordinator & Dietitian will monitor this aspect and report findings at the QI Meetings.	7/15/07

7A

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	06/22/2007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 7 supplemental resident, it was determined that facility staff failed to accurately code the Minimum Data Set (MDS) assessment for: a pressure sore for one (1) resident, weight for one (1) resident and insufficient fluids for one (1) resident. Residents #23, 24 and S1. The findings include: 1. Facility staff failed to accurately code a pressure sore on the admission MDS for Resident #23. A review of Resident #23's record revealed an admission nurse's note dated April 23, 2007 at 4:45 PM, "Dried eschar present on the left heel." According to the admission MDS completed May 6, 2007, the resident was coded in Section M1. The resident was coded in Section M2 as having one (1) pressure ulcer at Stage II. According to the, "MDS 2.0 User's Manual" page 3-160, " If eschar is present, prohibiting accurate staging, code the skin ulcer as Stage "4" until the eschar has been debrided ..." A face-to-face interview was conducted with Employee #12 on June 22, 2007 at 7:30 AM. Employee #12 was asked how he/she staged pressure ulcers with eschar. Employee #12 stated, "I can tell what stage the wound is underneath the eschar just by my experience." Employee #12 was asked if he/she staged pressure sores any differently for the MDS. Employee #12 stated, "No, I stage what I see and what I determine by my experience." The record was reviewed June 22, 2007.	F 278		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	06/22/2007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 8 2. The facility staff failed to record the resident's correct weight on the significant change MDS for Resident #24. A review of the Resident #24's record revealed a significant change MDS, completed November 14, 2006, Section K2 [Height and Weight], recorded the resident's weight as 148 pounds. The "Monthly Vital Signs Flow" sheet for November 1, 2006 and the Medication Administration Record (MAR) for November 2 and 9, 2006 indicated the resident's weight was 138 pounds. The record was reviewed June 20, 2007. 3. Facility staff failed to accurately code Resident S1 for fluid consumption. A review of Resident S1's record revealed a significant change MDS completed May 10, 2007. Section J, 1d, coded the resident for, "Insufficient fluids, did not consume all/almost all liquids during the last 3 days." A face-to-face interview with Employee #6 was conducted on June 21, 2007 at 8:00 AM. He/she stated that coding the resident for insufficient fluids was done in error and that a significant correction would be completed the same day. The record was reviewed June 21, 2007.	F 278		
F 279 SS=D	483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care	F 279	**F-279 Comprehensive Care Plans** 1. Care plans for residents 5, 11, were reviewed and updated with appropriate goals and approaches for potential adverse drug reaction and consequence of refusing care.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	06/22/2007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 9 plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interviews and record review for two (2) of 30 sampled residents, it was determined that facility staff failed to initiate a care plan with appropriate goals and approaches for: one (1) resident for potential adverse drug interactions from the use of nine (9) or more medications and one (1) resident who refused care. Residents #5 and 11. The findings include: 1. Facility staff failed to initiate a care plan with appropriate goals and approaches for potential adverse drug interactions from the use of nine (9) or more medications for Resident #5. A review of Resident #5's record revealed a physician's order dated and signed May 10, 2007 which prescribed the following: Norvasc, Pepcid, Feosol, Hydrochlorothiazide, Keppra, Glytrol,	F 279	2. Care plan audits were conducted for all residents prescribed 9 or more meds and for residents who wear splints. They were updated with appropriate, goals approaches for potential adverse reactions and conquenseces of refusing care if indicated. 3. In-service was conducted for all IDT members on requirements and compliance and issues. 4. The care plans are audited and findings are reported at the quarterly QI meetings.	7/15/07

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	06/22/2007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 10 Labetalol, Lisinopril, Senna Gen, Ativan, Haldol, and Lantus. The interdisciplinary care plan was last reviewed June 1, 2007 and failed to include appropriate goals and approaches for the potential adverse drug interactions from the use of nine (9) or more medications. A face-to-face interview was conducted with Employee #10 on June 18, 2007, at 3:50 PM. He/she acknowledged that Resident #5's care plan did not include goals and approaches for the potential adverse drug interactions from the use of nine (9) or more medications. The record was reviewed June 18, 2007. 2. Facility staff failed to initiate a care plan with appropriate goals and interventions for Resident #11's behavior of refusing to wear hand splints. On June 19, 2005 at 9:05 AM and June 22, 2007 at approximately 8:30 AM Resident #11 was observed in his/her room without hand splints. A face-to-face interview was conducted with Resident #11 on June 22, 2007 at 8:30 AM. He/she stated, "I don't wear them [the splints] they get in the way. I need to use my hands." A review of the care plan last updated March 22, 2007, did not include the resident's behavior of refusing care. A face-to-face interview was conducted with Employee #9 on June 20, 2007 at 11:00 AM. He/She acknowledged that the resident refuses to wear his/her splint and is not care planned for refusing to wear splints. The record was	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	06/22/2007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 11 reviewed June 22, 2007.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review for two (2) of 30 sampled residents, it was determined that facility staff failed to update the "Falls" care plan with additional goals and approaches to prevent further falls. Residents #5 and 11. The findings include: 1. Facility staff failed to update Resident #5's care plan for falls. A review of the nurses' notes revealed the following: " April 27, 2007 at 2:00 AM ...Resident	F 280	**F-280- Comprehensive Care Plans** 1. Residents 5 and 11 were re-assessed by the clinical team. The falls care plan was updated to reflect appropriate treatment and goal. 2. The care plans for all residents with a fall within the last 30 days were reviewed. No other resident was affected by this practice. 3. The staff was re-educated on falls prevention and post falls management and care planning. 4. The care plan audit is a part of the QI reporting submitted monthly. Audit outcomes will be reported at quarterly QI meetings.	7/15/07

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	06/22/2007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 12 was observed on the floor mattress with the foot end on low bed and head... No apparent injury noted ..." " May 1, 2007 at 11:40 PM ... resident noted sitting on the floor mattress leaning on the bed. No apparent injury noted." Resident #5's record revealed a care plan dated April 11, 2007 for "Resident has diagnosis of seizures disorder ... Fall Risk ..." There was no evidence that additional goals and approaches were developed in response to the resident's April 27 and May 1, 2007 falls. A face-to-face interview was conducted with Employee #10 on June 18, 2007 at 3:50 PM. He/she acknowledged that Resident #5's care plan was not updated to reflect additional goals and approaches in response to the above cited falls. The record was reviewed June 18, 2007. 2. Facility staff failed to update Resident #11's care plan for falls. A review of the nurses' notes revealed the following: "October 29, 2006 at 5:30 PM ...outside resident fell from wheelchair while reaching for peanuts on the ground. No injuries ... " " October 31, 2006 at 5:30 AM, Resident observed on the floor between the bed and the wheelchair ..." Resident #11's record revealed a care plan last updated March 21, 2007 for "At risk for falls related to limited mobility " . There was no evidence that additional goals and approaches were developed in response to the resident's	F 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	06/22/2007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 13 October 29 and 31, 2006 falls. A face-to-face interview was conducted with Employee #9 on June 19, 2007 at 11:50 AM. He /She acknowledged that Resident #11's care plan was not updated to reflect additional goals and approaches in response to the above cited falls. The record was reviewed June 19, 2007.	F 280		
F 281 SS=D	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review for two (2) of 30 sampled residents, it was determined that facility staff failed to accurately stage a pressure sore for Residents #5 and 23. The findings include: According to the U.S. Department of Health and Human Services publication entitled, "Pressure Ulcers in Adults: Prediction and Prevention - Clinical Practice Guidelines Quick Reference," page 1, "Purpose and Scope", "Stage IV: full thickness skin loss with extensive destruction, tissue necrosis [eschar] or damage to muscle, bone or supporting structures..." 1. Facility staff failed to accurately stage a pressure sore for Resident #5. A review of Resident #5's record revealed an admission nurse's note dated April 12, 2007 at 10:15 AM, "Stage II pressure ulcer on L [left] heel	F 281	**F-281 Comprehensive Care Plans** 1. Resident 5 was re-assessed by the clinical team and the pressure sore had healed. Resident 23 was re-assessed by the clinical team and the staff was provided information regarding accurate documentation and staging of wound. 2. Audits were conducted of medical records of residents with pressure ulcers to determine accuracy in staging. No other residents were affected by this practice. 3. In-service was given to the licensed nursing staff regarding staging criteria and documentation of pressure ulcers wounds. 4. The MDS Coordinator will monitor pressure sore coding and will report findings at quarterly QI meetings.	7/15/07

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	06/22/2007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 14 measuring 6 x 4 x 0 x 0 cm ... ulcer covered by stable eschar..." A nurses note dated June 19, 2007 at 8:00 AM revealed "... L heel 2.5 x 2 x 0 x 0 cm 100% stable eschar, no drainage, stage II pressure ulcer..." 2. Facility staff failed to accurately stage a pressure sore for Resident #23. A review of Resident #23's record revealed an admission nurse's note dated April 23, 2007 at 4:45 PM, "Dried eschar present on the left heel." The wound nurse's notes were as follows: May 11, 2007 (no time noted): "Resident has a Stage II pressure ulcer 100% unstable eschar measuring 3 x 3 x 0 x 0 (centimeters)..." May 17, 2007 at 9:30 AM: "Pressure ulcer assessment: Left heel 4 x 3 x 0 x 0 cm. 50% unstable eschar, 50% pink Stage II..." June 7, 2007 (no time noted): "Pressure ulcer assessment on left heel 3.5 x 3.5 x 0 x 0 100% unstable eschar surrounded by callus, minimum drainage, Stage II..." A face-to-face interview was conducted with Employee #12 on June 22, 2007 at 7:30 AM. He/she acknowledged that the pressure sore was incorrectly staged. The record was reviewed June 20, 2007.	F 281		
F 309 SS=D	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical,	F 309		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	06/22/2007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PREGEDED 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 15 mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, for three (3) of 30 sampled residents and one (1) supplemental resident, it was determined that facility staff failed to: apply cradle boots as ordered for one (1) resident; obtain an order to administer a medication for one (1) resident; re-weigh one (1) resident after a weight loss; and administer a medication per physician's orders to one (1) resident. Residents #5, 19, 28 and JH1. The findings include: 1. Facility staff failed to apply cradle boots to Resident #5 as ordered by the physician. A physician's order signed on May 10, 2007 directed, "Cradle boots at all times except during ADL (activities of daily living) care". On June 18, 2007 at 1:50 PM, June 19, 2007 at 2:40 PM and June 20, 2007 at 11:15 AM the cradle boots were not observed on the resident's feet as ordered. On June 22, 2007 at 9:45 AM in the presence of Employee #14, Resident #5 was observed without the cradle boots in place. A face-to-face interview was conducted with Employee #14 on June 22, 2007 at 9:45 AM. He/She acknowledged that the cradle boots were not applied to the resident per the physician's	F 309	F-309 Quality of Care 1. Resident 5 was re-assessed and physician's order was changed to use cradle boots at bed time. Resident 19's orders for Aransep was obtained and the record was corrected. Resident #28 was discharged prior to the survey. Unable to retrospectively correct. Resident JH1's medication record was reviewed and resident is currently receiving medication as ordered and orders were reviewed. 2. An audit of the POS was conducted and all physician orders are accurate. The weights for all residents were reviewed for accuracy. There were no other residents who needed to be re-weighed. 3. -In-Services were done on documentation, specifically addressing the transcription of orders and medication passes. Additionally in-services were done on weight accuracy specifically on re-weight. 4. Monitoring the clinical record is a part of the QI reportings at the QI meeting.	7/15/07

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	06/22/2007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 16 order. The record was reviewed June 22, 2007. 2. The facility staff failed to obtain a physician's order for Aransep for Resident #19. The MAR (Medication Administration Record) dated June 2007 included, "Aransep 0.1 mg (milligram)/ ml (milliliter) every week for Anemia." The original order date was June 4, 2007. The resident was hospitalized from June 5 through June 14, 2007. The medication was initialed, indicating that it was administered on June 20, 2007. A review of Resident #19's record revealed that readmission orders were signed by the physician on June 15, 2007. An order for the medication Aransep was not included. A face-to-face interview with Employee #7 was conducted on June 21, 2007 at 10:40 AM. He/she reviewed the resident's record and stated "[The transcribing nurse] forgot to add it to the new orders." The record was reviewed on June 21, 2007. 3. Facility staff failed to re-weigh Resident #28 after an eight (8) pound weight loss in one month. Resident #28 was admitted on December 12, 2006. Admission weight on the "Monthly Vital Signs Flow Sheet " was 116 pounds. The record included dietician progress notes dated January 5, 12 and 15, 2007 which revealed that interventions for the weight loss were initiated. According to the facility's policy, "Food & Nutrition	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	06/22/2007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 17 Services Policy - Weight Loss or Gain", under "Purpose/Procedure," page 1, under "2. Residents with weight loss or weight gain of more than five (5) pounds must be re-weighed." On January 5, 2007, the resident's weight was 108 pounds. There was no evidence that the resident was reweighed after loosing eight (8) pounds. The record was reviewed on June 20, 2007. 4. Facility staff failed to administer a medication to Resident JH1 as per physician's orders. A physician's order dated April 13, 2007 directed, "Omeprazole 20 mg one (1) capsule daily for GERD (Gastroesophageal Reflux Disease)." According to the MAR, the resident's medication was to be administered at 9:00 AM. On June 18, 2007, during the morning medication pass at approximately 9:40 AM, Employee #17 administered one (1) Senna-S tablet and one (1) Oscal-D 500 mg to Resident JH1. Employee #17 did not administer Omeprazole 20 mg for Resident JH1. A face-to-face interview was conducted with Employee #9 on June 18, 2007 at approximately 1:30 PM. He/She acknowledged the error.	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	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	06/22/2007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 18 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 observations, staff interview and record review for two (2) of 30 sampled residents, it was determined that facility staff failed to follow up on an identified pressure sore for one (1) resident and follow clean technique for two (2) of four (4) wound treatment observations. Residents #4 and 26. The findings include: 1. Facility staff failed to follow up on an identified pressure sore for Resident #4 and failed to maintain clean technique during a pressure sore dressing. A. Review of Resident #4's record revealed a nurse's note dated May 2, 2007 at 10:20 AM documented, "Right foot area measuring 2 x 2 x 0 x 0x noted 100% stable eschar. No treatment needed at this time but monitor site ..." There was no evidence of reassessment or treatment of the right foot wound after the May 2, 2007 entry. Observation of the resident's right foot was conducted on June 19, 2007 at 1:15 PM. The area on the right foot was dime sized and approximately one (1) centimeter in depth. The area was covered with eschar. A pressure sore was observed on the left foot.	F 314	**F-314 Pressure Sores** 1. Resident 4 was re-assessed by the physician and the area on the right foot has healed. Additionally, Resident 4 and Resident 26's skin was evaluated by the clinical team and there was no adverse effect; pressure sores were cleaned and healing. 2. Review of the residents who have alterations of the skin was conducted and no other residents were affected. 3. All staff responsible for dressing changes will be re-educated on dressing change and disposal of the soiled dressing. 4. Staff Development Coordinator monitors the treatment and reports findings at the QI meeting.	7/20/07

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	06/22/2007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 19 The left foot pressure sore was approximately the same size and in the same location of the foot as the pressure sore on the right foot. A treatment was initiated for the left foot pressure sore on December 15, 2006. A face-to-face interview was conducted with Employee #8 on June 20, 2007 at 8:30 AM. He/she acknowledged that the physician should have been notified of the right foot pressure sore. The record was reviewed June 19, 2007. B. Facility staff failed to maintain clean technique during a pressure sore dressing for Resident #4. A pressure sore observation was conducted on June 19, 2007 at 1:15 PM. Employee #13 assembled items from the treatment cart including an opened package of 100 4 x 4 gauze pads and placed them in a basket. The basket was taken into the resident's room and placed on the resident's dresser. A sterile barrier was placed on the unwashed over bed table and the basket placed on the barrier. Employee #13 washed his/her hands, donned gloves and removed the resident's dressings. He/she disposed of the dressings. Employee #13 failed to wash his/her hands and removed gloves from his/her uniform pocket and donned gloves. At the completion of the wound treatment, Employee #13 disposed of the soiled dressings into a non-hazardous trash container located in the soiled utility room. Employee #13 returned to the resident's room, removed the basket and the opened package of 4 x 4 gauze pads and placed them on the treatment cart. 2. Facility staff failed to follow clean technique	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	06/22/2007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 19 The left foot pressure sore was approximately the same size and in the same location of the foot as the pressure sore on the right foot. A treatment was initiated for the left foot pressure sore on December 15, 2006. A face-to-face interview was conducted with Employee #8 on June 20, 2007 at 8:30 AM. He/she acknowledged that the physician should have been notified of the right foot pressure sore. The record was reviewed June 19, 2007. B. Facility staff failed to maintain clean technique during a pressure sore dressing for Resident #4. A pressure sore observation was conducted on June 19, 2007 at 1:15 PM. Employee #13 assembled items from the treatment cart including an opened package of 100 4 x 4 gauze pads and placed them in a basket. The basket was taken into the resident's room and placed on the resident's dresser. A sterile barrier was placed on the unwashed over bed table and the basket placed on the barrier. Employee #13 washed his/her hands, donned gloves and removed the resident's dressings. He/she disposed of the dressings. Employee #13 failed to wash his/her hands and removed gloves from his/her uniform pocket and donned gloves. At the completion of the wound treatment, Employee #13 disposed of the soiled dressings into a non-hazardous trash container located in the soiled utility room. Employee #13 returned to the resident's room, removed the basket and the opened package of 4 x 4 gauze pads and placed them on the treatment cart. 2. Facility staff failed to follow clean technique	F 314		

20 A

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	06/22/2007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 20 during Resident #26's wound treatment. Employee #12 washed the bedside stand, placed a barrier and put wound treatment supplies on the barrier. He/she sprayed Epicleanse on the gauze and cleaned the wound. He/She started cleaning the inner aspect of the wound and used the same gauze to wipe the entire area surrounding the ulcer. Employee #12 repeated the procedure with the same gauze. The dressing change was observed at approximately 10:20 AM on June 20, 2007.	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: Based on observations during the survey period, it was determined that facility staff failed to maintain an environment free of accident hazards as evidenced by: electrical cords in the walking path of staff and unattended housekeeping carts. The findings include: 1. Electrical cords to the motor controlling the alternating pressure mattresses were observed to be in the walking path of staff members on 2 Blue rooms 204 and 211. Residents residing in the two (2) rooms were non-ambulatory. Employee #16 acknowledged the above cited observations. 2. Housekeeping carts were left unattended with cleaning products on the top of the cart	F 323	**F- 323- Accidents** 1. Environmental Services and Nursing staff repositioned the electrical cords behind the beds to ensure that they would not be in the walking path of the staff. The residents are non-ambulatatory and not affected by this observation. All Environmental Services Staff moved the item from the top of cart and placed the item under lock and key. 2. The residents rooms were checked for electrical cords, and the common area was checked for safety. No other areas were affected by this observation. The housekeeping carts were checked and no other carts were affected by this practice. 3. Supervisors will in-service staff on safety; the placement of electrical cords on the opposite side of bed and storing cleaning products in locked cabinet. 4. Environmental Services supervisors will audit monthly on QI tool.	7/20/07

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	06/22/2007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 21 unsecured as follows: 3 Blue on June 18, 2007 at 8:40 AM 2 Blue on June 19, 2007 at 9:10 AM 1 Blue on June 19, 2007 at 9:30 AM There was no staff or residents in the immediate area at the time of each observation. A face-to-face interview was conducted with Employees #27 (3 Blue), 28 (2 Blue) and 29 (1 Blue) when they returned to the carts. The employees acknowledged that they were not to leave the cart unattended.	F 323		
F 325 SS=D	483.25(i)(1) NUTRITION Based on a resident's comprehensive assessment, the facility must ensure that a resident maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for three (3) of 30 sampled residents, it was determined that the dietitian failed to assess and initiate interventions for the nutritional status of three (3) residents with weight loss. Residents #4, 13 and 21. The findings include: 1. The dietician failed to ensure that interventions were initiated timely for the nutritional status of Resident #4 after a weight loss of 11 pounds in one month.	F 325	**F- 325 Nutrition** 1. Residents 4, 13 and 21 were evaluated by the clinical team and nutritional interventions are in place. Unable to retrospectively correct for resident's 4 and 13 documentation. Resident 21, the 5 pound weight loss cited did not meet 5% guidelines for significant weight loss. Per policy and MDS guidelines, dietitian focus on 5% weight loss X30 days and 10% in 180 days. 2. An internal audit for residents with weight loss issues within the last 60 days was conducted. Insidious weight loss was also reviewed and will continue to be monitored. No other resident were affected by this practice.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	06/22/2007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 325	Continued From page 22 A review of Resident #4's "Monthly Vital Signs Flow Sheet" recorded the resident's weight for October 5, 2006 as 113 pounds. The weight recorded on November 5, 2006 was 102 pounds. There was no assessment or follow up for the 11 pound weight loss. Dietary notes were present in the record for September 19 and December 7, 2006. On December 7, 2006, one month later, dietary notes revealed that a complete assessment was done and interventions were initiated. On June 5, 2007 the resident weighed 108 pounds. A face-to-face interview was conducted on June 18, 2007 at 4:20 PM with Employee #22. When asked if there was any follow up for the 11 pound weight loss in November 2006, he/she stated, "I guess we just missed it." The record was reviewed June 18, 2007. 2. The dietician failed to ensure that interventions were initiated for the nutritional status of Resident #13 after a weight loss of 10 pounds in one month. According to Resident #13's "Vital Signs and Monthly Weight" form, the resident weighed 170.4 pounds on December 2006. On January 1, 2007 the resident weighed 160.2. The dietary progress note dated January 5, 2007 revealed, "Wt. (weight) for 1/07 pending." There was no evidence that the dietician followed up on the 10 pound weight loss for January 2007. On June 5, 2007 the resident weighed 168 pounds.	F 325	3. An in-service will be presented to the nursing staff regarding the importance of consistent written notifications of weight loss issues. 4. Monthly charts reviews and audits will be conducted by the dietitian/ nutritionist and findings will be presented to the QI committee for review.	7/20/07

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	06/22/2007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 325	Continued From page 23 A face-to-face interview was conducted on June 20, 2007 at 11:30 AM with Employee #7. He/she acknowledged that the resident had lost weight. The record was reviewed June 20, 2007. 3. The dietician failed to ensure that interventions were initiated for the nutritional status of Resident #21 after a weight loss of 5 pounds in one month. According to Resident #21's "Vital Signs and Monthly Weight" form, the resident weighed 184 on May 7, 2007. On June 8, 2007 the resident weighed 179. The last dietary progress note in the record was dated April 30, 2007. A face-to-face interview was conducted on June 22, 2007 at 10:30 AM with Employee #11. He/she acknowledged that the resident lost weight. The record was reviewed June 20, 2007.	F 325		
F 329 SS=D	483.25(l) UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical	F 329	**F 329 Unnecessary Drugs** 1. An INR, for Resident 25 was found to be within therapeutic range. Physician was contacted and order changed to monthly INR. 2. An audit was conducted for all residents with orders for INR to determine compliance. No other resident was affected by this practice.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	06/22/2007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE
F 329	Continued From page 24 record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, for one (1) of 30 sampled residents, it was determined that facility staff failed to obtain a resident's INR (International Normalized Ratio) as per physician's order. Resident # 25. The findings include: A physician's order dated January 19, 2007 and signed by the physician on February 11, 2007, directed, " Warfarin 4 mg daily for clot prevention. Weekly INR monitoring (for anticoagulant therapy)." The order was renewed March 1 and May 24, 2007. Weekly INR lab values were present in the record for January, February, March and April 2007. There was no evidence that weekly INR lab values were obtained after April 24, 2007. An INR was done on June 22, 2007. The INR was within the therapeutic range. A face-to-face interview was conducted with Employee #10 on June 21, 2007, at approximately 3:10 PM. He/She acknowledged that the physician failed to follow up with his/her order to monitor the resident's INR weekly labs.	F 329	3. Reviewed processes/ procedures for review of monthly MAR& Physicians Orders. 4. Monitoring labs is conducted weekly and reported quarterly at the QI Meeting.	6/27/07

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

PRINTED: 07/05/2007
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
	095014	A. BUILDING _____ B. WING _____	06/22/2007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 25 The record was reviewed June 21, 2007.	F 329		
F 371 55=E	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 during the survey, it was determined that dietary services were not adequate to ensure that foods were served and prepared in a sanitary manner as evidenced by: soiled plates and can opener, expired milk and nutritional supplements and unlabeled food. These findings were acknowledged in the presence of the Food Service Director and nursing staff. The findings include: 1. The top surfaces of melanized plates were soiled and stained after washing in the dishwasher in 32 of 48 observations of plates at approximately 2:15 PM on June 18, 2007 in the presence of Employee #26. 2. The cutting and gear surfaces of a manual can opener in the salad preparation area were observed soiled with metal shavings at approximately 8:45 AM on June 18, 2007 in the presence of Employee #26. 3. Five (5) gallons of milk were stored in a crate in the produce refrigerator beyond the expiration dates. Three (3) gallons were dated May 31,	F 371	**F- 371 Sanitary Conditions-Food Prep & Service** 1. All melanized plates were removed from use and replaced with china plates on the same day as kitchen survey. It was determined that the salad person was in the process of preparation for the lunch meal when surveyor approached the area. The manual can opener was cleaned and sanitized immediately. Stock room person removed all expired items from the refrigerator and items were dated correctly. Several items in the pantry refrigerator were not opened. Additionally, unopened items belonged to the employees. 2. The kitchen, and pantry areas were reviewed by the nursing and dietary department, a sanitization audit was conducted of the kitchen pantry, No other areas found to be deficient. 3. Nursing and FNS staff will be in-service on dating and labeling, foods. And first in, first out rotation of food items. 4. Weekly and sanitization audits will be presented at the QI meeting.	7/20/07

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	06/22/2007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 26 2007, one (1) gallon dated June 6, 2007 and one (1) gallon dated June 10, 2007 observed at approximately 9:00 AM on June 18, 2007 in the presence of Employee #26. 4. Two (2) cartons of chocolate milk were stored in the walk in refrigerator beyond the expiration date of June 16, 2007 in two (2) of 22 observations of chocolate milk at 9:05 AM on June 18, 2007 in the presence of Employee #26. 5. Foods such as: chicken or tuna salad, sliced tomatoes, trays of sandwiches, apple sauce, pudding, and yogurt were stored in the walk in refrigerator without labels or dates in six (6) of 10 observations at 8:45 AM on June 18, 2007 in the presence of Employee #26. 6. Pantry refrigerators were observed with unlabeled and/or undated food items as follows: 1 Green: one (1) carton of regular milk, one (1) can of soda and one (1) cartons of Orange Splash were observed on June 20, 2007 at 10:00 AM in the presence of Employee #9. 2 Green: one (1) can of Boost, two (2) cartons of Orange Splash, one (1) carton of milk, container of grapes, one (1) sandwich dated June 9, 2007, two (2) large plastic containers of cut-up fresh fruit, were observed on June 20, 2007 at 8:30 AM in the presence of the Employee # 10. 3 Green: four (4) cartons of prune juice, two (2) cartons of orange juice, one (1) can of Boost, one (1) carton of Orange Splash, one (1) apple, and a plastic container of strawberries in the freezer, were observed on June 20, 2007 at 8:20 AM in the presence of Employee # 11.	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	06/22/2007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 27 1 Blue: Three (3) bottles of salad dressing, five (5) containers of prune juice, three (3) containers of applesauce, two (2) plastic bags of food, one (1) container of chocolate syrup, and in the freezer: four (4) frozen uncooked fish, and three (3) frozen bottles of water were observed on June 18, 2007 at 10:10 AM in the presence of Employee # 3. 2 Blue: Two (2) containers of prune juice and two (2) containers of orange juice, one (1) carton of 2% milk, one (1) can of Boost, 12 containers of 32oz. Med Pass, one (1) bottle of orange juice, and in the freezer one-half container of peach cobbler ice cream, four (4) bottles of frozen water, one (1) container of prune juice, one (1) container of orange juice, and one (1) can of diet soda. 26 cans of Neutren 1.5, a tube feeding product, were observed in a cabinet. 1 case (24 cans) expired April 26, 2007; one (1) can expired March 20, 2007, and one (1) can expired February 6, 2007 and were observed in the presence of Employee #16 on June 18, 2007 at 10:40 AM. 3 Blue: Three (3) containers of blueberry yogurt, one (1) container of Orange Splash, one (1) container of chocolate milk, three (3) bottles of water, three (3) pieces of cake, one (1) bottle of opened water, and in the freezer one (1) bottle of strawberry-kiwi juice and one (1) bottle of cranberry-grape juice were observed in the presence of Employee #15 on June 18, 2007 at 9:15 AM .	F 371		
F 386 SS=D	483.40(b) PHYSICIAN VISITS The physician must review the resident's total program of care, including medications and	F 386		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	06/22/2007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 386	Continued From page 28 treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review for five (5) of 30 sampled residents, it was determined that the physician failed to: completely assess two (2) residents for skin impairments, follow up on laboratory test results for one (1) residents, and follow up on the weekly monitoring of one (1) resident's INR levels and document all illnesses on an annual history and physical (H&P)examination. Residents #5, 6, 25, 26 and 30. The findings include: 1. The physician failed to complete a full skin assessment for Resident #5. Resident #5 was admitted to the facility on April 11, 1007. The history and physical examination that was completed by the physician on April 12, 2007 indicated under skin "no lesion or ulcer." The admission nursing assessment dated April 12, 2007 at 10:15 AM indicated, "Resident has a Stage II pressure ulcer on "L" [left] heel measuring..." A review of the nursing notes dated May 2 and	F 386	**F-386 Physician Visits** 1. Residents 5, 6, 25, and 26, were re-assessed by the Nursing Department in consultation with the physician and the nursing team. Physician notes were updated to address skin assessments, monitoring of lab tests and reviewing H&P's. Resident 30 was reviewed, unable to retrospectively correct. 2. The Physician Orders and Progress notes for the residents were reviewed for accuracy with emphasis on skin impairments, lab test results and monitoring of residents INR levels and documentation of all illnesses on an annual history and physical examination. No other residents were found to be affected by this practice. 3. The Medical Director will re-educate physicians regarding documentation requirements. All survey issues were reviewed with the Medical Director. 4. The physician's documentation is a part of the quality improvement tool for the medical staff and will be reported at medical staff meetings, and at the QI meetings.	7/20/07

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	06/22/2007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 386	Continued From page 29 14, 2007 revealed that facility staff continued to document the assessment of Resident #5's left heel ulcer. A review of the physician's notes dated April 26, May 10 and 15, 2007 lacked evidence that the physician addressed the resident's left heel ulcer. The record was reviewed on June 18, 2007. 2. The physician failed to follow up on laboratory test (labs) results for Resident #6. A review of Resident #6's record revealed that labs VDRL (venereal disease research laboratory), FBS (fasting blood sugar) and HgA1C (hemoglobin A1C), were drawn on March 30, 2007. There was no evidence in the resident's record that the lab results were received at the time of this review. A face-to-face interview with Employee #3 was conducted on June 19, 2007 at 12:15 PM. He/she acknowledged that the lab results should have been in the resident's record. Lab results were obtained on June 20, 2007 and were within normal limits. The record was reviewed June 19, 2007. 3. The physician failed follow up on monitoring Resident #25's INR test results. A physician's order dated January 19, 2007 and signed by the physician on February 11, 2007, directed, " Warfarin 4 mg daily for clot prevention. Weekly INR monitoring (for anticoagulant therapy)." The order was renewed March 1 and	F 386		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	06/22/2007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 386	Continued From page 30 May 24, 2007. Weekly INR lab values were present in the record for January, February, March and April 2007. There was no evidence that weekly INR lab values were obtained after April 24, 2007. An INR was done on June 22, 2007. The INR was within the therapeutic range. A face-to-face interview was conducted with Employee #10 on June 21, 2007, at approximately 3:10 PM. He/She acknowledged that the physician failed to follow up with his/her order to monitor the resident's INR weekly labs. The record was reviewed June 21, 2007. 4. The physician failed to completely review and document illnesses on the H&P for Resident #26. A review of Resident #26's record revealed a physician's note dated March 22, 2007, "Yearly physical exam. Please see H&P." A review of the H&P revealed that under the area entitled, "Has the resident had any of the following illnesses? (Circle and describe below if not previously described) " was "See Chart." A face-to-face interview with Employee #9 was conducted on June 21, 2007 at 8:30 AM. He/She stated, "I will give the form to the physician to complete at the next visit." The record was reviewed June 21, 2007. 5. The physician failed to conduct a full skin assessment for Resident #30. Resident #30 was admitted to the facility on	F 386		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	06/22/2007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 386	Continued From page 31 March 9, 2007. A history and physical examination by the physician was dated March 15, 2007 and indicated under "Skin - intact" . The admission nursing assessment dated March 9, 2007 indicated, "...sacral lesions." A telephone order dated March 9, 2007 and signed by the physician on March 15, 2007 indicated, "Cleanse sacrum with wound cleanser, pat dry and apply Polysporin powder and DuoDerm every 3 days and PRN (as necessary)". The physician did not assess a sacral lesion on the admission physical examination. The record was reviewed on June 20, 2007.	F 386		
F 387 SS=D	483.40(c)(1)-(2) FREQUENCY OF PHYSICIAN VISITS The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 30 sampled resident, it was determined that the physician failed to visit the residents every 30 days for the first 90 days after admission. Resident #6. The findings include: A review of Resident #6's record revealed that the	F 387	**F-387 Frequency of Physician Visits** 1. Resident 6 records were reviewed and labs were signed May 16 & 22, 2007, by the physician indicating review The physician was notified regarding the requirements for seeing a new admission every 30 days for the first 90 days. No retrospective correction can be accomplished. 2. A review of the medical records for new admissions who have been admitted within the last 90 days was completed. No other residents were affected by this practice. 3. The Medical Director will re-educate physicians on the Physician visit requirements. 4. Nurse Management will monitor all new admissions for 90 days for completion of Physician's visits and update of orders. This information will be reported at the QI meetings.	7/20/07

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	06/22/2007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 387	Continued From page 32 resident was admitted on March 16, 2007 and had a history and physical examination on April 3, 2007. A review of the "Physician's Progress Notes" revealed that the resident was seen by the attending physician on April 3, 2007 and June 15, 2007. There was no evidence in the "Physician's Progress Notes" that the resident was seen by the attending physician in the month of May 2007. A face-to-face interview with Employee #3 was conducted on June 19, 2007 at 12:15 PM. He/she acknowledged that there was no evidence of an attending visit during the month of May 2007. The record was reviewed June 19, 2007.	F 387		
F 425 SS=E	483.60(a),(b) PHARMACY SERVICES The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.	F 425	**F-425 Pharmacy Services** 1. All open multi-dose medication identified during the survey were dated appropriately. All staff items in the refrigerator were removed immediately. 2. All multi –dose vials on the medication carts were checked, dated and initialed, as necessary. All medications refrigerators were cleaned of all food items. 3. Licensed staff was re-educated on multi dose medication vials and storage of food in medication refrigerator. 4. Monitoring the medication carts and the medication refrigerator by licensed staff is conducted and will be reported at the QI meeting.	7/15/07

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	06/22/2007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425	Continued From page 33 This REQUIREMENT is not met as evidenced by: Based on the observation of five (5) of nine (9) nursing units, it was determined that facility staff failed to date and initial opened multi-dose medication vials and store medications properly. The findings include: 1. The facility staff failed to date and initial opened multi-dose medication vials. On June 21, 2007, at approximately 1:30 PM through 2:00 PM, during the observation of the medication carts, six (6) of 12 multi-dose containers were opened, but not dated and/or initialed when first opened. The medication included: 3rd Floor Blue unit - Xalatan ophthalmic drops three (3) vials Orange unit - Xalatan ophthalmic drops two (2) vials 1st Floor Green unit - Xalatan ophthalmic drops one (1) vial Employees #21 (3 Orange), 30 (3 Blue) and 31 (1 Green) acknowledged that the Xalatan vials were not dated and/or initialed at the time of the observations. 2. The facility staff failed to store medications properly.	F 425		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	06/22/2007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425	Continued From page 34 The Facility's policy 4.1, titled, "General Guidelines for Medication Storage" stipulates, "Refrigerated medications are ...separated from ... foods used in administering medication. Other food (e.g. employee lunches, activity department refreshment) may not be stored in the medication refrigerator." On June 18, 2007, the medication refrigerators were inspected and findings were as follows: 2 Green - One (1) 16 ounce container of Green Tea at 1:45 PM 3 Green - One (1) cake and one (1) 16 ounce orange soda at 2:30 PM	F 425		
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 environmental tour, it was determined that proper procedures were not followed to control the spread of communicable diseases as evidenced by: soiled ice machine trays, a dusty fan blowing on clean laundry, disposal of soiled wound dressings in a	F 441	**F-441 Infection Control** 1 The trays under the ice machines on 2 green and 3 green were cleaned immediately, and the laundry fan cover has been cleaned. The red plastic bags were placed in the room for treatment usage. The table tops and cushion observed in the Rehab area was removed immediately. 2. All ice machines were checked. No other fan was in the laundry area. All nursing units were checked and all red bags were checked. The Rehab staff was instructed to ensure that no other items are placed on the floor. No resident were affect by this practice.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	06/22/2007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE
F 441	Continued From page 35 non-biohazard container and equipment stored on the floor in the Rehabilitation Department. The findings include: 1. Trays under the spout on the ice machines were observed soiled with debris on units 2 Green and 3 Green on June 22, 2007 between 8:40 AM and 9:20 AM in the presence Employees #10 (2 Green) and Employee #11 (3 Green). 2. A dusty fan was observed on June 20, 2007 at 11:40 AM blowing on clean linen in the presence of Employee # 20. 3. During a wound treatment observation on June 19, 2007 at 1:15 PM, Employee #13 disposed of a soiled dressing in a clear plastic bag into a non biohazard trash container. 4. Rehabilitation equipment, a table top and cushion was observed on the floor on June 22, 2007 at 11:45 AM in the presence of Employee #24.	F 441	3. Environmental and Engineering staff reviewed existing monitoring programs and temperatures meet guidelines which prevents the spread of infection. In-service were provided on the water temperature requirement and the various cycles when using existing chemicals. 4. Monitoring the laundry temperature is a part of the QI program presented at the QI meetings.	7/13/07
F 445 SS=F	483.65(c) INFECTION CONTROL - LINENS Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and review of manufacturer's manuals, it was determined that facility staff failed to develop a monitoring program to ensure wash water temperatures for facility and resident laundry were within the manufacture's recommended range for each	F 445	**F 445- Infection Control-Linens** 1. A monitoring program has been in place and currently exists for the facility and resident laundry. 2. All washing machines were checked and the water temperature meets regulatory standards and manufacturer's recommendations.	6/21/07

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	06/22/2007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 445	Continued From page 36 chemical utilized in the washing cycle. The findings include: An observation of laundry being processed in one (1) of five (5) facility washing machines was conducted on June 20, 2007 at 10:10 AM. Water entering the washing machine from the facility was measured by a temperature gauge located on top of each machine. The temperature of the water entering the machine was observed at 160 degrees Fahrenheit (F). The washer being observed was equipped with a computer program displayed on a digital screen attached to the front of the washer. Among the information displayed was the formula/cycle (a program designed for each type of laundry), the step in the cycle and the water temperature. At the time of the observation, the machine was set on Cycle #3 (non-isolation linen) and was currently in the warm flush (rinse) stage. The temperature displayed on the computer screen was 141 degrees F. The surveyor asked Employee #20 what temperature was required for this step. He/she stated, " That temperature is okay. We use different chemicals to clean the clothes and they work in a range of temperatures. " The surveyor asked for the chemicals used and the temperature range for the chemicals. Employee #20 stated that he/she did not have that information, but would ask the chemical supplier to fax that information to the facility.	F 445	3. Environmental and Engineering staff reviewed existing monitoring programs and temperatures meet guidelines which prevents the spread of infection. In-service were provided on the water temperature requirement and the various cycles when using existing chemicals. 4. Monitoring the laundry temperature is a part of the QI program presented at the QI meetings.	6/21/07

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	06/22/2007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 445	Continued From page 37 The surveyor asked if temperatures were being monitored for each step. Employee #20 stated that the only temperature monitored was the water coming into the washer from the facility. The computer program pre-determined the temperature for each cycle and was set by the chemical man (representative from the chemical company) for the chemicals utilized by the facility. A listing of the manufacturer's recommendations for temperature ranges for the chemicals could not be located by Employee #20 in the chemical supplier's manuals. A facsimile was received from the chemical company at 5:40 PM on June 20, 2007, indicating the following: " The formula being used in your location accomplishes the following: 1. A flush is required and used to remove all particulate matter (body wastes). 2. The textiles are then washed in 160 degree water for 20 minutes. This includes the detergency for scrubbing and the chlorine bleaching for bacterial killing and whitening ... " At 5:45 PM, observation of isolation laundry (Formula #4) was conducted. The pre-programmed total cycle time was 54 minutes. The first 10 minutes of the cycle included a warm flush, drain and hot suds (wash) cycle. The manufacturer's temperature recommendation for the hot suds step was 160 degrees F. as listed in the above cited facsimile. Temperatures during the hot suds step did not exceed 141 degrees F. Employee #20 stated that the water used in this wash was sitting in the pipes all day, and the cycle was stopped, water drained and the	F 445		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	06/22/2007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 445	Continued From page 38 process re-started. The temperature during the hot suds step was 148 degrees F. The cycle was stopped again, water drained and the process re-started. The temperature during the hot suds step ranged from 161 degrees to 169 degrees F. The temperature was maintained above 160 degrees F for less than three (3) minutes. The surveyor requested that no laundry be processed until the issue of water temperatures could be resolved. On June 21, 2007 at 9:30 AM, a face-to-face interview was conducted with the Contractor #1 and Contractor #2 who maintained the computer program. Contractor #2 stated that each machine was programmed in the same way by Contractor #1. Contractor #1 explained that each chemical used in the facility worked within a range of temperatures, and that the programs were designed to fit the chemicals. The surveyor asked for a list of chemicals used in the facility and the temperature ranges. Contractor #1 did not have that information nor could he locate a listing in the manuals provided to the facility from the chemical company. After the interviews, at approximately 11:30 AM, Contractor #1 stated that the he/she would contact the chemical company supervisor for the requested information. A facsimile was received from the chemical company at 3:32 PM on June 21, 2007 and listed all the chemicals used in the facility's laundering	F 445		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	06/22/2007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 445	Continued From page 39 process and the range of recommended temperatures. The wash cycle for Formula #3 was observed on June 21, 2007 from 4:45 PM until 5:30 PM. At each step, temperature readings were observed and matched the manufacturer's recommended range for the chemicals used in each step. Processing of the laundry was resumed.	F 445		
F 454 SS=D	483.70 PHYSICAL ENVIRONMENT The facility must be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel and the public. This REQUIREMENT is not met as evidenced by: Based on observations during a tour of the Rehabilitation Department survey, it was determined that the doors to both rehabilitation rooms were propped open with door stoppers. The findings include: The physical and occupational therapy rooms were observed on June 22, 2007 at 11:30 AM propped open with rubber door stoppers. This observation was made in the presence of Employee # 24, who immediately removed the door stops.	F 454	**F-454 – Physical Environment** 1. Rubber door stoppers were removed from the doors of the Physical and Occupational Therapy rooms and the doors were closed immediately. 2. All doors in the Rehab have been checked and no other doors were affected by this practice. 3. Engineering Department will evaluate the doors for the installation of automatic closures. 4. The doors in therapy will be added in to the Engineering Department's monitoring program and reported at the QI meeting.	6/22/07
F 456 SS=D	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	F 456	**F-456 Space and Equipment** 1. The non-essential water faucet in the Rehab Department was repaired.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	06/22/2007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 456	Continued From page 40 by: Based on observation and staff interview, it was determined that the cold water faucet in the sink located in the Rehabilitation Department failed to function. The findings include: The cold water faucet located in the sink in the Rehabilitation Department failed to turn and engage the flow of cold water. This observation was made in the presence of Employee #24 on June 22, 2007 at 11:15 AM. Employee #24 stated that the sink needed to be fixed.	F 456	2. All cold water faucets in the rehab area were evaluated and no essential cold water faucet was affected. 3. The Rehab staff was advised to report equipment problems even if the equipment is not being used or non-essential. 4. Monitoring of equipment is a part of the Engineering program and is presented at the QI meeting.	6/22/07
F 469 SS=D	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 during the survey period, it was determined that the facility failed to maintain an effective pest control program as evidenced by the presence of pests in the the facility. The findings include: 1. Flying insects were observed by the tray line in the main kitchen on June 20, 2007 at approximately 10:00 AM in the presence of Employee #26.	F 469	**F-469 Physical Environmental Pest Control** 1. The Western Pest Control consultant was on site on the day of the observation as part of the existing Pest Control Program. The area of concern was addressed. 2. During a review of the facility there were no other observations of pests during the entire survey process. 3. A review of the current pest control program was conducted. 4. The Pest Control Program is a part of the Environmental Services monitoring program and is presented at the QI meeting.	6/20/0

EMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	06/22/2007

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

4) ID EFIX AG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(C5) COMPLETION DATE
F 469	Continued From page 41 2. A roach was observed in the 3 Green Pantry on June 20, 2007 at approximately 10:00 AM in the presence of Employee #11.	F 469		
F 492 SS=D	483.75(b) ADMINISTRATION The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review for one (1) of 30 sampled residents, it was determined that facility staff failed to comply with District of Columbia regulations as evidenced by failing to complete a history and physical examination for one (1) resident. Resident #15. The findings include: According to 22 DCMR 3207. 11, "Each resident shall have a comprehensive medical examination and evaluation of his or her health status at least every twelve (12) months and documented in the resident's record." A review of Resident#15's record revealed that the last history and physical examination was documented on April 27, 2006. Further review of the resident's record revealed physician progress notes dated May 6, 2007 and May 8, 2007. However, there was no evidence of a history and physical examination.	F 492	**F 492 Administrations** 1. The History & Physical for resident 15 was completed. on 6/21/07. 2. A full audit of medical records of all residents was undertaken by Medical Records staff. 3. A meeting was held with the Medical Director to review this finding on 6/22/07. 4. The Medical Director will present physicians requirements at Medical Staff Meeting. Monitoring the H&P is a part of the medical record audit. This information will be presented at the QI meeting.	7/27/07

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	06/22/2007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 492	Continued From page 42 A face-to-face interview was conducted with Employee #11 on June 22, 2007 at approximately 9:05 AM. He/she stated, "Physical exams are done once a year. I think it was done. I will check to make sure it has not been thinned." Documentation of a history and physical examination could not be located during the survey. The record was reviewed on June 20, 2007.	F 492		
F 502 SS=D	483.75(j)(1) LABORATORY SERVICES The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 30 sampled residents, it was determined that facility staff failed to follow up on laboratory test results for Resident #6. The findings include: A review of Resident #6' s record revealed that blood was drawn for the following tests: VDRL (venereal disease research laboratory), FBS (fasting blood sugar) and HgA1C (hemoglobin A1C), on March 30, 2007. There was no evidence in the resident's record that the laboratory test results were received. A face-to-face interview with Employee #3 was conducted on June 19, 2007 at 12:15 PM. He/she acknowledged that the test results were not in the resident's record and that there was not	F 502	**F 502 Laboratory Services** 1. The Blood work for Resident 6 was completed as ordered and was within the normal range. 2. An audit was conducted and the labs records are in the residents charts. No other resident was affected by this practice. 3. A meeting was held with all licensed staff on laboratory services. 4. Monitoring compliance of labs done. This information will be presented at QI Meetings.	7/9/07

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

PRINTED: 07/05/2007
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
	095014	A. BUILDING _____ B. WING _____	06/22/2007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 502	Continued From page 43 a system in place to follow up on laboratory tests ordered and drawn. Employee #3 received the laboratory test results on June 20, 2007 and they were within normal limits. The record was reviewed June 19, 2007.	F 502		
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: Based on observation, record review and staff interview for one (1) of 30 sampled residents, it was determined that facility staff failed to document the administration of a wound treatment for Resident #15. The findings include: A review of the Physician's Order Sheets (POS) for Resident # 15 revealed four (4) orders for wound treatments: (1) April 18, 2007, "Cleanse Lt. [left] buttock open area with wound cleanser pat dry then apply Polysporin powder Cover with DuoDerm q [every]	F 514	**F-514 Clinical Records** 1. The treatment order on Resident 15 was clarified and completed as ordered. 2. All residents' treatment orders were reviewed and compared with TAR (Treatment Administration Record) for accurate transcription. 3. All Treatment orders are to be audited by the licensed staff. A meeting was conducted with licensed staff regarding documentation. 4. Treatment orders are monitored and will be presented quarterly at the QI Meeting.	6/27/07

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

PRINTED: 07/05/2007
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
	095014	A. BUILDING _____ B. WING _____	06/22/2007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 44 3rd d [day] until healed." (2) April 19, 2007, "Cleanse open area to the sacrum with wound cleanser pat dry, then apply Polysporin powder Cover with DuoDerm q 3rd d till healed." (3) May 11, 20007, "Cleanse R (Right) heel with wound cleanser. Pat dry and apply Polysporin Powder and Santyl oint. (ointment) Daily. Cover with 4 x 4 and wrap with kerlix." (4) May 18, 2007, "Cleanse L (Left) heel with wound cleanser. Pat dry and apply polysporin powder and santyl oint. daily. Cover with 4 x 4 and wrap with Kerlix. " A review of the Treatment Administration Record (TAR) for June, 2007 revealed the following treatment orders: (1) "Polysporin Powder apply to left buttock open area every 3 days until healed after cleanse with wound cleanse. Pat dry cover with DuoDerm." (2) "Cleanse left heel with wound cleanse Pat dry and apply Polysporin Powder." (3) "Cleanse R heel with wound cleanser. Pat dry and apply Polysporin Powder and Santly (Santyl) oint (ointment). Cover with 4x4 and wrap with kerlix q (every) day." The TAR lacked evidence that the dressing on the sacrum was done every third day as ordered by the physician due to the omission of the transcription of the order on the TAR. Observation of the buttocks and sacrum revealed	F 514		

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

PRINTED: 07/05/2007
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
	095014	A. BUILDING _____ B. WING _____	06/22/2007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 45 two (2) open areas; one (1) on the left buttock and one (1) on the sacrum. The observation was made at 10:00 AM on June 22, 2007 in the presence of Employee #12. The dressing to the sacrum was dated June 21, 2007. The dressing to the left buttock was dated June 22, 2007. Both wounds were clean and without odor or drainage. A face-to-face interview was conducted with Employee #12 at 11:00 AM on June 20, 2007. He/She stated, "There are two (2) open areas on the resident, one (1) on the left buttock and one (1) on the sacrum. Both treatments are being done as ordered." The record was reviewed on June 20, 2007.	F 514		