Health Regulation Administration STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING HFD02-0020 01/16/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **2425 25TH STREET SE WASHINGTON NURSING FACILITY** WASHINGTON, DC 20020 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (EACH CORRECTIVE ACTION SHOULD BE CROSS-PRÉFIX **PREFIX** OR LSC IDENTIFYING INFORMATION) REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG TAG L 000 **Initial Comments** L 000 The filing of the Plan of Correction does not constitute an admission that the deficiencies actually did in fact exist. An annual licensure survey was conducted on This Plan of Correction is filed as evidence January 12 through 16, 2009. The following deficiencies were based on record review. of the facility's desire to comply with the observations, and interviews with residents and the regulatory requirements of responding facility staff. The sample included 30 residents to these citations and to continue to based on a census of 349 residents on the first day provide quality resident care. of survey and 59 supplemental residents. 3207.11 Nursing Facilities L 036 3207.11 Nursing Facilities L 036 Resident #7 1. This resident received her annual 1/31/09 Each resident shall have a comprehensive medical H&P. examination and evaluation of his or her health 2. An audit was done for all residents of status at least every twelve (12) months, and the facility to ensure that an annual 3/31/09 documented in the resident's medical record. dental screen was done. Correction were This Statute is not met as evidenced by: made whenever necessary. Based on record review and staff interview for one 3. The unit clerks will perform monthly (1) of 30 sampled residents, it was determined that quantitative audits noting the date of the the physician failed to complete an annual history last dental screening. Their findings will and physical for Resident be communicated to the consultant #7. dentist. The Clinical Managers will 3/31/09 monitor the timeliness of annual dental The findings include: screens and communicate their findings to the DON. A review of Resident #7's record revealed that the 4. The Department Head will present last history and physical examination was a report of the data collected and any action December 12, 2007. plans implemented to ensure sustained 4/3/09 compliance at the monthly QI Committee A face-to-face interview was conducted with which is chaired by the Administrator Employee #6 on January 13, 2009 at 2:25 PM. He/she acknowledged that an annual history and physical examination should have been completed in December 2008. The record was reviewed January 13, 2009. 3210.4 Nursing Facilities L 051 L 051 3210.4 Nursing Facilities A charge nurse shall be responsible for the following: Health Regulation Administration

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STATEMENT	OF	DEFICIENCIES
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(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

(X3) DATE SURVEY COMPLETED

HFD02-0020

A. BUILDING B. WING

01/16/2009

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

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L 000			deficiencies actually did in fact exist. This Plan of Correction is filed as evidence of the facility's desire to comply with the regulatory requirements of responding to these citations and to continue to	
L 036 3207.11 Nursing Facilities		L 036	3207.11 Nursing Facilities Resident #7 1. This resident received her annual	1/31/0
	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 medical record. This Statute is not met as evidenced by: Based on record review and staff interview for one (1) of 30 sampled residents, it was determined that the physician failed to complete an annual history and physical for Resident #7. The findings include: A review of Resident #7's record revealed that the		H&P. 2. An audit was done for all residents of the facility to ensure that an annual dental screen was done. Correction were	3/31/0
			made whenever necessary. 3. The unit clerks will perform monthly quantitative audits noting the date of the last dental screening. Their findings will be communicated to the consultant	
			dentist. The Clinical Managers will monitor the timeliness of annual dental screens and communicate their findings to the DON.	3/31/0
last history and physical examination was December 12, 2007.			4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly QI Committee	4/3/09
	A face-to-face interview was conducted with Employee #6 on January 13, 2009 at 2:25 P He/she acknowledged that an annual history physical examination should have been com in December 2008. The record was reviewe January 13, 2009.	M. v and pleted	which is chaired by the Administrator	
L 051	3210.4 Nursing Facilities	L 051	3210.4 Nursing Facilities	
	A charge nurse shall be responsible for the following:			

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	TEMENT OF DEFICIENCIES O PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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NAME OF PROVI	IDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	ATE, ZIP CODE		
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L 051 Co	ontinued From pag	je 1		L 051	3210.4 Nursing Facilities (conti	nued)	
ar	(a)Making daily resident visits to assess physical and emotional status and implementing any required nursing intervention;				1. Resident #2Anemia and MS 1. Resident #2's care plan was amer o include a care plan with goals and approaches for Anemia and Multiple Sclerosis.	nded	3/13/09
àc	(b)Reviewing medication records for completeness, accuracy in the transcription of physician orders, and adherences to stop-order policies;				2. Care Plans of all residents with the Diagnoses of Anemia and Multiple Sclerosis were reviewed for the sam deficient practice and changes made	e	3/13/09
ap	(c)Reviewing residents' plans of care for appropriate goals and approaches, and revising them as needed;				as needed. 3. Appropriate care plans with goal Approaches for Anemia and Multip Sclerosis will be evaluated using the	s and le	
	(d)Delegating responsibility to the nursing staff for direct resident nursing care of specific residents;				"Care Plan Audit" of the Nursing Quality Improvement Prog The members of the Nursing QI tear	ram.	3/31/09
	(e)Supervising and evaluating each nursing employee on the unit; and		ng		will collect date on this issue and fo that information to the DON for rev and evaluation.	rward	
he	er designee inform	tor of Nursing Service ed about the status of net as evidenced by:			4. The Department Head will prese a report of the data collected and an action plans implemented to ensure sustained compliance at the monthly	у	
int de ca foi so the int me (1 re Re Tr 1 . go	Based on observation, record review and staff interview for six (6) of 30 sampled residents, it was determined that the charge nurse failed to initiate care plans with appropriate goals and approaches for: one (1) resident with Anemia and Multiple Sclerosis, two (2) residents for anticoagulant therapy, two (2) residents for the potential adverse interaction for the use of nine (9) or more medications, three (3) resident for incontinence, one (1) resident for the use of side rails and one (1) resident for abusive/aggressive behaviors. Residents # 2, 5, 6, 7, 13 and 15. The findings include: 1. The charge nurse failed to initiate care plans with goals and approaches for Anemia and Multiple Sclerosis for Resident #2.			Quality Improvement Committee w is chaired by the Administrator.		4/3/09	

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(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

X2) MULTIPLE CONSTRUCTION	
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HFD02-0020

B. WING

01/16/2009

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

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According to the admission Minimum Data Set (MDS) assessment completed November 24, 2008, the resident was coded in Section I (Disease Diagnoses) for Anemia and Multiple Sclerosis (MS). A review of the resident's care plans initiated November 24, 2008, revealed that no care plan with appropriate goals and approaches was initiated for Anemia or MS. A face-to-face interview was conducted with the resident at approximately 8:15 AM on January 13, 2009. He/she acknowledged being aware that he/she had a diagnosis of Multiple Sclerosis. The resident stated, "I was diagnosed with MS many years ago [not sure how many]. I used to receive Avonex injections once a week for MS but I have not had any [injections] since I have been here. I didn't't get any injections while I was in the other hospital either. I thought I told someone about the injections when I first got here but I am not sure who I told." A face-to-face interview was conducted with the Employee #9 on January 15, 2009 at approximately 9:00 AM. He/she stated she was not aware of the diagnoses of Anemia and Multiple Sclerosis. He/she added, "I will look into that [the diagnoses]." In another face-to-face interview conducted with Employee #9 at approximately 9:30 AM on January 16, 2009 the employee stated, "I have spoken to the physician and the resident will be evaluated for Anemia and MS." The record was reviewed on January 12, 2009.	3/6/09 3/10/09 3/31/09 4/3/09

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUMB		(X2) MULTI A. BUILDIN B. WING	PLE CONSTRUCTION G	(X3) DATE SUF COMPLET	ED
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L 051	there was no care pl goals and approach	ge 3 dent's care plans revellan initiated with approves for the use of antic	opriate	L 051	3210.4 Nursing Facilities (com 3. Resident #6 Adverse Reac 1.Resident #6's care plan was amended to include appropriate goals and approa for the potential adverse interactions for	t ion I aches	3/6/09
	Employee #5 on Jar He/she acknowledge for the use of Plavix January 3. The charge nurse with appropriate goa	view was conducted w nuary 12, 2009 at 3:45 ed that there was no c The record was revi e failed to initiate a ca als and approaches fo	5 PM. care plan lewed re plans or the		use of 9 or more meds. 2. Medical records of all residents with more medications were reviewed if a corresponding care plan with appropriate goals and approaches for the potential adverse interactions. 3. Appropriate care plans with goals at Approaches for Adverse Interactions for Use of 9 or More Meds will be evaluated using the "Care Plan"	9 or	3/6/09
	or more medications A review of the clinic revealed a Physician on January 6, 2009 Colace, Folic Acid, F Procardia, Coumadi Suppository, Citrate tablets. Further revi no care plan was ini	teractions for the use is for Resident #6. cal record for Residen in 's Order Sheet (POwith medications which Furosemide, Labetalol in, Dilantin, Senokot, I of Magnesia and Tyleiew of the record reveilitated for the potential use of nine or medicat	at #6 S) signed ch included I, Keppra, Dulcalox enol aled that I adverse		Audit" of the Nursing Quality Improve Program. The members of the Nursing QI team will collect date on this issue and forware that information to the DON for review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee whice	ard	3/31/09
	A face-to-face interv Employee #6 on Jar 11:00 AM. He/she a for the potential inter more medications w	view was conducted w nuary 14, 2009 at app acknowledged that the raction of the use of n vas not on the record.	rith roximately e care plan ine or He/she		is chaired by the Administrator. 4A. Resident #7 Anti-coagula 1. Resident # 7's care plan was amendate to include goals and approaches for a	ant	3/6/09
	was reviewed on Jai 4. The charge nurse	ne on right now." Th nuary 13, 2009. e failed to initiate a car by and incontinence fo	e plan for		resident receiving anticoagulant therap 2. Care Plans of all residents receiving anticoagulant therapy were reviewed for goals and approaches for anticoagulant therapy and amended as needed. 3. Appropriate care plans with goals and	Dr .	3/10/09
	A. Facility staff failed anticoagulant therap	d to initiate a care plar by for Resident #7.	n for		Approaches for Anticoagulant Therapy will be evaluated using the "Care Plan Audit" of the Nursing Quality Improve Program.		
	Review of Resident	#7's record revealed a	a		The members of the Nursing QI team will collect date on this issue and forward	ırd	3/31/09

and evaluation.

that information to the DON for review

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L 051	renewed with each p January 6, 2009, for po (by mouth). " A review of the residence was no care p goals and approach therapy. A face-to-face interved Employee #6 on Jar He/she acknowledge for the use of Plavix January 13, 2009. B. The charge nurse incontinence. A review of Residen MDS assessments of 9, 2008 and the annompleted Septemb as frequently incontinuction in Section House of bladds stool in Section House of the residence was no care possible for the residence was no care possible for the residence was no care property and the residence was no care possible for the residence was no care possible for the residence was no care property and the residence was no car	ge 4 tiated December 12, 2 ohysician 's visit most " Plavix 75 mg q d (of dent's care plans revoluted initiated with appropriate the use of antic view was conducted who was conducted who was a conducted who was revoluted that there was no conducted who was revoluted to a conducted who was a conducted who was revoluted to a conducted who was a conducted who was revoluted to a conducted who was a conducted who was revoluted to a conducted who was a conducted who was revoluted to a conducted who was a conducted who was revoluted to a conducted who was a conducted who was revoluted to a conducted who was revoluted	ealed that opriate oagulant with open of the plan for a liquarterly and June resident dder liquarterly and june resident dder liquarterly and june are plan for liquarterly and june resident dder liquarterly and june are plan for liquarterly and june resident dder liquarterly and june are plan for liquarterly and june are plan for liquarterly and june resident dder liquarterly and june liquarterly and june are plan for liquarterly and june liquart	L 051	4A. Resident #7 (continued) 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator. 4B. Resident #7 Incontinence 1. Resident #7 Incontinence 1. Resident #7 scare plan was amento include goals and approaches for resident who has incontinence. 2. Care Plans of all residents who has incontinence were reviewed for goals and approaches for incontinent and amended as needed. 3. Appropriate care plans with goal Approaches for Incontinence will be evaluated using the "Care Pl Audit" of the Nursing Quality Improprogram. The members of the Nursi will collect date on this issue and fo that information to the DON for revand evaluation. 4. The Department Head will prese a report of the data collected and an action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee wis chaired by the Administrator.	anded a as as ace s and lan ovement ing QI team orward iew nt	4/3/09 3/6/09 3/31/09 4/3/09
	A face-to-face interv Employee #6 on Jar	riew was conducted w nuary 13, 2009 at 2:25 ed that there was no c	PM.				

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Health Regulation Administration

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NAME OF PROVIDER OR SUPPLIER

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

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STREET ADDRESS, CITY, STATE, ZIP CODE

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L 051	Continued From page 5	L O	51	3210.4 Nursing Facilities (continued)	
	plan for incontinence. The record was rev	iewed		EA Decident #42 Incontinues	
	January 13, 2009.			5A. Resident #13 Incontinence	3/6/09
,	·			1. Resident # 3s care plan was amended to include goals and approaches for a	3/0/09
	5. The charge nurse failed to initiate care			resident who has incontinence.	
	Resident #13 for incontinence and aggres abusive behaviors.	sive/		2. Care Plans of all residents who has	3/31/09
	abusive benaviors.			incontinence were reviewed for	3/31/09
	A. Engility staff failed to initiate a pare plan	for		goals and approaches for incontinence	•
	A. Facility staff failed to initiate a care plar incontinence for Resident #13.	1 101		and amended as needed.	
	incommence for resident #15.			3. Appropriate care plans with goals and	
	Review of Resident #13's record revealed	tho		Approaches for Incontinence	
	admission MDS completed May 21, 2008	I .		will be evaluated using the "Care Plan	3/31/09
	resident as usually incontinent of bowel ar			Audit" of the Nursing Quality Improvement	
	incontinent of bladder. The quarterly MDS			Program. The members of the Nursing QI team	
	assessments completed July 24 and Octo			will collect date on this issue and forward	
	2008 and January 21, 2009 coded the res			that information to the DON for review	
	Section H as usually incontinent of bowel	and		and evaluation.	
	bladder.			4. The Department Head will present	
				a report of the data collected and any	
	A review of the resident's care plans revea			action plans implemented to ensure	4/2/00
	there was no care plan initiated with appro- goals and approaches for bowel and blade			sustained compliance at the monthly Quality Improvement Committee which	4/3/09
	incontinence.	iei			
	modification.			is chaired by the Administrator.	
	A face-to-face interview was conducted wi	th			•
	Employee #5 on January 13, 2009 at 11:0	0 AM.		5B. Resident #13 Behaviors	
	He/she acknowledged that there was no o			1. The care plan was amended	3/6/09
	for incontinence. The record was reviewe	d January		to include goals and approaches for a	
	13, 2009.			resident exhibiting both aggressive/	
				abusive behaviors.	
	B. The charge nurse failed to initiate a car			2. Medical records of all residents	3/6/09
	aggressive/abusive behaviors for Residen #13.	٠		who exhibit aggressive/abusive	
	π I Q .			behaviors were reviewed for corresponding	
	According to a review of Resident #13's of	the		goals and amended as needed.	
]	"Initial Psychiatric Evaluation" dated Octo			3. Appropriate care plans with goals and Approaches for aggressive/abusive behaviors	
	2008, "[Resident] admits to being verba			will be evaluated using the "Care Plan	3/31/09
	abusive to other patients at times and phy			Audit" of the Nursing Quality Improvement	5/5/1/09
	assaultive off and on " The resident wa	s		Trans. of the reasons Quarty improvement	
	prescribed Seroquel 50 mg orally twice da	ily and			•

PRINTED: 03/04/2009 FORM APPROVED Health Regulation Administration STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING HFD02-0020 01/16/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **2425 25TH STREET SE WASHINGTON NURSING FACILITY** WASHINGTON, DC 20020 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID 1D (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (EACH CORRECTIVE ACTION SHOULD BE CROSS-PREFIX PREFIX REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG OR LSC IDENTIFYING INFORMATION) TAG L 051 L 051 Continued From page 6 3210.4 Nursing Facilities (continued) Klonopin 1 gm orally daily for agitated behaviors. 5B. Resident #13 Behaviors (continued) Program. The members of the Nursing OI team According to a quarterly MDS assessment will collect date on this issue and forward completed July 24, 2008, the resident was coded in that information to the DON for review Section E (Mood and Behaviors) for verbal abuse. and evaluation. 4. The Department Head will present A review of the "Psychoactive Medication Monthly a report of the data collected and any Flow Sheet " which monitored target behaviors and action plans implemented to ensure medication side effects were blank for October. sustained compliance at the monthly 4/3/09 November, December 2008 and January 2009. Ouality Improvement Committee which is chaired by the Administrator. A review of the resident 's care plans revealed that 5A. Resident #15 Adverse Reaction there was no care plan initiated with appropriate A. Adverse Interactions for 9+ medications goals and approaches for abusive/aggressive 1.Resident #15's care plan was amended 3/6/09 behaviors. to include appropriate goals and approaches for the potential adverse interactions for the A face-to-face interview was conducted with use of 9 or more meds. Employee #5 on January 13, 2009 at 11:00 AM. 2. Medical records of all residents with 9 or 3/31/09 He/she acknowledged that there was no care plan for incontinence and aggressive/abusive behaviors. more medications were reviewed if a The record was reviewed January 13, 2009. corresponding care plan with appropriate goals and approaches for the potential 5. The charge nurse failed to initiate a care plans adverse interactions. with appropriate goals and approaches for the 3. Appropriate care plans with goals and potential adverse interactions for the use of nine (9) Approaches for Adverse Interactions for the or more medications and for the use of full side rails Use of 9 or More Meds for Resident #15. will be evaluated using the "Care Plan A. Review of the clinical record for Resident #15 Audit" of the Nursing Quality Improvement revealed a Physician 's Order Sheet (POS) signed Program. on January 6, 2009 with medications which included The members of the Nursing OI team 3/31/09 Aspinn, Coreg. Lasix, Glipizide, Keppra, Synthroid,

Simvastatin, Prednisone, Zantac, Zaroxylin and

revealed that no care plan was initiated for the use

Tylenol tablets. Further review of the record

of nine or more medications for Resident #15.

A face-to-face interview was conducted with

4/3/09

will collect date on this issue and forward

that information to the DON for review

4. The Department Head will present

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

is chaired by the Administrator.

and evaluation.

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(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PROVIDER'S PLAN OF CORRECTION. (X4) ID (EACH CORRECTIVE ACTION SHOULD BE CROSS-PREFIX PREFIX OR LSC IDENTIFYING INFORMATION) REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG TAG L 051 L 051 Continued From page 7 3210.4 Nursing Facilities (continued) Employee #6 on January 14, 2009 at approximately 5B. Resident #15 Full Side Rail 3:00PM. He/she acknowledged that the care plan 1. Resident care plan was amended 3/6/09 for potential adverse interaction for the use of nine to include a care plan for the use of or more medications was not on the record. He/she added. "I will put one on right now." The record full side rails. was reviewed on January 13, 2009. 2. Medical records of all residents using 3/6/09 B The charge nurse failed to initiate a care plan for full side rails were reviewed for a the use of full side rails for Resident # 15. corresponding care plan for the use of Resident #15 was observed lying in bed with full side rails and care plan amended as side rails up on January 13, 2009 at approximately needed. 12:30PM and 4:10PM on January 14, 2009. The 3. Appropriate care plans with goals and resident was asked why the side rails were up and Approaches the use of Full Side Rails she responded, " They keep me from falling out of will be evaluated using the "Care Plan the bed." The resident was then asked whether Audit" of the Nursing Quality Improvement she could release the side rails. She responded, Program. No. ' The members of the Nursing QI team 3/31/09 According to the facility 's policy entitled "Nursingwill collect date on this issue and forward Physical Restraints: Policy # 1404399A.000 " Page that information to the DON for review 1 of 2 under the heading of "Definition" it is stated and evaluation. "Physical restraints are any manual method or 4. The Department Head will present physical or mechanical device, material, or a report of the data collected and any equipment attached or adjacent to the resident 's action plans implemented to ensure body that the individual cannot remove easily which restricts freedom of movement or normal access to sustained compliance at the monthly one's body." In addition, on Page 2 of 2 of the Quality Improvement Committee which 4/3/09 aforementioned policy under the heading of ' is chaired by the Administrator. Examples of Restraining Devices " the following examples are listed: " 1. Merry Walker 2. Velcro seat belt 3. Soft waist belt 4. Clip belt 5. Lap buddy 6. Lap Tray 7. Reverse Seat belt 8. Reclining Geri-chair without tray 9. Straight back Geri-chair with trav 10. Bed rails not requested by the resident

Health Regulation Administration STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING HFD02-0020 01/16/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **2425 25TH STREET SE WASHINGTON NURSING FACILITY** WASHINGTON, DC 20020 SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-PRÉFIX OR LSC IDENTIFYING INFORMATION) REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG TAG L 051 Continued From page 8 L 051 11. Bed against the wall. " A review of the clinical record revealed a Side Rail Assessment Form dated December 5, 2008 which documented the following; "Recommendation: Full side rails indicated to serve as enabler to promote independence." There was no evidence in the record that the side rails were requested by the resident. A face-to-face interview was conducted with Employee #6 on January 14, 2009 at approximately 3:00 PM. He/she acknowledged that there was no care plan on the record for the use of side rails and stated, "I will add the care plan to the record." The record was reviewed on January 13, 2009. L 052 L 052 3211.1 Nursing Facilities 3211.1 Nursing Facilities Sufficient nursing time shall be given to each resident to ensure that the resident receives the following: (a)Treatment, medications, diet and nutritional supplements and fluids as prescribed, and rehabilitative nursing care as needed; (b)Proper care to minimize pressure ulcers and contractures and to promote the healing of ulcers: (c)Assistants in daily personal grooming so that the resident is comfortable, clean, and neat as evidenced by freedom from body odor, cleaned and trimmed nails, and clean, neat and well-groomed hair; (d) Protection from accident, injury, and infection; (e)Encouragement, assistance, and training in selfcare and group activities;

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	(f)Encouragement a	and assistance to:			•		
	(1)Get out of the bed and dress or be dressed in his or her own clothing; and shoes or slippers, which shall be clean and in good repair;						
	(2)Use the dining ro	oom if he or she is able;	and				
	(3)Participate in me activities, with eatin	aningful social and recr g;	eational				
(g)Prompt, unhurried assistance if he or s requires or request help with eating;			e				
	(h)Prescribed adapt him or her in eating independently;	tive self-help devices to	assist				
	(i)Assistance, if nee including oral acre;	eded, with daily hygiene, and	,				
	j)Prompt response t help.	to an activated call bell o	or call for				
	Based on observati	on, record review and s	taff				

interview, for 10 of 30 sampled residents and six (6) supplemental residents, it was determined that sufficient nursing time was not given to each resident as evidenced by failing to: stop wound care treatments to re-assess the residents for complaints of pain for three (3) residents, follow an order for administration of topical antifungal cream for three (3) residents, follow the physician's order to treat with skin cream for one (1) resident, follow up with a physician's order for a cardiology consult for one (1) resident, administer dilantin as per physician's order for one (1) resident, obtain a physician's order to discontinue a foley catheter for one (1) resident,

PRINTED: 03/04/2009 FORM APPROVED Health Regulation Administration STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING HFD02-0020 01/16/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2425 25TH STREET SE WASHINGTON NURSING FACILITY WASHINGTON, DC 20020 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-DATE TAG OR LSC IDENTIFYING INFORMATION) REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG L 052 L 052 Continued From page 10 3211.1 Nursing Facilities obtain a physician's order for use of full side rails for one (1) resident, obtain an order for velcro seat 1A. Resident #11 belt for one (1) resident, follow a wound care order 1. Staff where resident resides to fluff gauze for one (1) resident, failed to follow the were given inservice on facility policy physician's order for administration of medication on Pain Management focusing on pain 1/18/09 for two (2) residents, obtain the physician's order assessment and intervention during prior to medication administration for three (3) wound treatment. residents, inaccurate staging of a pressure sore for 2. Facility staff on all units were given 1/18/09 one (1) resident and follow clean technique for a inservice training on facility policy pressure sore dressing for two (2) residents. on Pain Management focusing on pain Residents #11, 20, 27, 1, 2, 8, 11, 14, 15, 19, JH1, assessment and intervention during JH2, JH8, JH 9, JH10, and S2. wound treatment. 3. Observation of wound treatments The findings include: will be done by Nursing Supervisors to ensure compliance with the facility's 1. Sufficient nursing time was not given to pain management protocols... Wound care will be evaluated using

the "Treatment Observation" tool of the

Nursing Quality Improvement Program.

will collect date on this issue and forward

that information to the DON for review

4. The Department Head will present

a report of the data collected and any

action plans implemented to ensure

sustained compliance at the monthly

is chaired by the Administrator

Quality Improvement Committee which

and evaluation.

The members of the Nursing QI team

- Residents #11, 20 and 27 as evidence by facility staff failing to re-assess residents for complaints of pain during pressure ulcer dressing changes.
- A. Facility staff failed to stop and re-assess Resident #11 for a complaint of pain during a wound care treatment.

A wound care treatment observation was conducted on January 14, 2009 at approximately 11:30 AM for Resident #11 who had left lower lateral leg wound.

The resident was pre-medicated on January 14. 2009 with Tylenol 325 mg two (2) tablets at 11:00 AM, as per physician's orders dated December 15, 2008

A review of the resident's clinical record revealed a physician's order signed and dated December 15, 2008 that directed "... Cleanse left lower lateral leg with NS [normal sterile saline]. Apply thin layer of silvadene cream, cover with dry gauze

ealth Regulation Administration TATE FORM

WPBP11

3/31/09

4/3/09

Health R	egulation Administrat	tion				FORM	I APPROVED
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L 052	Continued From pagand change daily."	ge 11		L 052	3211.1 Nursing Facilities		
	Employee #26 intro- explained what he/s #11 was positioned the pant leg on the I wound to be dresse the left lower lateral grimaced and said,	duced self to the resid the intended to do. Re on his/her right side, p left lower leg to expose d. As Employee #26 o leg wound, the reside "That's sore" Employ	esident culled up e the deansed ent ee #26		1B. Resident #20 1. Staff where resident resides were given inservice on facility polon Pain Management focusing on passessment and intervention during wound treatment including fluffing wound treatment gauze per MD ord the specifics of clean technique.	oain ; ; the	1/18/09
	to wipe the area with with normal sterile s	orry." Employee #26 on the same in the sam	stened ne with		2. Facility staff on all units were gi inservice training on facility policy on Pain Management focusing on passessment and intervention during wound treatment including fluffing the wound treatment gauze per MD	oain S	1/18/09
	treatment to re-asse to-face interview wa on January 15, 2009 He/she acknowledg wound care treatme	d to stop the wound cases the resident's pain as conducted with Emp at approximately 2:4 ed that he/she did not to re-assess the record was reviewed.	A face- bloyee #26 5 PM. stop the sident's		order. 3. Observation of wound treatment will be done by Nursing Supervisor to ensure compliance with the facil pain management protocols includifully following the physician's wound treatment order.	s rs lity's	
	B. Facility staff failed pain during a wound physician's order to	d to reassess Residen d treatment and follow fluff the wound treatm in clean technique dur	the ent gauze		Wound care will be evaluated using the "Treatment Observation" tool Nursing Quality Improvement Program The members of the Nursing QI tea will collect date on this issue and for that information to the DON for regard evaluation.	of the gram. am orward view	3/31/09
	on January 14, 2009 who had sacral and		ident #20		4. The Department Head will press a report of the data collected and ar action plans implemented to ensure sustained compliance at the monthl Quality Improvement Committee w	ny e y	4/3/09
		e-medicated on Janua			is chaired by the Administrator.		

The resident was pre-medicated on January 14, 2009 with Percocet two (2) tablets at 11:00 AM, as per physician's orders dated November 8, 2008.

According to the physician's telephone order

FORM APPROVED Health Regulation Administration STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING HFD02-0020 01/16/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **2425 25TH STREET SE WASHINGTON NURSING FACILITY** WASHINGTON, DC 20020 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-PRÉFIX OR LSC IDENTIFYING INFORMATION) REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE TAG TAG L 052 L 052 Continued From page 12 3211.1 Nursing Facilities dated December 22, 2008 and unsigned, "(1) Cleanse left ischium with normal sterile saline (NSS). Pat dry. Pack with fluffy gauze and Santyl ointment. Cover with 4 x 4 (gauze) and Coversite BID and PRN (twice daily and as needed ... (4) Cleanse sacral wound with NSS and pat dry. Pack with fluffy gauze and Santyl ointment. Cover with 4 x 4 (gauze pads) and ABD (abdominal pad) then tape until healed BID and PRN." The resident was positioned on his/her left side, exposing both wounds. The nurse cleaned the left ischial wound. Employee #23 cleansed the interior of the wound twice and the exterior of the wound twice. Each time Employee #23 cleansed the wound, the resident moaned loudly. Employee #23 applied the 4 x 4 gauze pads and Santyl ointment and failed to fluff the gauze to pack the wound as per the physician's order. Employee #23 failed to stop the wound treatment and reassess the resident's pain. After completing the treatment on the left ischial wound, Employee #23 began treatment on the sacral wound. Employee #23 cleansed the interior of the sacral wound twice and the exterior of the wound three times. Each time Employee #23 cleansed the wound, the resident moaned. After cleansing the sacral wound the first time Employee #23 stated to the resident, "I know it hurts. I'm sorry but we are almost done." Employee #23 applied the 4 x 4 gauze pads with Santyl ointment and failed to fluff the gauze to pack the wound as per physician's orders. Employee #23 then applied the Coversite. The resident

moaned during the application of the dressing. The wound treatments were completed at 12:30 PM.

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L 052	B. Sufficient nursing #20 as evidenced by clean technique dur. A wound treatment January 14, 2009 at an ischial and sacra completed the ischia wash hands and chathe treatment on the Employee #23 failed bedside table that we treatment equipment. C. Facility staff faile Resident #27 for concare treatment and pressure sore. 1. A wound care treatment and pressure sore. 1. A wound care treatment and pressure ulcer. The resident was pressure ulcer. The resident was pressure ulcer. The resident was pressure ulcer. A review of the resident pressure and pressure sore as pressure ulcer. A review of the resident was pressured and pressure ulcer. A review of the resident was pressured and pressure ulcer.	time was not given to y facility staff failing to ing a wound treatment observation was conditionally a sacral wound. Employee # al wound treatment arrange gloves before been sacral wound treatment of to clean the resident was used to house work. If to stop and re-assemplaint of pain during failed to accurately statement observation was arry 15, 2009 at approximation of the conditional physician is telephone. The clinical record of the conditional record	ofollow of the control of the contro	L 052	3211.1 Nursing Facilities (con C. Resident #27 1. Staff where resident resides was given inservice on facility pol on Pressure Ulcer staging. 2. Facility staff on all units were g Inservice training on facility policy Pressure Ulcer Staging. 3. Observations of pressure ulcer swill be done by Nursing Supervisor To ensure compliance with the fact pain management protocols. Press Staging will be evaluated using the "Treatment Observation" tool of the Nursing Quality Improvement Protocols The members of the Nursing QI Towill collect data on this issue and for that information to the DON for reand evaluation. 4. The Department Head will press a report of the data collected and a action plans implemented to ensure sustained compliance at the month QI Committee which is chaired by Administrator.	icy given y on staging ors ility's sure Ulcer e ne gram. eam orward view sent ny e	3/31/09 3/31/09 3/31/09
	The resident was po	sitioned on his/her le	rt side,				

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L 052	exposing the sacral cleansed the sacral cleansed the ulcer, grimaced. Employe	ge 14 s of the resident's ostor I pressure ulcer. Employe I ulcer. As the Employe the resident moaned a ee #27 continued with ployee #27 applied Sa	oyee # 27 ee #27 and the wound	L 052	3211.1 Nursing Facilities (cont 2. Resident #27 1. Staff where resident resides was given inservice on facility polic on Pressure Ulcer staging. 2. Facility staff on all units were gill Inservice training on facility policy	cy	3/31/09 3/31/09
	fluffy 4 x 4 gauze pa secured the dressin Employee #27 failed re-assess the resident 2. Sufficient nursing #27 to accurately st A " Weekly Wound 29, 2008 coded an	ads, packed the wound and with pre-labeled taped to stop the wound treent's complaint of pain time was not given to tage a pressure sore. I Progress Report " dainitial observation of a e 1.5 cm x 4 cm x 0.10	eatment to Resident Ited July Stage III		Pressure Ulcer Staging. 3. Observations of pressure ulcer swill be done by Nursing Supervisor To ensure compliance with the facina pain management protocols. Pressus Staging will be evaluated using the "Treatment Observation" tool of the Nursing Quality Improvement Progulation The members of the Nursing QI Te will collect data on this issue and for that information to the DON for revenil servations.	taging es lity's lite Ulcer e gram. am orward	3/31/09
	and Prevention" by and Human Service thickness skin loss dermis. The ulcer is clinically as an abra Stage III: Full thickness of subcut down to but not throulcer presents clinic without undermining. There was no evide documented damage tissue.	sure Ulcers in Adults. Fithe U.S. Department of the U.S. Department on the U.S. Department of the U.S. Department	of Health Partial Ind/or ents or crater. In damage lay extend or Indian		and evaluation. 4. The Department Head will prese a report of the data collected and an action plans implemented to ensure sustained compliance at the monthly QI Committee which is chaired by the Administrator.	y y	4/3/09
	approximately 1:15 the sacral pressure	PM during a wound tre ulcer by	eatment to				

PRINTED: 03/04/2009 FORM APPROVED Health Regulation Administration (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A BUILDING B. WING HFD02-0020 01/16/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **2425 25TH STREET SE WASHINGTON NURSING FACILITY** WASHINGTON, DC 20020 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX OR LSC IDENTIFYING INFORMATION) TAG TAG L 052 L 052 Continued From page 15 3211.1 Nursing Facilities (continued) Employee #27. 2A. Resident #1 1. Podiatrist order for antifungal medication 3/6/09 A face-to-face interview was conducted with was clarified . PMD notified. Employee #9 on January 15, 2009 at approximately 2. Medical records of all residents seen by 4:20 PM. He/she acknowledged that the pressure 3/13/09 should have been identified as a Stage II. The the podiatrist with an order for an antirecord was reviewed January 15, 2009. fungal medication were reviewed to ensure that the order was clarified if necessary. 2. Facility staff failed to follow-up with and clarify the 3. Routine review of medical records of 3/31/09 podiatrist's plan of care for use of over the counter residents seen by the podiatrist will be (OTC) topical anti-fungal medication for Residents # reviewed if orders for antifungal medication 1 and 11. A. Facility staff failed to clarify an order for an antiand other orders were clarified whenever fungal medication for Resident #1. necessary. Clinical Mangers will report the results of this review and data collection to the Director of Nurses. Resident #1 was seen by the podiatrist on November 25, 2008. The podiatrist's plan of care 4. The Department Head will present a report of the data collected and any included the following: "All mycotic nails were debrided ... The patient is not a candidate for oral action plans implemented to ensure antifungal. OTC topical may be used. Tinactin antisustained compliance at the monthly fungal medication was recommended." QI Committee which is chaired by the 4/3/09 Administrator. Use of a topical antifungal was included in the podiatrist's plan of care for Resident #1 on June 30, 2008. There was no evidence in the record that facility staff clarified the podiatrist's recommendation for the use of anti-fungal medication with the resident's primary physician.

A review of the resident's Medication Administration Record (MAR) for July 2008 through January 2009 lacked evidence that the resident was administered any topical antifungal medication for the feet.

A face-to-face interview was conducted with Employee #6 on January 16, 2009, at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

(X3) DATE SURVEY COMPLETED

HFD02-0020

A. BUILDING B. WING

01/16/2009

NAME OF PROVIDER OR SUPPLIER

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L 052	Continued From page 16 approximately 11:30 AM. He/she acknowled	dged	052	3211.1 Nursing Facilities (continued) 2B. Resident #11	
	that facility staff failed to follow-up with and of the podiatrist's plan of care for the use of top			1. Podiatrist order for antifungal medication was clarified . PMD notified.	3/6/09
	antifungal medication on the resident's feet. record was reviewed January 16, 2009.	The		2. Medical records of all residents seen by the podiatrist with an order for an antifungal medication were reviewed to	3/13/09
	B. Resident #11 was seen by the podiatrist of 15, June 17, August 26, and November 11, The Podiatrist's plan of care included the following the podiatrist of the Podiatrist's plan of the podiatrist of the Podiatrist's plan of the podiatrist of the Podiatrist's plan of the podiatrist of the Podiatris	2008.		ensure that the order was clarified if necessary. 3. Routine review of medical records of	3/31/09
	"All mycotic nails were debrided todayTo antifungals may be used as needed."			residents seen by the podiatrist will be reviewed if orders for antifungal medication and other orders were clarified whenever	3/3//09
	There was no evidence in the record that fact staff clarified the podiatrist's recommendation the use of anti-fungal medication with the reprimary physician.	n for		necessary. Clinical Mangers will report the results of this review and data collection to the Director of Nurses. 4. The Department Head will present	
	A review of the resident's MAR for July 200 through January 2009 lacked evidence that resident was administered any topical antifumedication.	the		a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly QI Committee which is chaired by the Administrator. 3. Resident #2	4/3/09
	A face-to-face interview was conducted with Employee #8 on January 16, 2009, at approximately 11:30 AM. He/she acknowled that facility staff failed to follow-up with and the podiatrist's plan of care for the use of top antifungal medication on the resident's feet. record was reviewed January 16, 2009.	dged clarify pical	·	I. Incident report completed. Pharmacy was notified. Discovered that the Kenalog Cream was placed in the treatment cart instead of the Medication cart. 2. MARs were audited to review that meds ordered were administered in a timely manner for all residents.	1/15/09
	Sufficient nursing time was not given to R #2 as evidenced by facility staff failing to foll physician's order to apply Kenalog Cream in	ow the		3. Facility staff were given an inservice training on Medication Administration placing special emphasis on calling pharmacy for meds.	
	timely manner. A review of Resident # 2's clinical record revielephone order dated January 12, 2009 whi	vealed a		Telephone Orders will be evaluated using the "Telephone/Verbal Orders" tool of the Nursing Quality Improvement Program.	
	stated, "Kenalog Cream to incision site on c [three times a day] for two (2) weeks for itch			The members of the Nursing QI Team will collect data on this issue and forward that information to the DON for review	3/31/09
	ation Administration			and evaluation.	

Health Regulation Administration

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L 052	Daily review of the N 2009, revealed that administered. According to an administered that administered. According to an administered.	MAR on January 12, 1 the medication was nording to the January 2 administered on January 13, 200 pm of the medicated was conducted was not given to facility staff failing to	ot 1009 MAR, ary 15, with an January [he/she] it." The 10. Resident collow up consult. Evealed an evember lit: confirm widence ician's widence ician's district was a Resident to obtain a otheter.	L 052	3211.1 Nursing Facilities (cont 3. Resident #2 (continued) 4. The Department Head will prese a report of the data collected and an action plans implemented to ensure sustained compliance at the monthly QI Committee which is chaired by the Administrator 4. Resident #8 1. Physician reviewed the total plant care on this resident to provide evide of the resident's cardiology consult. 2. All the medial records of this physician were reviewed to provide evidence of other residents who have had orders for cardiology cons 3. Physician Services meeting was held to review the physicians' responsibility in addressing specific resident issues. Monitoring of inclus of these issues in the physician progress notes will be done by the Clinical Managers who will forward any concerns to the Director of Nur. 4. The Department Head will prese a report of the data collected and an action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee w is chaired by the Administrator 5. Resident #14 1. MD notified and order carried ou 2. Medical records of all residents w discontinued foley catheters were at to ensure the presence of a physician order prior to discontinuing the cath	y y y he n of ence sults sustant y y hich t. with udited n's	4/3/09 3/31/09 3/31/09 4/3/09 1/16/09 3/31/09
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L 052	Continued From page	 ge 18		L 052	3211.1 Nursing Facilities (conti	inued)	
	2008. Section H3 "Continence/Appliar resident as having a A review of the resident	o the facility on Septer nces and Program " co an indwelling catheter. dent's clinical record re heet and Physician Pla	oded the		5. Resident #14 (continued) 3. Facility staff were given an insertion on the facility protocol for Insertion removal of a foley catheter. Discontinued catheter orders will be evaluated using the "urethral Cathet	and e er" tool	
	sheet " that "Foley seen by MD [Medica change cath. [Cath The following order,	Catheter16FR [Frei al Doctor] " routine	nch], until care MAR,		of the Nursing Quality Improvemen The members of the Nursing QI Tea will collect data on this issue and fo that information to the DON for rev and evaluation. 4. The Department Head will prese	am orward riew	3/31/09
	Foley cath Fr. 16 ch discontinued on Oct A review of the residual control of	ange Q month" was tober 8, 2008. dent's clinical record l y staff obtained a phys	lacked		a report of the data collected and an action plans implemented to ensure sustained compliance at the monthly QI Committee which is chaired by t Administrator. 6. Resident #11	y	4/3/09
	A face-to-face intervent Employee #9 on Jar 12:45 PM. He/she a clinical record lacked obtained a physiciar	view was conducted winuary 15, 2009 at approceedings that the devidence of that facin's order to discontinuly catheter. The record	roximately resident's lity staff le		1. Involved nursing staff was couns for not administering/not documenti Dilantin 100 mg (2capsules 200mg) by mouth twice daily for seizures. P was notified of the lack of evidence Dilantin was administered. 2. MARs were audited for similar or sight of documentation.	MD that the	3/6/09
	#11 as evidenced by administered Dilanti A physician's order or signed by the physician's directed, "Phenytoin	time was not given to y facility staff failing to n as per the physician dated November 20, 2 cian on December 13, n100mgDilantin y mouth twice daily for	's order. 008 and 2008, 2		Non-compliance with the facility's process for MAR documentation will result employee being subjected to the facility disciplinary process. MAR documentation will be evaluated using the "Medication Pagof the Nursing Quality Improvement The members of the Nursing QI Teawill collect data on this issue and for that information to the DON for rev	in the ility's ss" tool t Program. am	3/31/09
	SCIZUI CS.				and evaluation.	IC W	J1/U7

Health Regulation Administration STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING HFD02-0020 01/16/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2425 25TH STREET SE **WASHINGTON NURSING FACILITY** WASHINGTON, DC 20020 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX ID (X5) COMPLETE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX OR LSC IDENTIFYING INFORMATION) TAG TAG L 052 L 052 Continued From page 19 3211.1 Nursing Facilities (continued) 6. Resident #11 (continued) A review of the resident's MAR for the month of 4. The Department Head will present August 2008 lacked evidence that the resident was a report of the data collected and any 4/3/09 administered Dilantin at 8:00 PM on August 26 and action plans implemented to ensure 29, 2008 as evidenced by absence of initials for Dilantin during the aforementioned dates indicating sustained compliance at the monthly Dilantin was not administered. The resident's OI Committee which is chaired by the clinical record lacked documentation as to why Administrator. Dilantin was not administered. There was no evidence in the record that the resident experienced 7. Resident #15 untoward effects from the omitted Dilantin doses. 1. Physician's order obtained for use of full 1/16/09 side rails for resident. A face-to-face interview was conducted with 2. Medical records of all residents using full 1/16/09 Employee #8 on January 14, 2009 at approximately side rails were reviewed to ensure 11:30 AM. He/She acknowledged that the resident's the presence of a physician's order. MAR lacked evidence that facility staff administered 3. Inservice training was given to facility Resident #11 Dilantin as per the physician 's order. staff on the facility protocol for use of The record was reviewed January 14, 2009. full side rails. Restraint documentation will be 7. Sufficient nursing time was not given to Resident evaluated using the "Physical Restraint" tool #15 as evidenced by facility staff failing to obtain a of the Nursing Quality Improvement Program. physician's order for the use of full side rails. The members of the Nursing OI Team On January 12, 2009 at approximately 4:00 PM. will collect data on this issue and forward January 13 at 12:30 PM and 4:10 PM on January that information to the DON for review 3/31/09 14, 2009. Resident #15 was observed lying in bed and evaluation. with full side rails up. 4. The Department Head will present In a face-to-face interview with the resident on a report of the data collected and any January 13, 2009 at approximately 12:30 PM action plans implemented to ensure he/she was asked why the side rails were up and sustained compliance at the monthly he/she responded, "They keep me from falling out OI Committee which is chaired by the of the bed." The resident was then asked whether 4/3/09 he/she could release the side rails. The resident Administrator. responded, "No." A review of the clinical record revealed that there was no physician's order for the use of full side rails for Resident #15. A face-to-face interview was conducted with Employee # 6 at approximately 4:00 PM on

FORM APPROVED **Health Regulation Administration** STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING B. WING HFD02-0020 01/16/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **2425 25TH STREET SE WASHINGTON NURSING FACILITY** WASHINGTON, DC 20020 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (X4) ID PREFIX ID. (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-OR LSC IDENTIFYING INFORMATION) REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG TAG L 052 L 052 Continued From page 20 **3211.1 Nursing Facilities** (continued) January 14, 2009. He/she acknowledged that there was no order for the use of full side rails for 8. Resident #19 Resident #15. The employee added, "I will call the 1. The clamp style seat belt was discontinued, physician for an order for the use of the side rails." and replaced with the Velcro seat belt per The record was reviewed on January 13, 2009. physician's order. RP was notified and 1/15/09 consent obtained. 2. Medical records of all residents 8. Sufficient nursing time was not given to Resident 3/13/09 #19 as evidenced by facility staff failing to follow using a clamp style seat belt were audited physician's orders to use a Velcro seat belt. to ensure a corresponding physician order. A review of Resident #19's record revealed a Changes were made whenever necessary. telephone order dated December 18, 2008 at 4:00 3. Inservice was given to facility staff re' PM, signed by the physician on the same date that the difference between a Velcro self release directed, "Obtain consent for seat belt (self release) seat belt that a resident can self release from guardian. Resident to have self release seat and a clamp style seat belt that a resident belt on while sitting up in w/c (wheelchair)." is unable to self release(Physical Restraint) Restraint documentation will be "Consent for the Use of a Physical Restraint" for a evaluated using the "Physical Restraint" tool seat belt (Velcro) was signed by the responsible of the Nursing Quality Improvement Program. party on December 22, 2008. The members of the Nursing OI Team will collect data on this issue and forward Care plan #7, "Restraint device ..." was updated that information to the DON for review 3/31/09 on December 22, 2008 when the Velcro seat belt and evaluation. was applied to Resident #19. 4. The Department Head will present a report of the data collected and any action An observation of Resident #19 was conducted in plans implemented to ensure sustained 4/3/09 the presence of Employee #13 on January 15, compliance at the monthly OI Committee 2009 at 2:15 PM. Resident #19 was observed with which is chaired by the Administrator. a clamp type seat belt and was unable to open the belt when asked. Employee #13 acknowledged that the resident was wearing a clamp type seat belt and was unable to open the belt. The record was reviewed January 15, 2009. 9. Sufficient nursing time was not given to Residents JH1 and JH2 as evidenced by facility staff failing to follow the physician's orders for administration of medication. A. Sufficient nursing time was not given to

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/	CLIA	(X2) MULT	IPLE CONSTRUCTION	(X3) DATE SUF	RVEY
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L 052	Continued From page			L 052	2244 4 Numing Equilities (cont		
					3211.1 Nursing Facilities (cont 9A. Resident JH1	inuea)	
		denced by facility state			1. The involved staff member was		
	administration.	's orders for medication	on ·		counseled with inservice given.		1/16/09
	administration.				2. Subsequent observations have		1, 10, 0,
	On January 13, 200	9, at approximately 1°	1·40 AM		been done on all nurses to ensure th	eir	
		on pass, Employee #2			ability to pass medications as order		3/31/09
		tamin, Plavix 75mg, G			3. MAR documentation will be		
		50mg, Amlodipine 5m			evaluated using the "Medication Pa	ss" tool	
*		ex EC 500mg to Resid			of the Nursing Quality Improvemen		
					The members of the Nursing QI Te		
}	After reconciling the	Physicians Orders SI	heet		will collect data on this issue and fo		
		ated on January 10, 2			that information to the DON for rev	iew	3/31/09
		inistration Record (M/		,	and evaluation.		
		s discovered that Sim			4. The Department Head will prese		
	mg was omitted duri	ing the medication pa	SS.		a report of the data collected and an plans implemented to ensure sustain		4/3/09
	A 6 1- 6 i-1				compliance at the monthly QI Com		4/3/09
		view was conducted o			which is chaired by the Administra		
		mately 1:05 PM, Emp medication during the			winer is chance by the Administra	101	
		it morning." the medic			9B. Resident #JH2		
		ng administered durin			1. The involved staff member was		
	morning medication		3		counseled with inservice given.		1/16/09
		•	*		2. Subsequent observations have		
	B. Sufficient nursing	time was not given to	Resident	*	been done on all nurses to ensure th	eir	•
		y facility staff failing to			ability to pass medications as order	ed.	3/31/09
	physician's orders fo	or medication adminis	tration.		3. MAR documentation will be		
					evaluated using the "Medication Pa		
)9, at approximately 9			of the Nursing Quality Improvemen		
		on pass, Employee #4			The members of the Nursing QI Te		
		tamin, Amlodipine 10ı SA 325 mg, Vitamin B			will collect data on this issue and for that information to the DON for rev		3/31/09
•		d Haloperidol 1 mg to			and evaluation.	'ICW	3/31/09
	JH2.	a maiopondor i nigito	i vosiderit		4. The Department Head will present		
	J , <u></u> .				a report of the data collected and any ac	ction	
	After reconciling the	Physicians Orders SI	heet		plans implemented to ensure sustained		4/3/09
		ated on December 18			compliance at the monthly Ql Committ	ee	

After reconciling the Physicians Orders Sheet (POS) signed and dated on December 18 2008

6899

which is chaired by the Administrator.

PRINTED: 03/04/2009 FORM APPROVED Health Regulation Administration STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A BUILDING B. WING HFD02-0020 01/16/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **2425 25TH STREET SE WASHINGTON NURSING FACILITY** WASHINGTON, DC 20020 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX (X5) COMPLETE DATÉ (EACH CORRECTIVE ACTION SHOULD BE CROSS-(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX OR LSC IDENTIFYING INFORMATION) REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG TAG L 052 Continued From page 22 L 052 3211.1 Nursing Facilities (continued) and an Interim order signed and dated December 16, 2008 with the MAR for January 2009, it was 10A. Resident #JH8 discovered that Alphagan 0.15% ophthalmic drops, 1. Employee involved was counseled and Cospt ophthalmic drops, Cardiazem ER180mg and received education regarding the facility's Ranitidine 150 mg tablets were omitted during the Pharmacy policies and procedures. 1/31/09 medication pass. 2. MARs and Controlled Substance sign-Out sheets for all residents were 1/31/09 A face-to-face interview was conducted on January reviewed to ensure compliance. 16, 2009, at approximately 1:15 PM, Employee #40 3. MAR documentation will be stated, "I am not familiar with this floor. I looked evaluated using the "Medication Pass" tool and asked someone to help me find it. I of the Nursing Quality Improvement Program. administered the all medication before 12:00 PM." The members of the Nursing QI Team will collect data on this issue and forward 10. Failed to obtain the physician's order prior to that information to the DON for review 3/31/09 medication administration. Residents and evaluation. JH8, JH9, and JH10. 4. The Department Head will present a report of the data collected and any action A. Review of the physician 's order for Resident plans implemented to ensure sustained 4/3/09 JH8, signed and dated June 23, 2008, directed, ' compliance at the monthly OI Committee D/C [Discontinue] Percocet ii [two] tabs 5/325 mg g which is chaired by the Administrator [every] Monday before tx [treatment] and gd [daily] before tx [treatment]. " 30 tablets were dispensed. On January 15, 2009, at approximately 12:00 PM during the inspection of the medication carts for 1 South, a blister package containing 10 tables of Oxycodone/APAP 5/325mg (Percocet) tablets were observed stored in the medication cart. A review of the Controlled Drug Record documented that medication was removed on July 7, 8, 19 and 20, 2008 and August 24, 2008. This medication was dispensed after the physician had

discontinued the order.

Oxycodone/APAP 5/325mg was not transcribed onto the MAR for July and August 2008 because it was discontinued. There was no evidence that

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L 052	Continued From pag	ge 23		L 052	3211.1 Nursing Facilities (cont	inued)	
	the resident receive	d the medication on th	ne above				
	cited days.				10B1. Resident # JH9		
					1. Employee involved was counsel		
		view was conducted o			received education regarding the fa	cility's	1/21/00
		mately 12:15 PM with			Pharmacy policies and procedures. 2. MARs and Controlled Substance	cian_	1/31/09
	findings.	wledged the above st	aleu		Out sheets for all residents were	sign-	1/31/09
	ilitalings.				reviewed to ensure compliance.		1/51/05
	B1 A review of the	physician 's order sig	ned for		3. MAR documentation will be		
		ated July 11, 2008, di			evaluated using the "Medication Pa		
	Tylenol #3, two tabs	stat, i [one] q4h [eve	ry 4 hours]	•	of the Nursing Quality Improvemen	ıt Program.	
		n for five days for den	tai		The members of the Nursing QI Te		
•	extraction " 30 table	ets were dispensed.			will collect data on this issue and for		2/21/00
	On Januari 16, 200	10. at approximately 1	0.00 004		that information to the DON for revaluation.	/iew	3/31/09
		09, at approximately 1 n of the medication ca			4. The Department Head will prese	nt h	
		kage containing 22 tal			a report of the data collected and ar		
		mg/ 15mg (Tylenol #3			plans implemented to ensure sustain		4/3/09
	were observed store	ed in the medication c	art.		compliance at the monthly QI Com	mittee	
		•			which is chaired by the Administra	itor.	
	A review of the Con		240		·		
		olets of Oxycodone/Al red on September 16			B2. Resident #JH9		
	11 and 16 and Nove	ember 13, 2008, for a	total of		1. Employee involved was counsel		•
		oved after the medica		•	received education regarding the fa Pharmacy policies and procedures.	cility's	1/31/09
	discontinued.				2. MARs and Controlled Substance	sign-	1/31/03
					Out sheets for all residents were	6	1/31/09
		nce on the Septembe		•	reviewed to ensure compliance.		
		MAR that the medica	ation was		3. MAR documentation will be		
	administered to the	resident.			evaluated using the "Medication Pa		
	A food to food inter-	iou was senduated a	n lanuar:		of the Nursing Quality Improvemen		3/31/09
		riew was conducted ic mately 12:15 PM with	ni January		The members of the Nursing QI Te		
		54. They acknowledg	ed the		will collect data on this issue and for that information to the DON for rev		
		,			I mai imormation to the DON 101 fev	IC W	

above stated findings.

B2. A physician's order dated April 15, 2008 directed, "APAP W/codeine #3 (Tylenol #3) two (2)

tablets po every 6 hours as needed for pain."

and evaluation.

4. The Department Head will present

a report of the data collected and any action plans implemented to ensure sustained

compliance at the monthly QI Committee

which is chaired by the Administrator.

4/3/09

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER. IDENTIFICATION NUMBER		(X2) MULTI	PLE CONSTRUCTION G	(X3) DATE SUI COMPLET	
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L 052	The physician did r when orders were 22, and November 22, and November According to the C #3, two (2) tablets September 1 (twice November 22, Nov 2008. There was no evide October and Nover resident received the A face-to-face inter 15, 2009 at approx Employees #8 and above stated findin C. Review of the plus JH10, signed and c Tylenol #3 q6h [examples of the plus	pensed for Resident on the renew the above of signed on August 21, 24, 2008. ontrolled Drug Record were removed on Auge), October 17, Octobe ember 24 and November 24 and November 2008 MARs that he medication. They was conducted imately 12:15 PM with 54. They acknowledges. hysician 's order for Related October 2, 2008 every 6 hours] prn [as	ted order September Tylenol ust 24, er 22, ber 28, eptember, the on January ged the esident , directed, needed]	L 052	C. Resident #JH10 1. Employee involved was counse received education regarding the farmacy policies and procedures 2. MARs and Controlled Substanc Out sheets for all residents were reviewed to ensure compliance. 3. MAR documentation will be evaluated using the "Medication P of the Nursing Quality Improveme The members of the Nursing QI To will collect data on this issue and for that information to the DON for reand evaluation. 4. The Department Head will press a report of the data collected and a plans implemented to ensure susta compliance at the monthly QI Con which is chaired by the Administres.	led and acility's e sign- ass" tool nt Program. eam orward view ent ny action ined nmittee	1/31/09 1/31/09 3/31/09 4/3/09
	On January 14, 200 during the inspection 3 North unit, a blist APAP/Codeine 300 was observed store According to the Cotablet was removed on Omediation was discontinuous d	ys, dental extractions. Insect. 09, at approximately 3 on of the medication carrier package containing 0 mg/ 15mg (Tylenol # ded in the medication carrolled Drug Record on October 7 and on actober 8, 2008, after the continued by the physicience on the MAR for Continued	: 30 PM arts on the seven (7) 3) tablets art. , one (1) e (1) tablet ne cian.				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/IDENTIFICATION NUMB		(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SUF COMPLET	
		HFD02-0020		B. WING		04/4/	2/2000
	ON ADED OD CHIDDINED	HFD02-0020	STREET AND	RESS, CITY, ST.	ATE ZID CODE	<u> </u>	6/2009
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L 052	2008 that the medic	ge 25 ation was administere ed by no initials were		L 052	3211.1 Nursing Facilities (cont 11. Resident # S2 1. The staff involved was counseled	,	
	A face-to-face interv 15, 2009 at approxir	riew was conducted o mately 3: 45 PM with I wledged the above sta	Employee		given a 1:1 inservice. 2. Nursing staff from other units were given inservice training in protechniques before and after		1/31/09 3/31/09
	findings. 11. Sufficient nursin Resident S2 as evid	g time was not given the desired by facility stafful ue during a wound tre	to failed to		each wound treatment. 3. Wound treatments will be observed by ADONs, Clinical Mgrs, & Nursi supervisors to ensure that proper teachers were used during the treatment. Da	ng chniques	3/31/09
	January 15, 2009 at placed a package of Isagel (hand cleanse	observation was cond 11:45 AM. Employed 4 x 4 gauze pads, bo er) and bottle of norman meable barrier on top stand.	e #22 ottle of al sterile		through the Nursing Quality Improvement Program's Treatment Observation 1 Will be forwarded to the Director of and her Ql team for evaluation. 4. The Department Head will prese a report of the data collected and an action plans implemented to ensure sustained compliance at the monthly	vement Fool f Nurses nt y	
	#22 removed the so permeable barrier, p gauze, the bottle of bottle of lsagel direct stand. Employee #2 treatment waste, ret and placed the pack the bottle of Isagel a saline in the treatment.	the wound treatment, liled dressing and the placing the package of normal sterile saline actly on the top of the board of the wourned to the resident age of 4 x 4 gauze spind the bottle of normal toart. Additionally, the beside table after a	non- f 4 x 4 and the edside und 's room oonges, al sterile Employee		Quality Improvement Committee w is chaired by the Administrator		4/3/09
L 091	3217.6 Nursing Faci	lities		L 091	3217.6 Nursing Facilities		
	infection control poli implemented and sh services, including h	of Committee shall ensicies and procedures a call ensure that environ nousekeeping, pest co	are nmental introl,				

PRINTED: 03/04/2009 FORM APPROVED Health Regulation Administration (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING HFD02-0020 01/16/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **2425 25TH STREET SE WASHINGTON NURSING FACILITY** WASHINGTON, DC 20020 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETE DATE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (EACH CORRECTIVE ACTION SHOULD BE CROSS-PREFIX OR LSC IDENTIFYING INFORMATION) TAG REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG L 091 L 091 Continued From page 26 3217.6 Nursing Facilities (continued) the requirements of this chapter. This Statute is not met as evidenced by: 1. Resident #11 1. Employee involved was counseled and Based on observation and record review for two (2) of 30 sampled residents, it was determined that provided inservice with return facility staff failed to: wash hands after reaching into demonstration to ensure competency. 3/6/09 a pocket before proceeding with a wound care 2. Wound treatment observation was done treatment for one (1) resident, and clean a soiled with nursing staff to ensure their competency 3/31/09 mattress for one (1) resident. Residents #11 and with infection control and wound care. 3. Inservice training regarding proper handwashing while in the process of doing The findings include: wound care treatments was provided to the staff. Compliance will be monitored 3/31/09 1. Facility staff failed to wash his/her hands after through the Nursing Services Quality reaching into his/her pocket and before proceeding Improvement Program's tool for "Infection with a wound care treatment for Resident #11. Control." The Nursing QI Team will forward their findings to the Director of Nursing for her evaluation. Employee #26 was observed during a wound care 4. The Department Head will present 4/3/09 treatment to Resident #11 on January 14, 2009 at approximately 11:30 AM. He/she introduced self to a report of the data collected and any the resident and explained what he/she was going action plans implemented to ensure to do. He/she washed hands, cleaned the table and sustained compliance at the monthly QI covered with a barrier before putting the treatment Committee which is chaired by the supplies on the table. Administrator. Employee #11 reached into his/her pant's pocket, 2. Resident #27 took out keys and locked the treatment cart. He/she 1. Employee involved was counseled and failed to wash his/her hands before proceeding with provided inservice. 3/6/09 the wound care treatment procedure after locking 2. There are no other residents in the the treatment cart. facility with both a colostomy and who require wound care. 3/6/09. A-face-to-face interview was conducted with 3. Inservice training regarding proper Employee# 26 on January 16, 2009 at Infection Control under the cited approximately 10:30 AM. He/she acknowledged circumstances was provided to the

cart.

that he/she failed to wash his/her hands after taking

2. Facility staff failed to clean Resident # 27's soiled

mattress after removing bed linen soiled

the keys from his/her pocket to lock the treatment

3/31/09

evaluation.

staff. This practice will be monitored

Improvement Program's tool for "Infection

through the Nursing Services Quality

Director of Nursing for her review and

Control." The Nursing QI Team

will forward their findings to the

Health Regulation Administration STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA. (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING HFD02-0020 01/16/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2425 25TH STREET SE **WASHINGTON NURSING FACILITY** WASHINGTON, DC 20020 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (EACH CORRECTIVE ACTION SHOULD BE CROSS-PREFIX OR LSC IDENTIFYING INFORMATION) REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE TAG TAG L 091 L 091 Continued From page 27 3217.6 Nursing Facilities and soaked with the contents of the resident's colostomy bag and before making the bed with 2. Resident #27 (continued) clean linens. 4. The Department Head will present 4/3/09 a report of the data collected and any action plans implemented to ensure Resident # 27 was observed during a wound sustained compliance at the monthly QI treatment on January 15, 2009 at 1:15 AM by Committee which is chaired by the Employee #27. The resident's body and bed linens were observed soiled and soaked with the contents Administrator. of the resident's colostomy bag. After Employee #27 completed the resident's wound care treatment, Employee #29 took over from Employee #27 to clean the resident. Employee #29 stripped the bed of a fitted and flat sheets, picked up some crumbs on the mattress and applied clean linens (a fitted and flat sheets) to make the bed. Employee #29 failed to clean the stained mattress before applying clean bed linens to make the bed. A face-to-face interview was conducted with Employee #29 on January 15, 2009 at approximately 2:35 PM. He/she acknowledged that the stained mattress was not cleaned after stripping the soiled linens from the bed and before making the bed with clean linens. 3219.1 Nursing Facilities L 099 L 099 3219.1 Nursing Facilities Food and drink shall be clean, wholesome, free from spoilage, safe for human consumption, and served in accordance with the requirements set forth in Title 23, Subtitle B, D. C. Municipal Regulations (DCMR), Chapter 24 through 40. This Statute is not met as evidenced by: Based on observations during the survey period, it was determined that dietary services were not adequate to ensure that foods were served in a safe and sanitary manner as evidenced by: foods

observed undated in the walk-in refrigerator, reach-

in refrigerator and the dry storage area;

01/16/2009

Health Regulation Administration

STATEMENT	OF	DEFICIENCIES
AND DLAN OL	- ~	ODDECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

A. BUILDING

B. WING

(X3) DATE SURVEY COMPLETED

HFD02-0020

AME OF PR	ME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE					
WASHING	CTON NUIDCING FACILITY	2425 25TH STREET SE WASHINGTON, DC 20020					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGUL OR LSC IDENTIFYING INFORMATION)	LATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS- REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET DATE		
L 099	Continued From page 28		L 099	3219.1 Nursing Facilities (continued)			
		. 1		A. Undated Food in the Refrigerators and			
	soiled dome covers, ice machine, ceiling tile			Dry Storage Areas			
	rack and food carts; damaged ceiling tile in			1. Food found undated was taken out of			
	storage area; and serving utensils were obs			storage and discarded.	1/16/09		
	wet; foods were observed being plated with			2. All food in the walk-in and reach-in	1/10/03		
	incorrect ladle [scoop size] during the tray li			refrigerators and the dry storage areas			
	service; a pan of vegetables placed on the f line service and use gloved hands to place i			were reviewed to ensure proper dating.	1/16/09		
	on resident plates when plating food; failed			3. Nutritional Services staff was inserviced	1/10/09		
	gloves when checking ladles sizes; and con			regarding the need to date all perishable			
	used gloves when testing food temperature			and canned goods upon delivery to the	3/31/0		
	findings were acknowledged by Employees				3/31/0		
	41 at the time of the observations.	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		facility. Monitoring of this practice will			
				be done by the members of the Nutritional Services Quality Improvement			
	The findings include:			, , ,			
Ì	The indings include.			Committee. who will collect data			
,	6 The full control for the control of the first design of the firs			on this criteria and forward their information			
	A. The following foods were observed undated			recommendations to the Director of			
,	the walk-in refrigerator, reach-in refrigerator	and the		Nutritional Services for his review and			
Ï	dry storage area:			evaluation.			
		ĺ		4. The Department Head will present			
	Two (2) bundles of withered lettuce			a report of the data collected and any	di.		
	One (1) box of withered kale	nd white		action plans implemented to ensure			
	One (1) case of strawberries with a green at substance on the berries and side of the car			sustained compliance at the monthly	4/2/00		
	One (1) pan of lemon pudding undated	10115		Quality Improvement Committee which	. 4/3/09		
	Two (2) of four (4) cartons of packed parme	san		is chaired by the Administrator B. Ice machine Interior			
}	cheese undated			1. The interior of the ice machine was			
	Three (3) of three (3) cans of gelatin undate	ed .		cleaned upon discovery.	1/16/0		
	Two (2) of seven (7) containers of pudding v		,	2. There are no other ice machines in the	1/10/0		
	unclearly dated [January 2009], facility staff	unable		kitchen area.	1/16/0		
1	to determine if the date was January 9, 2009	9 or		3. Nutritional Services staff was inserviced	171070		
	January 2009	1		regarding the need to routinely clean the	l		
. \	•			interior of the ice machine. Monitoring of			
	B. The following were observed soiled and/o	or		this practice will be done by the members	3/31/09		
1	damaged in the main kitchen:			of the Nutritional Services Quality	2.31,0		
		}.		Improvement Committee. who will collect	{		
Ì	One (1) of one (1) ice machine interior surfa	ice was	•	data on this criteria and forward their			
	observed soiled in the main kitchen			information recommendations to the			
1	Ceiling tiles were soiled in the chemical room	m		Director of Nutritional Services for his			
		Ì		review and evaluation.	1		
				4. The Department Head will present			

01/16/2009

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION A. BUILDING

(X3) DATE SURVEY COMPLETED

HFD02-0020

B. WING STREET ADDRESS, CITY, STATE, ZIP CODE

2425 25TH STREET SE

14/4 CLUNICTON NUIDCING FACULITY			5 25TH STREET SE SHINGTON, DC 20020			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGUL OR LSC IDENTIFYING INFORMATION)	ATORY PRE	D EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS- REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
L 099	Continued From page 29	L 09	9	3219.1 Nursing Facilities (continued)		
	One (1) damaged ceiling tile in the dry stora	ne area		4. (continued)		
	One (1) of one (1) spice rack was soiled	ge alea		a report of the data collected and any		
	24 of 51 food carts were observed soiled			action plans implemented to ensure		
	One (1) full size pan of serving utensils were	.		sustained compliance at the monthly		
	observed wet and was stored for reuse	1 .		Quality Improvement Committee which	4/3/09	
	Seven (7) of 41 dome covers were observe	soiled		is chaired by the Administrator.	i	
	and were store for reuse			C. Ladle Size		
				1. The employee involved with the		
	C. During tray line observations on January	12		use of the wrong sized ladle was		
	2009 at 1:40 PM on the 1st floor dining room			counseled and inserviced.	1/16/09	
	during the tray line service on January 13, 2			2. All servers were inserviced on the	1/10/07	
	12:40 PM on the 3rd floor, dietary staff was	003 81		size of ladles.	3/31/09	
	observed plating the following foods for resid	dents		3 Monitoring of the ladles	3/31/09	
	with the incorrect ladle [scoop size]: Season	I .		will be done by the members	3/31/09	
	spinach, mechanical soft pork and rice	•		of the Nutritional Services Quality	3/31/0	
	The ladle sizes were verified with Employee	#14 on		Improvement Committee, who will collect		
	January 14, 2009 at approximately 4:00 PM.			data on this criteria and forward their		
1	D. During the tray line observation on Janua			information recommendations to the		
	2009 at 1:44 PM on the 1st floor dining room			Director of Nutritional Services for his		
	Employee #40 was observed removing a loa					
	vegetables [covered with foil] from the warm			review and evaluation.		
	placing it on the floor and then putting it bac	k into		4. The Department Head will present		
	the food warmer. At the time of the finding	İ		a report of the data collected and any		
	Employee #40 acknowledged what happene			action plans implemented to ensure		
	stated that the pan was hot and he/she had			sustained compliance at the monthly	4/2/00	
	down. Approximately five minutes later the			Quality Improvement Committee which	4/3/09	
	removed from the warmer by Employee #41			is chaired by the Administrator		
				E1. The Noodle		
	E. During tray line observations on January			1. The employee was corrected and the plate was discarded.	1/12/00	
	2009 at 1:40 PM in the 1st floor dining room	, the		2. All servers were monitored to ensure	1/13/09	
	following was observed:					
				proper serving and infection control	1/16/00	
1	1. Employee #42 was observed placing loos			technique.	1/16/09	
	noodles on resident plates with gloved hand	not a		3. Inservice was done on the proper use		
	utensil.	}		of gloves and serving utensils when		
				handling food and taking temperatures.		
	2. Dietary staff was observed checking the ladle			Compliance will be monitored through the		
	sizes with ungloved hands.			Nutritional Services Quality Improvement	2/21/00	
		-		Program's tool for "Infection Control." The	3/31/09	
				QI team will forward their findings to the Director of Nutritional Services for his		
				Director of Nutritional Services for his		

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:		COMPLETED
	HFD02-0020	B. WING	01/16/2009

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

MACHINICTON MUDCINIC EACH ITV			2425 25TH STREET SE WASHINGTON, DC 20020			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REG OR LSC IDENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS- REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
L 099	Continued From page 30	40	L 099	3219.1 Nursing Facilities (continued) A. The Noodle (continued) review and evaluation.	3/31/09	
	F. During tray line observations on January 13, 2009 at 12:40 PM the 3rd floor dining services staff was observed using one (1) gloved hand when testing the temperatures for the mechanical soft			4. The Department Head will present a report of the data collected and any action plans implemented to ensure		
	Salisbury steak, mechanical soft chicken, carrots, mashed potatoes and baked potatemployee #42 inserted the thermometer vigloved hand and cleaned the thermomete	toes. vith the		sustained compliance at the monthly Quality Improvement Committee which Is chaired by the Administrator. E2.	4/3/09	
	ungloved hand. The above mentioned findings were acknowledged.			 The ladle was taken out of service upon discovery. All servers were monitored to ensure 	1/12/09	
	by Employee #14 and 41.	, meagea		proper serving and infection control technique. 3. Inservice was done on the proper use	1/16/09	
L 128	3224.3 Nursing Facilities The supervising pharmacist shall do the fo	ollowing:	L 128	of gloves and serving utensils when handling food and taking temperatures. Compliance will be monitored through the		
	(a)Review the drug regimen of each resident at least monthly and report any irregularities to the Medical Director, Administrator, and the Director of Nursing Services; (b)Submit a written report to the Administrator on the status of the pharmaceutical services and staff performances, at least quarterly; (c)Provide a minimum of two (2) in-service sessions per year to all nursing employees, including one (1) session that includes indications, contraindications and possible side effects of commonly used medications;			Nutritional Services Quality Improvement Program's tool for "Infection Control." The QI team will forward their findings to the Director of Nutritional Services for his 4. The Department Head will present	3/31/09	
				a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which	4/3/09	
			÷	Is chaired by the Administrator F. 1. The thermometer in question was cleaned using an alcohol pad and a gloved hand. 2. All servers were monitored to ensure	1/13/09	
	(d)Establish a system of records of receipt disposition of all controlled substances in detail to enable an accurate reconciliation	sufficient		proper serving and infection control technique. 3. Inservice was done on the proper use of gloves and serving utensils when headling food and taking temperatures.		
	(e)Determine that drug records are in order and			handling food and taking temperatures. Compliance will be monitored through the Nutritional Services Quality Improvement		

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FORM APPROVED Health Regulation Administration (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A RUILDING B. WING HFD02-0020 01/16/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2425 25TH STREET SE **WASHINGTON NURSING FACILITY** WASHINGTON, DC 20020 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX TAG OR LSC (DENTIFYING INFORMATION) L 128 L 128 Continued From page 31 3219.1 Nursing Facilities (continued) F. Continued that an account of all controlled substances is Program's tool for "Infection Control." The 3/31/09 maintained and periodically reconciled. QI team will forward their findings to the This Statute is not met as evidenced by: Director of Nutritional Services for his Based on record review and staff interview for two 4. The Department Head will present (2) of 30 sampled residents, it was determined that a report of the data collected and any the pharmacist failed to: recommend attempting a action plans implemented to ensure dose reduction for antipsychotics for two (2) sustained compliance at the monthly residents, and review one (1) resident's medication monthly. Residents #5 and 13. **Quality Improvement Committee which** 4/3/09 Is chaired by the Administrator. The findings include: 3224.3 Nursing Facilities 1A. Resident #5 1. The pharmacist failed to recommend attempting 1. Consultant Pharmacist was made a dose reduction for Resident #5 who was 3/6/09 prescribed Seroquel for five (5) months and of the oversight. complete a review of the Drug Regimen for one (1) 2. Other charts were checked to ensure month. the monthly Drug Regimen Review was A. The pharmacist failed to review Resident #5's completed. No further notification to the 3/9/09 medications for November 2008. Consultant Pharmacist was necessary. 3. Monitoring of the Consultant A review of Resident #5's record revealed that the Pharmacists notes will be added to the pharmacist reviewed the resident's medications on monthly audit tool completed by the 4/1/09 July 29, August 28, September 29, October 27 and Unit Clerks. Discrepancies will be December 24, 2008. There was no evidence that brought to the attention of the Consultant the pharmacist reviewed the resident's medications Pharmacist immediately upon discovery. for November 2008. by the Director of Nurses. 4. The Department Head will present 4/3/09 A face-to-face interview with Employee #5 was a report of the data collected and any conducted on January 12, 2009 at 3:45 PM. action plans implemented to ensure He/she acknowledged that the pharmacist did not sustained compliance at the monthly QI review the resident's medications for November

Health Regulation Administration

2008. The record was reviewed January 12, 2009.

B. Review of Resident #5 's record revealed that

4, 2008, directed, "Seroquel 25 mg twice daily;

Seroquel 400 mg at bedtime. '

admission orders, signed by the physician on July

Committee which is chaired by the

1. Psychiatrist consult will be ordered

for this resident requesting to evaluate

the resident for a gradual dose reduction

Administrator.

1B. Resident #5

of her Seroquel.

3/31/09

FORM APPROVED Health Regulation Administration STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING HFD02-0020 01/16/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **2425 25TH STREET SE** WASHINGTON NURSING FACILITY WASHINGTON, DC 20020 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (EACH CORRECTIVE ACTION SHOULD BE CROSS-PREFIX REFERENCED TO THE APPROPRIATE DEFICIENCY) OR LSC IDENTIFYING INFORMATION) TAG TAG L 128 Continued From page 32 L 128 3224.3 Nursing Facilities A review of the "Chronological Record of 1B. Resident #5 (continued) Medication Regimen Review " revealed that the 2. For any other resident on Seroquel who pharmacist reviewed the resident 's medication on July 29, August 28, September 29, October 27 and has not been evaluated for a gradual December 24, 2008. The pharmacist did not review dose reduction, staff will request a the resident 's medication in November 2008. consultation from the Psychiatrist. 3/31/09 3. Compliance will be monitored through the Nursing Services Quality There was no evidence that the pharmacist Improvement Program's tool for 3/31/09 recommended attempting a gradual dose reduction "Psychoactive Drug Review." for Resident #5's Seroquel. The Nursing QI Team will forward their findings to the Director of Nursing for her A face-to-face interview was conducted with review and evaluation. Employee #5 on January 12, 2009 at 3:45 PM. 4. The Department Head will present He/she acknowledged that the pharmacist failed to a report of the data collected and any 4/3/09 recommend attempting a gradual dose reduction for action plans implemented to ensure Resident #5's Seroquel. The record was reviewed January 12, 2009. sustained compliance at the monthly Ol Committee which is chaired by the Administrator. 2. The pharmacist failed to recommend a gradual 2. Resident #13 dose reduction for Resident #13 who was 1. Psychiatrist consult will be ordered prescribed Seroquel for three (3) months. for this resident requesting to evaluate the resident for a gradual dose reduction 3/31/09 A review of Resident #13's record revealed the of her Seroquel. psychiatrist's order dated October 9, 2008, 2. For any other resident on Seroquel who "Seroquel 50 mg po twice daily for agitated behaviors. Klonopin 1 mg po daily for agitation." has not been evaluated for a gradual dose reduction, staff will request a consultation from the Psychiatrist. 3/31/09 There was no Behavior Flow Sheet located by 3. Compliance will be monitored Employee #5 at the time of this review for October through the Nursing Services Quality and December 2008. The November 2008 Behavior Flow Sheet was blank. Improvement Program's tool for "Psychoactive Drug Review." The Nursing QI Team will forward their

Health Regulation Administration

Seroquel for Resident #13.

The pharmacist reviewed the resident's medications

on October 19, November 19, and December 18, 2008. The pharmacist failed to recommend a

gradual dose reduction for the use of Klonopin and

A face-to-face interview with Employee #5 was

4/3/09

findings to the Director of Nursing for her

Committee which is chaired by the Administrator,

4. The Department Head will present

a report of the data collected and any

action plans implemented to ensure sustained compliance at the monthly OI

review and evaluation.

01/16/2009

Health Regulation Administration

STATEMENT	OF	DEFICIENCIES
AND PLAN OF	F C	ORRECTION

NAME OF PROVIDER OR SUPPLIER

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION	
N BUILDING	

(X3) DATE SURVEY COMPLETED

HFD02-0020

STREET ADDRESS, CITY, STATE, ZIP CODE

B. WING _

2425 25TH STREET SE

I MACHINICTON NUIDCINIC EXCULITY			I STREET SI TON, DC 20		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REG OR LSC IDENTIFYING INFORMATION)	ULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS- REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 128	Continued From page 33 conducted on January 13, 2009 at 3:45 PM He/she acknowledged that the a gradual d reduction was not recommended by the ph The record was reviewed January 13, 2009	lose narmacist.	L 128		
L 157	3227.8 Nursing Facilities	:*	L 157	3227.8 Nursing Facilities	
	Each refrigerator that is used for storage of medication shall operate at a temperature thirty-six degrees (36°F) and forty-six (46°l Fahrenheit; each refrigerator shall be equil a thermometer that is easily readable, according proper working condition.	between F) pped with		1. Medication Refrigerators 1. Noted refrigerator temperatures were retaken at the time of the survey and found to be in range. 2. All medication refrigerators were checked for the correct temperature and no corrections were needed. 3. Medication refrigerators are checked monthly by the Consultant Pharmacist,	1/16/09
	This Statute is not met as evidenced by: Based on observation, record review and sinterview, it was determined that the facility failed to properly store medication under ptemperature controls for one (1) of six (6) to refrigerators and stored Xalatan unopened medication cart for one (1) of six (6) medicarts observed. The findings include:	y staff roper unit I in the		monthly by the Maintenance QI Team and routinely by the nursing staff. Fluctuations in temperature are brought to the attention of the Director of Maintenance for review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly QI Committee which is chaired by the Administrator.	3/31/09
	1. Facility staff failed to properly store med under proper temperature controls.	lication			
	On January 15, 2009, at approximately 10 during the inspection of the medication refit the 3 North medication refrigerator 's tempread 24 F.	rigerators,		 Xalatan eye drops found improperly stored at the time of the survey were discarded upon discovery All medication carts were checked for the improper storage of Xalatan eye 	1/16/09
Health Regula	According to the monthly unit pharmacy inserports for 2008, the temperature of the 3 refrigerator in November was 28 Fation Administration			drops and no corrections were necessary.	1/16/09

Health R	egulation Administra	tion				——	
AND PLAN OF CORRECTION IDENTIFICATION N		(X1) PROVIDER/SUPPLIER/IDENTIFICATION NUMB			IG	(X3) DATE SURVEY COMPLETED	
		HFD02-0020		DEGG OITY OF	· -	1/16/2009	
NAME OF PR	OVIDER OR SUPPLIER				FATE, ZIP CODE		
WASHING	STON NURSING FACI	LITY		STREET S TON, DC 20			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY		
L 157	L 157 Continued From page 34 and December 35 F. A face-to-face interview was conducted at the ti			L 157	3227.8 Nursing Facilities (continued) 2. (continued) 3. Inservice training regarding proper storage of Xalatan eye drops was provided to the staff.		
	acknowledge that the and immediately ad correct temperature	vation with Employee #29. He/she ge that the refrigerator was out of range ately adjusted the refrigerator to the perature.			Compliance will be monitored through the Nursing Services Quality Improvement Program's tool for "Med Pass." The Nursing QI Team	3/31/09	
	Two (2) unopened von January 16, 200 medication cart on 2	erved stored in the me e vials were unopened vials of Xalatan were of 9 at 9:00 AM stored in 2 North.	d. observed the		will forward their findings to the Director of Nursing for her review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly QI Committee which is chaired by the	4/3/09	
	"Store unopened bo F to 46 F."	ottle (s) under refrigera	ation at 36		Administrator. 3227.12 Nursing Facilities		
	of the observation v	view was conducted a vith Employees #8 and the unopened Xalatan the refrigerator.	54. Both	·	1. Expired medication found in the medication area of 3 North and 2 South at the time of the survey were disposed of per policy 2. All medication areas were inspected	1/31/09	
L 161	3227.12 Nursing Fa			L 161	for the presence of expired meds and no further issues were found. 3. Expired medication disposition	1/31/09	
	usage. This Statute is not a Based on observation was determined that remove expired medians.	met as evidenced by: ons during the survey t the facility staff failed dications from the med (6) medication storag	period, it I to dication		will be monitored by the Clinical Manger throughout the month. The results of their monitoring will be given to the Director of Nurses for her review and evaluation. 4. The Department Head will present	3/31/09	
	The findings include	: :			a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly QI Committee	4/3/09	

According to the manufacturer's specifications, "A vial of Tuberculin PPD which has been entered and

in use for 30 days must be discarded."

which is chaired by the Administrator

Health R	tequiation Administrat	tion				FORM	APPROVED
AND PLAN OF CORRECTION IDENTIFICATION NUM		(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMI		(X2) MULTIP A. BUILDING B. WING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED 01/16/2009	
NAME OF PE	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	ATE, ZIP CODE		<u> </u>
	GTON NURSING FACI	LITY		STREET SE			_
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY			ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION SH REFERENCED TO THE APPROPE	HOULD BE CROSS-	(X5) COMPLETE DATE
L 161	Continued From pag	ge 35		L 161	-		
	during the inspection North the following in the medication cars are supported by the medication cars. Buspirone 10 mg, 365/28/2008 Risperdal 1 mg, 506 Multivitamin, 50 table Loperamide 2 mg, 50 Alprazolam 0.25 mg Tylenol #3, 12 table Clonazepam 0.5 mg Fluvirin 5 ml injection Tubersol 5 TU vial - 2 South observed of	0 tablets, expiation datablets, 2/15/2008 lets, 2/15/2008 capsules, 9/13/2008 capsules, 12/28/20 ts, 8/6/2008 cy 9 tablets, 5/30/2008 copened, 1 vial, 1/3/20 n January 16, 2009 a	rea on 3 nd expired ate 008 3 009 t 9:00 AM				
	Diphenhydramine 2: Loperamide 2 mg ca Tylenol 325 mg tabl		;				
	#8 and 54 on Janua	riew was conduct with ry 14, 2008, after the acknowledge that the of the inspection.	carts were				

date.

L 168 3227.19 Nursing Facilities

The facility shall label drugs, and biologicals in accordance with currently accepted professional

principles, and include the appropriate accessory and cautionary instructions, and their expiration

Based on observations during the survey period, it was determined that the facility staff failed to

This Statute is not met as evidenced by:

WPBP11

L 168

3227.19 Nursing Facilities

STATEMENT	OF	DEFICIENCIES
AND DI AN OI	F C	ORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

(X3) DATE SURVEY COMPLETED

HFD02-0020

A. BUILDING B. WING

01/16/2009

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

2425 25TH STREET SE

WASHINGTON NURSING FACILITY		WASHINGTON, DC 20020		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULA OR LSC IDENTIFYING INFORMATION)	ATORY ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS- REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 168	Continued From page 36 date and initial opened multi-dose vials in two six (6) medication storage areas. The findings include: On January 14, 2008 between during the instruction of two (2) of six (6) the medication storage are was determined that multi-dose vials were not and initialed when first opened. 1 North (2) Lantus 10 ml vial Novolog 10 ml vial (2) Pneumococcal vaccine 1 ml vials Heparin 10,000 unit, 10 ml vial	pection reas, it	3227.19 Nursing Facilities (continue) 1. Opened Multi-dose vials found not to be dated or initialed at the time of the survey were destroyed upon discovery. 2. All multi-dose vials were inspected to insure proper documentation if opened. No other issues were found. 3. Multi-dose vial documentation will be monitored by the Clinical Manger throughout the month. The results of their monitoring will be given to the Director of Nurses for her review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly QI Committee	1/16/09 1/16/09 3/31/09
L 214	3 North Lorazepam Injection mg ml 10 ml vial 3234.1 Nursing Facilities	Ł 214	which is chaired by the Administrator 3234.1 Nursing Facilities 1. Extension Cords 1. Extension cords were removed upon discovery and replaced with a surge protector.	1/16/09
	Each facility shall be designed, constructed, located, equipped, and maintained to provide functional, healthful, safe, comfortable, and supportive environment for each resident, emand the visiting public. This Statute is not met as evidenced by: Based on observation, staff interview and recreview, it was determined that facility staff fairmaintain a hazard free environment as evide by: extension cords in residents' rooms, a miselectrical socket face plate, a non-skid backet in a resident's room, four (4) treatment carts in a resident and treatment and treatment carts.	cord led to nced ssing ed rug	 All residents' rooms were searched for the use of extension cords. No other instances were found. Extension cord use will be monitored by the Maintenance Quality Improvement Team. Any data collected on this issue will be forwarded to the Director of Maintenance for his review and evaluation. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly 	1/16/09
	unlocked and unattended, Resident #19's focin a side rail and medication left unattended (1) medication cart. The findings include:		Quality Improvement Committee which is chaired by the Administrator 2. Wall Outlet Cover 1. Wall outlet cover were replaced upon discovery. 2. All residents' rooms were searched	1/16/09

3234.1 Nursing Facilities (continued) Page 37A of 121

 Outlet Covers (continued) for the missing outlet covers. No other instances were found. Missing outlet covers will be monitored by the Maintenance Quality Improvement Team. Any data collected on this issue will be forwarded to the Director of Maintenance for his review and evaluation. The Department Head will present a report of the data collected and any action plans implemented to ensure 	1/16/09
sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator 3. Rug	4/3/09
1. The throw rug was removed by the	1/16/09
resident upon discovery. 2. All resident rooms were evaluated for the presence of a throw rug without a	1/31/09
non-skid backing. No other issues were uncovered. 3. Housekeeping staff were inserviced on the need to report the presence of a throw rug without a non-skid backing to the nursing staff and the housekeeping supervisor. Monitoring of this issue will be done by the Housekeeping Quality Improvement Team as they collect data on the issues which may be present in the resident rooms. The data collected with be brought to the Director of housekeeping for her review and	3/31/09
evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator	4/3/09

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		HFD02-0020		B. WING		01/16/2009
WASHINGTON NURSING FACILITY 2425 25TH			2425 25TH	STREET SE	Ē	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	ATEMENT OF DEFICIENCIES I BE PRECEDED BY FULL REG NTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD E REFERENCED TO THE APPROPRIATE DE	E CROSS- COMPLETE
L 214	Extension cords residents' rooms:	were observed in the f	-	L 214	3234.1 Nursing Facilities (cont A. Unlocked Med Cart 1. Treatment carts found unlocked time of the survey were locked pro- upon discovery.	at the 1/16/09
	approximately 2:25 Room 205 plugged 2:50 PM on January 2. A wall outlet cove first floor dining room 10:50 AM. 3. A rug with a non- room 357 on Janua These findings were	into a multiple plug de PM on January 13, 20 into a radio at approxi y 13, 2009. Fr was observed mission January 14, 2009 at skid backing was obsery 13, 2009 at 11:05 A e acknowledged by Enter time of the observation.	mately ng in the t erved in M. nployees		2. All treatment carts were assessed for ability to be locked and being lowhen in use of being stored. No or issues were found 3. Inservice training was given to fastaff about the importance of making sure that treatment carts are locked when not in use for safety reasons. Monitoring of the locking of treatments will be done through the Nurs	ocked ther acility ag 3/31/09 ent ing
	A. During a wound to January 14, 2009 at Employee #23 remote from the treatment of resident 's room. Et reatment cart again resident 's room and treatment cart was I When the wound treesident 's door was	reatment observation 12:00 PM on unit 3 Soved wound treatment observation and placed them is imployee #23 position ast the wall in the hallwing discount of the door. The eff unlocked and unattent was completed so opened and two (2) e hallway in close process.	of their data collection will be break the Director of Nurses for her reversal valuation. 4. The Department Head will present the data collected and action plans implemented to ensure the sustained compliance at the monous Quality Improvement Committee is chaired by the Administrator the residents		ults ght to w and ent	
	cart included tubes ointment, Urea 40% wound dressing oin Valerate 0.2% ointm	he top drawer of the tr of Santyl ointment, Ba cream, Collagen hyd tment and Hydrocortis nent. vas observed unlocke ree #23 immediately a	rogel one d in the		B. Unlocked Med Cart 1. Treatment carts found unlocked time of the survey were locked prorupon discovery. 2. All treatment carts were assessed for ability to be locked and being lowhen in use of being stored. No of issues were found	nptly d 1/31/09 cked

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER			(X2) MULTI	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		HFD02-0020		B. WING_		01/16/2009	
NAME OF PE	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, ST	ATE, ZIP CODE	0 11 10 2003	
WASHIN	GTON NURSING FACIL	LITY	•	STREET S TON, DC 20	•		ļ
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REC NTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD B REFERENCED TO THE APPROPRIATE DE	E CROSS- COMPLET	ΓE
L 214	wound treatment way B. During a wound to January 15, 2009 at removed wound treatment cart. Employee #22 towards the wall by hallway on 1 North at The treatment cart voluntened. After the completed, the residual treatment cart. The top drawer of the tubes of Collagen by ointment.	reatment observation 11:45 AM. Employee atment items from the turned the cart drawe the resident 's room i and closed the resider vas left unlocked and ne wound treatment w lent 's door was open ng in a wheelchair ne retreatment cart conta ydrogel wound dressir	treatment ers n the nt's door. as ned. One xt to the ers nthe ng	L 214	3234.1 Nursing Facilities (cont B. Unlocked Med Cart 3. Inservice training was given to fa staff about the importance of makin sure that treatment carts are locked when not in use for safety reasons. Monitoring of the locking of treatm carts will be done through the Nurs Quality Improvement Team and the "Treatment Observation" tool. Res of their data collection will be brouthe Director of Nurses for her revie evaluation. 4. The Department Head will prese a report of the data collected and an action plans implemented to ensure sustained compliance at the month! Quality Improvement Committee wis chaired by the Administrator	ent ing sir ults ght to w and ent ing)
	The treatment cart was observed in the presence of Employee #22 immediately after the wound treatment was completed. C. During a wound treatment observation on January 15, 2009 at 1:15 PM, Employee #27 removed wound treatment items from the treatment cart. Employee #27 turned the cart 's drawers towards the door of the resident 's room in the hallway on 3 North. The resident 's door was left opened. Resident #27 's bed was by the window away from the entry door and the privacy curtain was pulled. The treatment cart was left unlocked and unattended. Several residents were observed walking up and down the hallway returning from the dinning room. The contents of the top drawer included the following wound dressing ointments: Accuzyme, Bacitracin, Collagen hydrogel Santyl, and Urea 40% cream.			C. Unlocked Med Cart 1. Treatment carts found unlocked time of the survey were locked prorupon discovery. 2. All treatment carts were assessed for ability to be locked and being lowhen in use of being stored. No of issues were found 3. Inservice training was given to fastaff about the importance of makin sure that treatment carts are locked when not in use for safety reasons. Monitoring of the locking of treatments will be done through the Nurse Quality Improvement Team and the "Treatment Observation" tool. Resof their data collection will be broughthe Director of Nurses for her review evaluation.	mptly d 1/31/09 cked cher acility ng 3/31/09 ent cing cir cults ght to)	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED	
	HFD02-0020		B. WING	01/16/2009	
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE			

MARCHINICTON MITIDRING EACH ITV			2425 25TH STREET SE			
		WASHING	NGTON, DC 20020			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL RE OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS- REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
L 214	Continued From page 39 The treatment cart was observed unlocked unattended in the presence of Employee immediately after the wound treatment work completed. Employee #27 eventually see treatment cart in the clean utility room. A-face-to-face interview was conducted work Employee #27 on January 15, 2009 at approximately 2:45 PM. He/she acknowled the treatment cart was not locked.	#27 as cured the with edged that	L 214	3234.1 Nursing Facilities (continued) C. (continued) 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator D. Unlocked Med Cart 1. Treatment carts found unlocked at the time of the survey were locked promptly upon discovery.	4/3/09	
	D. During a tour of the facility on January at approximately 10:35 AM, Employee #3 Resident A2 's room. In the presence of #10, it was observed that Employee #30 treatment cart unlocked and unattended hallway on 3 South. Several residents we	30 was in Employee left the in the		2. All treatment carts were assessed for ability to be locked and being locked when in use of being stored. No other issues were found 3. Inservice training was given to facility	1/31/09	
	observed walking up and down the hallware turning from the dinning room and othe around the facility. The contents of the top drawer included the following wound dressing ointments: Amriactate, Ketoconazole shampoo, Hydrocolactate, Ketoconazole shampoo, Hydrocolactate, Ketoconazole shampoo, Hydrocolactate, Collagen hydrogel Urea 40% cream and plastic bags. A face-to-face interview was conducted with the treatment cart was unlocked and unattended with the aforementioned contributions.	he monium ortisone, l, Santyl, with		staff about the importance of making sure that treatment carts are locked when not in use for safety reasons. Monitoring of the locking of treatment carts will be done through the Nursing Quality Improvement Team and their "Treatment Observation" tool. Results of their data collection will be brought to the Director of Nurses for her review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure	3/31/09	
٠.	5. Facility staff failed to provide adequate supervision for Resident #19 who's foot was stuck in a side rail. A review of Resident #19's record revealed a nurse's note dated December 24, 2008 at 12:00 AM, "Resident's foot stocked [stuck] in the bedside rail"			sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator. 5. Resident #19	4/3/09	
				1. The resident is currently using a low bed with half rails.	3/20/09	
				2. Other residents who may have an order for half rails were evaluated. No other issues were found.	3/31/09	

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

(X3) DATE SURVEY COMPLETED

HFD02-0020

A. BUILDING B. WING

01/16/2009

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

WASHINGTON NURSING FACILITY		2425 25TH STREET S VASHINGTON, DC 2		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGUL) OR LSC IDENTIFYING INFORMATION)	ATORY ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS- REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET DATE
L _. 214	Continued From page 40	L 214	3234.1 Nursing Facilities (continued) 5. Resident #19 (continued)	
	The resident was hospitalized from Decemb 2008 through January 6, 2009 for a deep vei thrombosis.	in	3. Inservice training will be given to the facility staff regarding making frequent rounds and checking all residents during their tour of duty paying close attention to resident's body parts during the rounds	
	A telephone order dated January 14, 2009 at PM, unsigned by the physician noted, "Need for 1/2 side rails to aid in bed mobility for resi	s order	Monitoring of the side rail incidents will be done through the Nursing Quality Improvement Team. Results	3/31/0
	Resident #19 was observed on January 15, 27:45 AM in bed with the top side rails in the uposition. A face-to-face interview was conduwith the resident at the time of the observation When asked if he/she remembered getting help stuck in the side rails, the resident replied don't remember." The record was reviewed	up ucted on. is/her	of their data collection will be brought to the Director of Nurses for her review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly	
	January 15, 2009. 6. Facility staff left medication unattended on medication cart.	the .	Quality Improvement Committee which is chaired by the Administrator 6. Unlocked Med Cart 1. Med carts found unlocked at the	4/3/0 1/16/0
	On January 12, 2009, at approximately 9:56		time of the survey were locked promptly upon discovery. 2. All med carts were assessed	1/31/0
	during the medication pass, Employee #23 le medication unattended on the medication cal front of Resident # JH7's room while he/she attended to the resident. The following medication on top of the medication cart:	rt iņ	for ability to be locked and being locked when in use of being stored. No other issues were found 3. Inservice training was given to facility	175 176
	Multivitamin/Iron, Lisinopril 20mg, Isosorbid Dinitrate 20mg, Hydrochlothiazide 25mg, Dig 0.25mg, Caredilol 25mg and Docusate 100m Employee #23 entered the resident's room. T medication cart was out of the sight of Emplo	ng when The	staff about the importance of making sure that med carts are locked when not in use for safety reasons. Monitoring of the locking of med carts will be done through the Nursing Quality Improvement Team and their "Med Pass" tool. Results of their data collection will be brought to the Director of	3/31/09
	A face-to-face interview was conducted at the time of this observation with Employee #23. He/she acknowledged that the medications were left on the medication cart.		Nurses for her review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator.	4/3/09

STATEMENT	OF	DEFICIE	NCIES
AND PLAN OF	F C	ORRECT	ION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

(X3) DATE SURVEY COMPLETED

HFD02-0020

A. BUILDING B. WING ____

01/16/2009

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

(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) COMPLETE DATE
L 410	Continued From page 41	L 410		
L 410	Each facility shall provide housekeeping and maintenance services necessary to maintain the exterior and the interior of the facility in a safe, sanitary, orderly, comfortable and attractive manner. This Statute is not met as evidenced by: Based on observations during the survey period, it was determined that housekeeping and maintenance services were not adequate to ensure	L 410	3256.1 Nursing Facilities Soiled Ceiling Tiles 1. Ceiling tiles were changed upon discovery. 2. Ceiling tiles throughout building were assessed and changed if needed. 3. All areas of the building are assessed my maintenance on a frequent basis for soiled or damaged ceiling tiles. Ceiling Tile is a criteria for review under "Resident	1/14/09 1/16/09 3/31/09
	that the facility was maintained in a safe and sanitary manner as evidenced by: soiled ceiling tiles, floors, walls, wheel chairs/chairs/gerichairs, faucets, roller carts, and hair dryer; damaged ceiling tiles, doors, wheelchair arms, baseboards and walls; excessive items in resident rooms; and items stored on the floor in storage areas.		Floor Maintenance" in the Maintenance Quality Improvement Program. The Maintenance QI team will collect data on this criteria and forward it to the Director of Maintenance for review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly	
	The environmental tour was conducted on January 12, 2009 from 3:06 PM to 4:10 PM, January 13, 2009 from 9:25 AM to 4:20 PM and January 14, 2009 8:15 AM to 4:25 PM in the presence of Employees #11, 29, and 30. The findings were		Quality Improvement Committee which is chaired by the Administrator. Soiled Floors and practice Stairs 1. The floor and stairs in the Rehab Gym were scrubbed and waxed upon discovery.	4/3/09 1/15/09
	acknowledged at the time of the observations. 1. The following areas were observed soiled: Ceiling Tiles Two (2) of six (6) soiled utility rooms, 1S and 2N;		2. The floor in the Rehab Gym is scheduled for cleaning every afternoon. 3. The Director of Housekeeping and her Team of supervisors visually verifies the cleanliness of the Rehab Gym floor/stairs each morning and makes immediate corrections	1/15/09
	two (2) of six (6) clean linen rooms, 1N and 1S; 11 of 31 resident rooms, 137, 159, 110, 116, 122, 136, 231, 232,244, 206 and 333; one (1) of six (6) storage rooms, 1S; one (1) of six (6) nourishment rooms, 1S; one (1) of 12 resident hallway bathrooms, 1S; and one (1) of 12 resident lounge areas, 1N		when needed. Cleanliness of the floor is found in the "Common Area" section of the Housekeeping Quality Improvement Program. The Housekeeping Ql Team will collect data on this criteria and forward their information and recommendations to the Director of Housekeeping.	3/31/09

STATEMENT OF	F DEFICIENCIES
AND PLAN OF (CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY	
A. BUILDING		

HFD02-0020

B. WING _

01/16/2009

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

2425 25TH STREET SE

I MARCUNICTON NUIDONIC EACH ITV		WASHINGTON, DC 20020		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATOR OR LSC IDENTIFYING INFORMATION)	RY PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS- REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 410	Floors- in the Rehabilitation Gym and practice si in the rehabilitation gym		3256.1 Nursing Facilities (continued) 4. The Department Head will present a report of the data collected and any action plaimplemented to ensure sustained compliance at the monthly	ans
	Walls- in two (2) of 31 resident rooms 135 and 1 and two (2) of three (3) in the resident dining roo 2nd and 3rd floors		Quality Improvement Committee which is chaired by the Administrator. Walls	4/3/09
	Chairs Wheel chair/gerichair- room 110 in one (1) of 39 observed	9	 Both resident rooms and dining room walls were scrubbed upon discovery. Other resident rooms and the 1st 	1/16/09
	Resident arm chairs three (3) of 12 soiled in the resident lounge area	3N	floor dining room were evaluated for cleanliness and corrections made when indicated.	3/31/09
	Beauty Shop Two (2) of two (2) sink faucets; two (2) of two (2) hair roller carts; and one (1) of three (3) hair drye were observed soiled		3. Housekeeping Supervisors are monitoring the walls for on-going cleanliness each day with a daily report of their findings done each day. Wall cleanliness is part of the Housekeeping Quality	
	2. The following items/areas were observed damaged:		Improvement Program. The Housekeeping QI Team will collect data on this criteria and forward their information and recommenda-	3/31/09
	A. Walls- in two (2) of 31 rooms, 110 and 136; a one (1) of six (6) janitor 's closet, 3S	nd	tions to the Director of Housekeeping. 4. The Department Head will present a report of the data collected and any	
	B. Ceiling tiles-1N resident hallway bathroom, ro 109,	oom	action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator	4/3/09
	C. The entry door to resident 's room was obser to be split at the top in one (1) of 31 resident ent doors, room 257.		Chairs 1. The one geri-chair and 3 arm chairs, identified at the time of the survey as	1/16/09
	D. Wheel chair - armrest was damaged in two (2 39 observed, wheel chairs observed in room are 126A and 102B.		being soiled was cleaned immediately. 2. All facility geri-chairs and wheel-chairs were checked for cleanliness and corrections were made if	
·	E. Baseboards- in one (1) of six (6) janitor 's clo in one (1) of six (6) nourishment rooms; in one (of 12 resident lounge areas; and in two (2) of 31 rooms 110 and 122	(1)	any were necessary. 3. All geri-chairs and wheelchairs are on a routine monthly and PRN cleaning schedule. Chair cleanliness is part of the Housekeeping Quality	1/16/09

3256.1 Nursing Facilities (continued) Page 43A of 44	
Chairs (continued) Improvement Program. The Housekeeping	3/31/0
QI Team will collect data on this criteria and forward their information and	
recommendations to the Director of Housekeeping.	
4. The Department Head will present	
a report of the data collected and any action plans implemented to ensure	
sustained compliance at the monthly	1/2/02
Quality Improvement Committee which is chaired by the Administrator.	4/3/09
Beauty Shop	
1. Items found soiled were	
cleaned upon discovery.	1/16/09
2. All areas of the Beauty Shop	
were evaluated for cleanliness and	1/16/09
corrections were made if necessary.	
3. Cleanliness of the Beauty Shop	
Is included in the "Common Areas" Section of the Housekeeping QI	
Program. The Housekeeping	3/31/09
QI Team will collect data on this criteria and	3/31/07
forward their information and	
recommendations to the Director of	
Housekeeping.	
4. The Department Head will present	
a report of the data collected and any	
action plans implemented to ensure	
sustained compliance at the monthly Quality Improvement Committee which	4/3/09
is chaired by the Administrator	4/3/07
C. Entry Door	
The door was replaced immediately	
upon discovery.	1/16/09
2. Other doors were evaluated for damage	
	1/16/09
3. Door are included	
Maintenance QI Program. The Maintenance QI Team will collect data	
on this criteria and	3/31/09
forward their information and	3/31/07
recommendations to the Director of	
Maintenance for his review and	
evaluation.	
4. The Department Head will present	
a report of the data collected and any	
action plans implemented to ensure	
sustained compliance at the monthly Quality Improvement Committee which	4/3/09
Quanty improvement committee which	713107

3256.1 Nursing Facilities (continued) Page 43B of 44

C. Room Door (continued)	
is chaired by the Administrator	
D. Wheelchair	
The two armrests were replaced	
upon discovery.	1/16/09
2. Other wheelchair armrests	1/10/07
were evaluated and replaced if	
necessary.	1/16/09
3. Wheelchair repairs are included	1/10/03
Maintenance QI Program. The	
Maintenance QI Team will collect data	
on this criteria and	2/21/00
forward their information and	3/31/09
recommendations to the Director of	
Maintenance for his review and	
evaluation.	
4. The Department Head will present	
a report of the data collected and any	
action plans implemented to ensure	
sustained compliance at the monthly	
Quality Improvement Committee which	4/3/09
is chaired by the Administrator	
E. Baseboards	
1. Damaged baseboards were replaced	
or repaired upon discovery.	1/16/09
2. Other baseboards were evaluated	
for the need for repair or replacement	
and action was taken when necessary.	3/31/09
3. Baseboards are included	
Maintenance QI Program. The	•
Maintenance QI Team will collect data	
on this criteria and	3/31/09
forward their information and	
recommendations to the Director of	
Maintenance for his review and	
evaluation.	
4. The Department Head will present	
a report of the data collected and any	
action plans implemented to ensure	
sustained compliance at the monthly	
Quality Improvement Committee which	4/3/09
is chaired by the Administrator	

01/16/2009

Health Regulation Administration

STATE	MENT	ΟĘ	DEF	ICIEN	NCIES
AND D	IANO	FÓ		FCTI	ON

NAME OF PROVIDER OR SUPPLIER

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

(X3) DATE SURVEY COMPLETED

HFD02-0020

STREET ADDRESS, CITY, STATE, ZIP CODE

A. BUILDING
B. WING

MARCHINETON NUIDRING EACH ITV			STREET SE STON, DC 20020		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGUL OR LSC IDENTIFYING INFORMATION)	LATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS- REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET DATE
L 410	Continued From page 43		L 410	3256.1 Nursing Facilities (continued)	
	F. Walls - in one (1) of six (6) clean linen roo	oms, 1N;		F. Walls	
	in one (1) of six (6) soiled utility room, 1S; ar	nd in		Noted wall damage was corrected	
l	one (1) of six (6) janitor 's closet, 3N	1		Immediately upon discovery.	1/16/09
				2. Other wall areas were reviewed in	
	3. The following items/areas were observed			Ancillary spaces and corrections were made if	1/1//0
	marred/scarred: The wall in the 1S- residen	it lounge		necessary. 3. Walls are included Maintenance QI	1/16/09
	area in one (1) of 12 resident lounge areas			Program. The Maintenance QI Team will	
	observed and one (1) of 31 resident rooms observed, room 232			collect data on this criteria and forward their	
	Observed, 100111 232			information and	3/31/0
	4. Excessive items were observed in resider	nt rooms		recommendations to the Director of	
	in five (5) of 31 resident rooms observed: rooms			Maintenance for his review and	•
	110, 233, 317, 305 and 357			evaluation.	
	, ,			4. The Department Head will present	
	5. The following items were observed stored	d on	•	a report of the data collected and any	
	floor(s):			action plans implemented to ensure	
				sustained compliance at the monthly	
	1N - supply room five (5) of five (5) boxes			Quality Improvement Committee which	4/3/09
	3N-five (5) of five (5) boxes stored on the flo	or in		is chaired by the Administrator 3. Marred and Scarred	
	the storage closet			The two wall areas noted as being	
	Multiple prosthetic items and boxes were sto			marred or scarred at the time of the	
	the floor in the storage closet of the Rehabili	itation		survey were repaired upon	
	gym.			discovery.	1/16/09
	·			2. Other wall areas were reviewed in	
				Ancillary spaces and corrections were made if	
				necessary.	1/16/09
	•			3. Walls are included	
				Maintenance QI Program. The	•
				Maintenance QI Team will collect data on this criteria and forward their information	2/21/0
				and recommendations to the Director of	3/31/09
				Maintenance for his review and	
				evaluation.	
				4. The Department Head will present	
				a report of the data collected and any	
				action plans implemented to ensure	
				sustained compliance at the monthly	
				Quality Improvement Committee which	4/3/09
				is chaired by the Administrator.	

3256.1 Nursing Facilities (continued) Page 44A of 44

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4. Excessive Items	
Excessive items were removed upon	•
discovery.	1/16/09
2. Resident rooms were evaluated for the	
storage of excess items. Family members	
were called and asked to remove the	
tems whenever it was necessary to do so.	3/31/09
Resident Room Cleanliness/Clutter	
s part of the Housekeeping Quality	
mprovement Program. The Housekeeping	3/31/09
QI Team will collect data on this criteria and	
forward their information and	
ecommendations to the Director of	
Housekeeping.	
1. The Department Head will present	
a report of the data collected and any	
action plans implemented to ensure	
sustained compliance at the monthly	
Quality Improvement Committee which	4/3/09
s chaired by the Administrator	
5. Items stored on the Floor	
All items were removed and properly	
Stored upon discovery.	1/16/09
2. Other areas of Rehab were evaluated	
for proper storage and corrections made	
f necessary.	1/16/09
3. The Director of Rehabilitation inserviced	
nis staff regarding the proper storage of	
ehab equipment kept in their department.	3/31/09
1. The Rehab Director will ensure, through	
nonthly inspection and evaluation, that	
sustained correction has been made in this	4/3/09
irea.	
•	

