Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095038	A. BUILDING _____ B. WING _____	08/23/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METHODIST HOME	4901 CONNECTICUT AVENUE, NW WASHINGTON, DC 20008

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L 000	Initial Comments An annual licensure survey was conducted on August 22 through 23, 2006. The following deficiencies were based on observations, staff and resident interviews and record review. The sample size was 12 residents based on a census of 48 residents the first day of survey and two (2) supplemental records.	L 000	**THIS PLAN OF CORRECTION IS SUBMITTED FOR PURPOSES OF REGULATORY COMPLIANCE AND AS PART OF THE METHODIST HOME'S ONGOING EFFORTS TO CONTINUOUSLY IMPROVE THE CARE AND SERVICES PROVIDED. AS SUCH IT DOES NOT CONSTITUTE AN ADMISSION OF THE FACTS OR CONCLUSIONS CITED IN THE SURVEY REPORT FOR ANY PURPOSE WHATSOEVER.**	
L 052	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 self-care and group activities; (f)Encouragement 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 room if he or she is able; and	L 052		

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L 052	Continued From page 1 (3)Participate in meaningful social and recreational activities; with eating; (g)Prompt, unhurried assistance if he or she requires or request help with eating; (h)Prescribed adaptive self-help devices to assist him or her in eating independently; (i)Assistance, if needed, with daily hygiene, including oral acre; and j)Prompt response to an activated call bell or call for help. This Statute is not met as evidenced by: Based on observations, record review and staff interview for six (6) of 12 sampled residents and one (1) supplemental sampled resident, it was determined that sufficient nursing time was not provided to residents as evidenced by facility staff who failed to: monitor the behaviors of four (4) residents receiving antipsychotic medications; obtain a pacemaker check for one (1) resident; maintain infection control precautions one (1) resident during a wound treatment and administer prescribed medications and co-mingled non-prescribed medications with currently prescribed medications Residents # 2, 3, 4, 5, 6, 10 and JK1 . The findings include: 1. Facility staff failed to monitor behaviors for Resident #2 who was receiving an antidepressant medication. A review of Resident #2' s record revealed a	L 052	L 052 3211.1 Nursing Facilities **F329 483.25(l)(1) – Unnecessary Drugs** **- failure to monitor behavior of residents receiving antipsychotic (psychoactive) meds.** 1. Corrective Action for Residents Affected by Deficient Practice: Behavior monitoring sheets were instituted for the 4 residents identified during the survey who had this deficient practice. **Completion date: September 1, 2006.** 2. Method to Identify Other Residents At Risk for Deficient Practice: • Residents receiving psychoactive medications were identified using the Psychoactive Medication Report generated by the pharmacy. **Completion date: September 1, 2006.**	09/01/06 09/01/06

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L 052	Continued From page 2 physician's order initiated on December 20, 2002 and most recently renewed August 3, 2006, " Zoloft 25 mg daily and Zoloft 25 mg 1/2 tab daily to equal 37.5 mg daily for depression". There was no evidence in the record that facility staff had identified or monitored depressive behaviors. A face-to-face interview was conducted with the charge nurse on August 22, 2006 at 10:55 AM. He/she stated, "We don't monitor behaviors for antidepressant medication" The record was reviewed August 22, 2006. 2. Facility staff failed to monitor behaviors for Resident #3 who was receiving an antidepressant medication. A review of Resident #3's record revealed a physician's order initiated on admission and most recently renewed August 3, 2006, "Zoloft 100 mg daily for depression." There was no evidence in the record that facility staff had identified or monitored depressive behaviors. A face-to-face interview was conducted with the charge nurse on August 22, 2006 at 10:55 AM. He/she stated, "We don't monitor behaviors for antidepressant medication." The record was reviewed August 22, 2006. 3. Facility staff failed to monitor behaviors for Resident #4 who was receiving a medication for insomnia. A review of Resident #4's record revealed a physician's order initiated on July 6, 2006 and most recently renewed on August 3, 2006, " Trazodone HCL 50 mg tablet 1/2 tablet by mouth at bedtime for Insomnia". There was no evidence in the record that the facility staff had identified or	L 052	• In addition to the behavior monitoring sheets already in place for residents receiving antipsychotic meds, these sheets were also instituted for residents receiving antidepressants, hypnotics, and anxiolytic drugs. **Completion date: September 1, 2006.**	09/01/06
			3. <u>Measures or Systemic Changes to Ensure Deficient Practice Does Not Recur:</u> • Develop policy regarding appropriate use of Behavior Monitoring Sheets. **Completion date: September 15, 2006.**	09/15/06
			• Educate staff on implementation of the policy and correct documentation to be included on the Behavior Monitoring Sheets. **Completion date: September 30, 2006.**	09/30/06
			4. <u>Performance Monitoring to Ensure Solutions Are Sustained.</u> • Review Behavior Monitoring Sheets on a monthly basis for all residents listed on the Psychoactive Medication Report generated by the pharmacy. **Completion date: October 1, 2006 (and ongoing).**	10/1/06 & ongoing
			• Determine compliance with policy and appropriateness of documentation. • Report quarterly to the facility's Quality Assurance (QA) Committee. **Completion date: October 6, 2006 (and ongoing).**	10/6/06 & ongoing

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L 052	Continued From page 3 monitored the effects of the medication. A face-to-face interview was conducted with the charge nurse on August 22, 2006 at 10:55 AM. He/she stated, "We don't monitor those kinds of behaviors." The record was reviewed August 22, 2006. 4. Facility staff failed to monitor behaviors for Resident #5 who was receiving an antidepressant medication. A review of Resident #5's record revealed a physician's order renewed August 3, 2006, "Zoloft 25 mg daily for depression" There was no evidence in the record that facility staff had identified or monitored depressive behaviors. A face-to-face interview was conducted with the charge nurse on August 22, 2006 at 10:55 AM. He/she stated, "We don't monitor behaviors for antidepressant medication." The record was reviewed August 22, 2006. 5. Facility staff failed to perform a pacemaker check for Resident #6. A physician's order initiated on June 23, 2006 directed,"Pacemaker check every July-October-January". A review of the resident's record revealed that there was no evidence that a pacemaker check had been completed at the time of this review. A face-to-face interview was conducted with the charge nurse on August 22, 2006 at 4:12 PM. He /she acknowledged that the pacemaker check was not done in July and had not been completed at this time. The record was review on August 22	L 052	**F309 483.25 Quality of Care** - failure to obtain pacemaker check per physician order for resident #6. 1. Corrective Action for Resident Affected by Deficient Practice: The pacemaker check was obtained for the resident. **Completed August 24, 2006.** 2. Method to Identify Other Residents At Risk for Deficient Practice: Medical records of the 3 residents in the Health Care Center who have pacemakers were reviewed to determine if pacemaker checks were current per physician orders. None was found deficient. **Completed August 28, 2006.** 3. Measures or Systemic Changes to Ensure Deficient Practice Does Not Recur: • Nurses will continue to review TARs during the end-of-the-month changeover to ensure orders have been properly transcribed and dates/times for pacemaker checks have been identified (i.e. "blocked off") on the new month's TAR. Implementation date: **September 1, 2006 (and ongoing).** • TARs will be reviewed by the night shift nurse (24-hour checks) to ensure pacemaker checks have been completed according to schedule. Any pacemaker checks that have not been completed as scheduled will be reported to the DON the next day for follow up. Implementation date: **September 1, 2006 (and ongoing).** 4. Performance Monitoring to Ensure Solutions Are Sustained: Results from the nightly reviews are presented to the facility's Quality Assurance (QA) Committee quarterly. Implementation date: **September 30, 2006 (and ongoing).**	08/24/06 08/28/06 09/01/06 & ongoing 09/01/06 & ongoing 09/30/06 & ongoing

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L 052	Continued From page 4 , 2006. 6. Based on observations during a wound treatment, it was determined that facility staff failed to maintain infection control precautions for Resident #10. A. A wound treatment for Resident #10 was observed on August 22, 2006 at 2:40 PM. A Certified Nurse Aide (CNA) was assisting the nurse during the treatment. The CNA was observed removing a "light cover" from the resident, folded it up and placed it in the roommate's closet prior to the treatment. After the wound treatment was completed, the CNA removed the "light cover" from the roommate's closet and placed it on the resident. B. A wound treatment for bilateral necrotic heels was observed on August 22, 2006 at 2:40 PM. The nurse washed hands, donned gloves and removed the slippers and dressings from the left and right heels. The right heel had an approximately one (1) inch areas with a small amount of blood present. The left heel had no drainage. After washing hands, the nurse picked up the box of gloves and donned clean gloves. The nurse cleaned the right heel with 4 x 4 gauze pads previously moistened with normal sterile saline (NSS). He/she then picked up the tube of enzymatic ointment, applied the ointment onto a sterile cotton tipped applicator and applied the ointment to the right heel. Sterile 4 x 4 gauze pads and sterile gauze were applied to the wound . The nurse opened three (3) packages of 4 x 4 gauze pads, unscrewed the bottle of NSS and poured the NSS onto the gauze pads. Hands were not washed and gloves were not changed	L 052	**F314 483.25c Pressure Sores** - failure to maintain clean technique while administering the treatment to Resident #10. 1. Corrective Action for Resident Affected by Deficient Practice: Nurse involved was immediately educated regarding proper techniques to be used when changing residents' dressings. Completed August 23, 2006. 2. Method to Identify Other Residents At Risk for Deficient Practice: • Licensed nurses received copies of the facility's dressing change protocol. Completed August 24, 2006. • The Skin Care Book was reviewed to identify residents requiring dressing changes (including skin tears since no additional residents have pressure ulcers). Completed August 24, 2006. • Nurses were observed performing dressing changes by the Nurse Educator to ensure compliance with the dressing change protocol. Staff received instruction/correction in instances where protocol was violated. Completed August 30, 2006.	08/23/06 08/24/06 08/24/06 08/30/06

3. Measures or Systemic Changes to Ensure Deficient Practice Does Not Recur:

- Expand current infection control education to emphasize clean dressing change technique. Completion date: September 15, 2006. — 09/15/06
- Schedule all nurses to demonstrate competency in dressing change technique with specific emphasis on infection control. Completion date: September 22, 2006. — 0922/06

4. Performance Monitoring to Ensure Solutions Are Sustained:

Compile data from competency observations and present at quarterly QA meeting. Completion date: October 6, 2006. — 10/06/06

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L 052	Continued From page 5 before the nurse cleaned the left heel and applied ointment and a dressing. The National Pressure Ulcer Advisory Board, " Frequently Asked Questions, Wound Infection and Infection Control, " web site www.npuap.org/ woundinfection.html <http://www.npuap.org/ woundinfection.html>, revealed the following: In the response to question #309, " Care providers should wash their hands before they remove dressings from the (dressing) package in order to not contaminate the dressings by reaching into the package with soiled hands and/ or gloves. " According to the response of question #10, " One pair of clean (non-sterile) gloves can be used to treat multiple ulcers on the same patient. If this is done, start with the cleaner appearing wounds and move to the larger and /or most contaminated appearing wounds. When in doubt, change gloves between ulcers. Do not contaminate dressing supplies and wound care containers (i.e., solution bottles) with gloves that have been in contact with the ulcer. " The nurse administered the wound treatment to the cleaner wound first. Additionally, the nurse picked up a box of gloves, squeezed ointment from a tube, opened packages of gauze pads and a bottle of NSS without washing hands and changing gloves between these actions. 7. Facility staff failed to administer prescribed medications and co-mingled non-prescribed medications with currently prescribed medications for Resident JK1. An inspection of the medication cart revealed 32	L 052	**F 176 483.10(n) Self Administration of Drugs** - failure to assess Resident JK1 for self administration of drugs 1. Corrective Action for Resident Affected by Deficient Practice: The assessment of resident JK1's capability to self administer his nitroglycerin tablets were completed on August 24, 2006. 2. Method to Identify Other Residents At Risk for Deficient Practice: Medical records were reviewed to identify residents who may have physician orders to self administer medications and who may not have been assessed per policy. No residents were identified. Completed August 25, 2006. 3. Measures or Systemic Changes to Ensure Deficient Practice Does Not Recur: • Re-educate staff on self-administration policy. Completion date: Oct 6, 2006	08/24/06 08/25/06 10/06/06

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L 052	Continued From page 6 medications for Resident JK1, dispensed from four (4) different pharmacies other than facility's contract pharmacy. The physician's orders signed on August 3, 2006 prescribed 17 routine medications and four (4) as needed medications. All 21 medications were present in the medication cart. In addition to the prescribed medications, six (6) medications currently not prescribed were co-mingled in the medication cart,Ultram 50 mg, Synthroid 0.1 mg, Altace 5 mg, Fosamax 70 mg, Docusate Na 100 mg and Citracal (Calcium 630 mg and Vitamin D 400 International Units). During observation of medication pass on August 23, 2006 at approximately 8:45 AM, two (2) of the six (6) non-prescribed medications were administered to the resident, Citracal and Docusate Na. A face-to-face interview with the medication nurse was conducted on August 23, 2006 at 11: 30 AM. He/she acknowledged that the Citracal and Docusate were not prescribed by the physician and additional medications not prescribed were co-mingled with currently prescribed medications. The record was reviewed on August 23, 2006.	L 052	• Revise Twenty-Four Hour Report policy to require inclusion of residents being assessed for their ability to self-administer meds on 24-hour report. Completion date: Oct. 6, 2006 • Review 24-hour report daily to identify residents undergoing self-administration assessments. Sept. 1, 2006 • Review charts of these residents after 3-day assessment period to ensure assessment has been completed. Sept. 1, 2006 4. Performance Monitoring to Ensure Solutions Are Sustained: Report findings in Quarterly QA meeting. Completion date: Oct. 6, 2006.	10/06/06 09/01/06 09/01/06 10/06/06
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,	L 099		

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L 099	Continued From page 7 it was determined that dietary services were not adequate to ensure that foods were served and prepared in a safe and sanitary manner as evidenced by: soiled slats on the dish machine, hotel pans and sheet pans. These observations were made in the presence of the Director of Dietary Services. The findings include: 1. The outer surfaces of plastic slats on the dish machine were soiled with food and mineral deposits on the soiled and clean side in one (1) of one (1) observation at approximately 2:00 PM on August 22, 2006. 2. Hotel pans (14 x 24 x 4 inches) washed in the pot and pan wash area were not thoroughly cleaned of food residue and grease and allowed to dry before reuse in seven (7) of nine (9) observations at approximately 3:00 PM on August 22, 2006. 3. Sheet pans were stored with grease and residual food particles on the inner and outer surfaces and not allowed to dry before reuse in eight (8) of nine (9) observations at 3:15 PM on August 22, 2006.	L 099	3219.1 Nursing Facilities **F371 483.35(i)(2)** **SANITARY CONDITIONS – FOOD PREP & SERVICE** 1. The dish machine curtains were re-cleaned and sanitized. 8/24/06 2. Ecolab, our chemical company, was notified about replacing our curtain. 8/24/06 3. Director reviewed process and in-serviced the utility staff on proper sanitation and breakdown of the Dish machine. 8/24/06 4. Dining Services Director and Asst. Director will monitor compliance on a monthly basis & present to the Administrator for review. Will then be presented on a quarterly basis to the Quality Assurance Committee, with subsequent plans of correction developed and implemented as necessary. 8/25/06 and ongoing 1. Entire amount of hotel and sheet pans were rewashed and sanitized by the utility staff and supervised by the Director. 8/23/06 2. Director reviewed chemicals that are used at the pot sink as well as the ware washing procedure. 8/23/06 3. Director had in-service with entire utility staff on proper procedures for Pot and Pan washing. 8/24/06 4. Director & Asst. Director will monitor compliance on a monthly basis & will present to the Administrator for review. Will then be presented on a quarterly basis to the Quality Assurance Committee with subsequent plans of correction developed and implemented as necessary. 8/25/06 and ongoing	
L 410	3256.1 Nursing Facilities 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	L 410		

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L 410	Continued From page 8 ensure that the facility was maintained in a safe and sanitary manner as evidenced by: soiled exhaust vents, base surfaces on mechanical lifts and bathtubs; dust on top of closets and tables; and marred chairs, tables and foot boards in residents' rooms. The findings include: 1. The interior surfaces of exhaust vents in residents' rooms and common areas were soiled with dust in the following areas: First Floor Rooms 145, 147,153, 169 and bathing room in five (5) of nine (9) observations between 11:10 AM and 12:30 PM on August 22, 2006. Second Floor Rooms 249 and 261 in two (2) of nine (9) observations between 8:37 AM and 12: 10 PM on August 23, 2006. 2. The base surfaces of mechanical lifts and bathtubs were soiled with accumulated dust on the first and second floors between 4:00 PM and 4:45 PM on August 22, 2006 and 11:10 AM and 12:10 PM on August 23, 2006. 3. The top surfaces of tables and closets were soiled with dust and debris in rooms 145, 146, 247, 249, 253 and 256 in six (6) of 18 observations between 11:10 AM and 12:30 PM on August 22, 2006 and 8:37 AM and 9:30 AM on August 23, 2006. 4. The frontal areas of chairs, tables and foot boards were marred and scarred in residents' rooms. First Floor Rooms 146, 147, 151 and 153 in four (4) of nine (9) observations between 8:37 AM and	L 410	F 253 1. 1. The light dust identified during tour was removed on the interior surfaces of exhaust vents behind the grates in all cases. 08/24/06 2. Grates were removed and the interior of all exhaust vents were checked for dust on interior surface and no others were found to have dust. 08/24/06 3. In-service conducted and documented with all Maintenance Department on proper cleaning procedures. . 08/28/06 4. The Maintenance Supervisor is aware to monitor light dusting checks on monthly rounds. This information will be entered on the Quarterly QA report and monitored. 08/28/06 F 253 2. 1. The light dust identified on the mechanical Lift and tube during tour was removed in all cases. 08/23/06 2. All lifts and tubs were checked for dust on flat surfaces and no others were found to have dust. 08/23/06 3. In-service conducted and documented with all Light Duty Technicians on proper cleaning procedures. Housekeeping assignments updated to include weekly/monthly dusting of lifts and tubs. 09/06/06 4. The Housekeeping Supervisor is aware to monitor light dusting checks on weekly rounds. This information will be entered on the Quarterly QA report and monitored. 09/06/06	

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L 410	Continued From page 9 12:10 PM on August 22, 2006. Second Floor Rooms 249, 253 and 256 in three (3) of nine (9) observations between 8:37 AM and 12:10 PM on August 23, 2006.	L 410	F 253 3. 1. The light dust identified during tour was removed in all cases. 2. All resident rooms were checked for dust on flat surfaces of closets and furnishings and no others were found to have dust. 3. In-service conducted and documented with all Light Duty Technicians on proper cleaning procedures. Housekeeping assignments updated to include weekly/monthly dusting where dust was identified in resident rooms. 4. The Housekeeping Supervisor is aware to monitor light dusting checks on weekly rounds. This information will be entered on the Quarterly QA report and monitored. F 253 4. 1. The identified surfaces, of chairs, table legs and foot boards will be cleaned/repaired. 2. All resident rooms and common areas to be surveyed by staff to determine and and schedule cleaned/repaired if identified. 3. Condition of furniture will be added to daily housekeeping and maintenance rounds. 4. The Supervisors are aware to repair damage as discovered. This information will be entered on the Quarterly QA report and monitored.	08/22/06 08/25/06 09/06/06 09/06/06 09/29/06 09/29/06 09/29/06 09/29/06