PRINTED: 12/13/2007
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095005	A. BUILDING _____ B. WING _____	12/12/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WASHINGTON HOME	3720 UPTON STREET NW WASHINGTON, DC 20016

(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 000	Initial Comments A compliance survey was conducted on December 12, 2007 to determine if the plan of correction for the October 12, 2007 recertification and licensure survey was implemented. The census was 178 and the sample size was 61 residents. The following deficiencies were cited based on observations, record reviews and staff interviews.	L 000	The Washington Home is filing this Plan of Correction for the purposes of Regulatory Compliance. The facility is submitting this plan of correction to comply with applicable laws and not as an admission or statement of agreement with respect to the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the facility has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or the dates indicated. 1. **Corrective Action(s)** The records of residents S1, S2, S3, and W1 have been reviewed. These records cannot be changed because they have been transmitted to the state	12/19/07
L 001	3200.1 Nursing Facilities Each nursing facility shall comply with the Act, these rules and the requirements of 42 CFR Part 483, Subpart B, Sections 483.1 to 483.75; Subpart D, Sections 483.150 to 483.158; and Subpart E, section 483.200 to 483.206, all of which shall constitute licensing standards for nursing facilities in the District of Columbia. This Statute is not met as evidenced by: Based on record review and staff interview for four (4) of 27 sampled residents, it was determined that the RN (Registered Nurse) Assessment Coordinator failed to comply with 42 CFR (Code of Federal Regulations) 483.20(g) as evidenced by failure to ensure that all assessments were complete prior to signing at Section R2b. Residents S1, S2, S3 and W1. The findings include: According to the "MDS 2.0 User's Manual" page 3-212, "The RN Assessment Coordinator must not sign and attest to completion of the assessment until all other assessors have finished their portions of the MDS. " 1. A review of Resident S1 ' s record revealed that the dietician signed the Assessment	L 001	2. **Identification of Deficient Practices & Corrective Actions:** Other residents have the potential to be affected. The Clinical Manager or designee will audit 100% of all current residents' records to identify risks. Any and all negative findings at the time of discovery will be reported to the QA Committee for recommendations. 3. **Systemic Changes:** The MDS Coordinators have in-serviced the other disciplines that sign off on the MDS assessments. They have to sign the assessments on the date before or equal to the R2b date of the RN signature. 4. **Monitoring:** The RN QA Director or designee is responsible for maintaining compliance. The QA program includes an audit tool for monitoring the timely completion of review assessments. **Date of Compliance: 1/11/08**	12/19/07 12/19/07 12/19/07 12/19/07

Health Regulation Administration

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Interim Administrator — (X6) DATE: 1/4/08

STATE FORM 6899 HRO111 If continuation sheet 1 of 7

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L 001	Continued From page 1 Tracking Form, Section AA9, on December 5, 2007. The RN Assessment Coordinator signed the MDS, Section R2b on December 3, 2007 indicating that all assessments were completed. A face-to-face interview was conducted with Employee #2 at approximately 11:00 AM. He/She acknowledged that the RN signed at R2b prior to the completion of the assessment. The record was reviewed on December 12, 2007. 2. A review of Resident S2 ' s record revealed that the social worker signed the Assessment Tracking Form, Section AA9, on November 19, 2007. The RN Assessment Coordinator signed the MDS, Section R2b on November 16, 2007 indicating that all assessments were completed. A face-to-face interview was conducted with Employee #2 at approximately 11:00 AM. He/She acknowledged that the RN signed at R2b prior to the completion of the assessment. The record was reviewed on December 12, 2007. 3. A review of Resident S3 ' s record revealed that the Licensed Practical Nurse (LPN) and Recreational Therapist signed the Assessment Tracking Form, Section AA9, on November 18, 2007. The RN Assessment Coordinator signed the MDS, Section R2b on November 17, 2007 indicating that all assessments were completed. A face-to-face interview was conducted with Employee #2 at approximately 11:00 AM. He/She acknowledged that the RN signed at R2b prior to the completion of the assessment. The record was reviewed on December 12, 2007. 4. A review of Resident W1 ' s record revealed that the LPN signed the Assessment Tracking	L 001	1. **Corrective Actio(s)** The records of residents S1 S2, S3, and W1 have been reviewed. Th ese records cannot be changed because they have been transmitted to the state 2. **Identification of eficient Practices & Corre tive Actions:** Other residents have the po ntial to be affected. The Clinical Mana er or designee will audit 100% of all curren residents' records to identify risks. An and all negative findings at the time of discovery will be reported to the QA C mmittee for recommendations. 3. **Systemic Chang s:** The MDS Coordinators hav in-serviced the other disciplines that sig off on the MDS assessments. They h ve to sign the assessments on the date be ore or equal to the R2b date of the RN sign ture. 4. **Monitoring:** The RN QA Director or desi nee is responsible for maintaining compliance. The QA program includes a audit tool for monitoring the timely compl tion of review assessments. **Date of Compliance: 1/11/ 8**	12/19/07 12/19/07 12/19/07 12/19/07

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L 001	Continued From page 2 Form, Section AA9, on November 30, 2007. The RN Assessment Coordinator signed the MDS, Section R2b on November 29, 2007 indicating that all assessments were completed. A face-to-face interview was conducted with Employee #3 at approximately 10:30 AM. He/She acknowledged that the RN signed at R2b prior to the completion of the assessment. The record was reviewed on December 12, 2007. This is a repeat deficiency from the October 12, 2007 recertification/licensure survey. The plan of correction was: "...The RN Assessment Coordinator must not sign and attest to completion of the assessment until all other assessors have finished their portions of the MDS. The facility has reviewed its' currently [current] policy and procedure. The Clinical Managers and the IDT [Interdisciplinary Team] will be inserviced by the DON [Director of Nursing] and or designee on the provisions of 483.20(g)-(j) & MDS 2.0 Users Manual p.3-212 specifically the signature requirements for the Minimal [Minimum] Data Set..." Verification of inservice on MDS documentation was provided for three (3) of four (4) staff responsible for the MDS resident assessment.	L 001	1. **Corrective Actions)** The records of residents S1, S2, S3, and W1 have been reviewed. These records cannot be changed because they have been transmitted to the state. 2. **Identification of Deficient Practices & Corrective Actions:** Other residents have the potential to be affected. The Clinical Manager or designee will audit 100% of all current residents' records to identify risks. Any and all negative findings at the time of discovery will be reported to the QA Committee for recommendations. 3. **Systemic Changes:** The MDS Coordinators have in-serviced the other disciplines that sign off on the MDS assessments. They have to sign the assessments on the date before or equal to the R2b date of the RN signature. 4. **Monitoring:** The RN QA Director or designee is responsible for maintaining compliance. The QA program includes an audit tool for monitoring the timely completion of review assessments. **Date of Compliance: 1/11/08**	12/19/07 12/19/07 12/19/07 12/7/07
L 051	3210.4 Nursing Facilities A charge nurse shall be responsible for the following: (a)Making daily resident visits to assess physical and emotional status and implementing any required nursing intervention;	L 051		

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L 051	Continued From page 3 (b)Reviewing medication records for completeness, accuracy in the transcription of physician orders, and adherences to stop-order policies; (c)Reviewing residents' plans of care for appropriate goals and approaches, and revising them as needed; (d)Delegating responsibility to the nursing staff for direct resident nursing care of specific residents; (e)Supervising and evaluating each nursing employee on the unit; and (f)Keeping the Director of Nursing Services or his or her designee informed about the status of residents. This Statute Is not met as evidenced by: Based on observations, record review and staff interviews for two (2) of 10 sampled residents receiving oxygen, it was determined that the charge nurse failed to obtain an order for the use of oxygen for Residents S4 and W2. The findings include: 1. The charge nurse failed to obtain an order for the use of oxygen for Resident #S4. During the initial tour, it was observed that an oxygen concentrator was in Resident S4's room. A portable oxygen tank was observed on the back of Resident S4's wheelchair. A review of Resident S4's record revealed that there was no physician ' s order for the use of oxygen. There was no evidence in the record that the resident had used the oxygen during the month of December 2007.	L 051	1. **Corrective Action(s)** The records of residents S1, S2, S3, and W1 have been reviewed. These records cannot be changed because they have been transmitted to the state 2. **Identification of Deficient Practices & Corrective Actions:** Other residents have the potential to be affected. The Clinical Manager or designee will audit 100% of all current residents' records to identify risks. Any and all negative findings at the time of discovery will be reported to the QA Committee for recommendations. 3. **Systemic Changes:** The MDS Coordinators have in-serviced the other disciplines that sign off on the MDS assessments. They have to sign the assessments on the date before or equal to the R2b date of the RN signature. 4. **Monitoring:** The RN QA Director or designee is responsible for maintaining compliance. The QA program includes an audit tool for monitoring the timely completion of review assessments. **Date of Compliance: 1/11/08**	12/19/07 12/19/07 12/17/07 12/14/07

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L 051	Continued From page 4 A face-to-face interview with Employee #2 was conducted at 9:30 AM on December 12, 2007. He/she stated, "[Resident S4] just came back from the hospital at the end of last month (November 30, 2007). [Resident S4] needed oxygen when [he/she] was sent out 911 and we just left the concentrator in the room. It ' s there just for emergencies." After reviewing Resident S4's record, Employee #2 acknowledged that there was no order for oxygen. The record was reviewed December 12, 2007. 2. The charge nurse failed to obtain an order for the use of oxygen for Resident #W2. During the tour of Unit 2B on December 12, 2007 at approximately 8:00 AM, an oxygen concentrator was observed in Resident W2 ' s room. A review of Resident W2 ' s record revealed that there was no physician's order for the use of oxygen. The nurses ' notes included the following: December 10, 2007 at 10:30 PM, " ...Nasal O2 at 2 liters going continuously ... " December 10, 2007 at 11:30 P M, " ...Nasal O2 on at 2 liters per min (minute) ... " December 11, 2007 at 7:55 AM, " ...O2 at 2L/min ... " December 11, 2007 at 10:30 PM, " ...Nasal O2 on at 2 liters ... " December 12, 2007 at 6:00 AM, " ...O2 at 2 L via n/c (nasal cannula) ... " A face-to-face interview was conducted with	L 051	**1. Corrective Action(s)** Resident S4's record has been reviewed by the Clinical Team and orders for oxygen have been obtained. The Clinical Managers have educated the staff on the respective units for complete documentation. **2. Identification of Deficient Practices & Corrective Actions:** Other residents requiring oxygenation therapy with oxygen saturations parameters have the potential to be affected. The Clinical Managers or designees have audited 100% of the current resident's record to identify risks. Any and all negative findings at the time of discovery will be reported to the QA Committee for recommendations. **3. Systemic Changes:** The Clinical Team have been in-serviced that all residents receiving oxygen therapy should have a physician's order specifying the use of oxygen and the oxygen saturation parameter for administering the oxygen. **4. Monitoring:** The Assistant Director of Nursing or designee is responsible for maintaining compliance. The QA program includes an audit tool for monitoring the timely completion for monitoring the residents with oxygenation therapy. The Clinical Managers will audit monthly for residents with oxygenation therapy and report findings during the monthly QA Committee Meeting. **Date of Compliance: 1/11/08**	12/20/07 12/20/07 12/20/07 12/20/07

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L 051	Continued From page 4 A face-to-face interview with Employee #2 was conducted at 9:30 AM on December 12, 2007. He/she stated, "[Resident S4] just came back from the hospital at the end of last month (November 30, 2007). [Resident S4] needed oxygen when [he/she] was sent out 911 and we just left the concentrator in the room. It ' s there just for emergencies." After reviewing Resident S4's record, Employee #2 acknowledged that there was no order for oxygen. The record was reviewed December 12, 2007. 2. The charge nurse failed to obtain an order for the use of oxygen for Resident #W2. During the tour of Unit 2B on December 12, 2007 at approximately 8:00 AM, an oxygen concentrator was observed in Resident W2 ' s room. A review of Resident W2 ' s record revealed that there was no physician's order for the use of oxygen. The nurses ' notes included the following: December 10, 2007 at 10:30 PM, " ...Nasal O2 at 2 liters going continuously ... " December 10, 2007 at 11:30 P M, " ...Nasal O2 on at 2 liters per min (minute) ... " December 11, 2007 at 7:55 AM, " ...O2 at 2L/min ... " December 11, 2007 at 10:30 PM, " ...Nasal O2 on at 2 liters ... " December 12, 2007 at 6:00 AM, " ...O2 at 2 L via n/c (nasal cannula) ... " A face-to-face interview was conducted with	L 051	**1. Corrective Action(s):** Resident W2's record has been reviewed by the Clinical Team and order for oxygen have been obtained. The Clinical Managers have educated the staff on the respective units for complete documentation. **2. Identification of Deficient Practices & Corrective Actions:** Other residents requiring oxygenation therapy with oxygen saturation parameters have the potential to be affected. The Clinical Managers or designees have audited 100% of the current resident's record to identify risks. Any and all negative findings at the time of discovery will be reported to the QA Committee for recommendations. **3. Systemic Changes:** The Clinical Team have been re-serviced that all residents receiving oxygen therapy should have a physician's order specifying the use of oxygen and the oxygen saturation parameter for administering the oxygen. **4. Monitoring:** The Assistant Director of Nursing or designee is responsible for maintaining compliance. The QA program includes an audit tool for monitoring the timely completion for monitoring the residents with oxygenation therapy. The Clinical Managers will audit monthly for residents with oxygenation therapy and report findings during the monthly QA Committee Meeting. **Date of Compliance: 1/11/08**	12/20/07 12/20/07 12/20/07 12/20/07

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L 051	Continued From page 5 Employee #4 on December 12, 2007 at 11:18 AM. He/She stated, " We are just giving it (oxygen) to her for comfort. [Resident] had an episode of bradycardia on the 10th" . A face-to-face interview was conducted with Employee #3 on December 12, 2007 at approximately 11:30 AM. He/She acknowledged that there was no order for oxygen for the resident. The record was reviewed on December 12, 2007. (New finding)	L 051	1. **Corrective Action(s)** Molded tomatoes, cantaloupes, cucumbers and celery in the walk-in refrigerators were discarded immediately on 12/12/07. 2. **Identification of Deficient Practices & Corrective Actions:** Other meal prep items prepared for scheduled meal distribution and storage have the potential to be affected. The Food Services Manager and Food Services Supervisors will inspect any and all food items prior to storage for proper labels dates and initials. Any and all negative findings will be corrected at the time of discovery. 3. **Systemic Changes:** The facility has reviewed its current policy and procedures. The Food Service Manager or designee will perform a daily audit of food items in the walk-in refrigerator and submit a daily report that food items in the walk-in refrigerator are labeled, dated, free from spoilage and used before their expiration date. 4. **Monitoring:** The Dietician or designee will complete the Dietary Inspection report daily for maintaining compliance. The Dietary inspection report includes refrigerated stock or stored foods covered, dated, and without spoilage mold or foreign residue (FIFO). Findings will be reported to the QA Committee for recommendations for changes in current policy or practice and the need for further audits and or action plans. **Date of Compliance: 1/11/08**	12/12/07 12/12/07 12/12/07 12/20/07
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 in the walk-in refrigerator were labeled, dated, free from spoilage and used before the expiration date. These observations were made in the presence of Employee #1 on December 12, 2007 at 7:10 AM. The findings include: 1. Tomatoes, cantaloupe, cucumbers and celery were observed not free from spoilage (mold) in the walk-in refrigerator. 2. Four (4) 32-ounce containers of plain yogurt were observed with an expiration date of December 5, 2007.	L 099		

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L 099	Continued From page 6 3. Ten (10) gallon containers of assorted salad dressing were opened and undated. 5. One (1) package of cheese squares, one (1) package of shredded cheese and one (1) package of tortillas were open and undated. 6. One (1) container of tuna fish and one (1) container of peaches were unlabeled and undated. Employee #1 acknowledged these findings at the time of the observations. According to the plan of correction for the annual recertification and licensure survey completed October 12, 2007, "The Dietician will complete the Dietary Inspection Report weekly for maintaining compliance. The Dietary Inspection Report now includes sanitary conditions, food prep and storage of food Items..." Dietary staff conducted daily inspections of the walk-in refrigerator. The daily inspection check list included unlabeled/undated and expired food items, but failed to include observation of food free from spoilage (mold) food.	L 099	**1. Corrective Action(s)** **(2)** Four (4) 32 ounce containers of plain yogurt were observed with an expiration date of December 5, 2007. **(3)** Ten (10) gallon containers of assorted salad dressing were opened and undated. (5)One (1) package of cheese squares, one (1) package of shredded cheese and on (1) packages of tortillas were open and undated. **(6)** One (1) container of tuna fish and one (1) container of peaches were unlabeled and undated. All of these items were discarded. **2. Identification of Deficient Practices & Corrective Actions:** Other meal prep items prepared for scheduled meal distribution and storage have the potential to be affected. The Food Services Manager and Food Services Supervisors will inspect any and all food items prior to storage for proper labels dates and initials. Any and all negative findings will be corrected at the time of discovery. **3. Systemic Changes:** The facility has reviewed its current policy and procedures. The Dietary Services staff will be in-serviced by the Registered Dietician or designee in accordance with the requirements set forth in Title 23 subtitle B, D. C. Municipal Regulations (DCMR), Chapter 24 – 40. Specifically, sanitary conditions food prep and storage of food items. **4. Monitoring:** The Dietician or designee will complete the Dietary Inspection report daily for maintaining compliance. The Dietary inspection report includes refrigerated stock or stored foods covered, dated, and without spoilage mold or foreign residue (FIFO). Findings will be reported to the QA Committee for recommendations for changes in current policy or practice and the need for further audits and or action plans. **Date of compliance: 1/11/08.**	12/12/07 12/12/07 12/13/07 12/20/07