Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0005	A. BUILDING: _____ B. WING _____	02/21/2013

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 licensure survey was conducted February 13, through February 21, 2013. The deficiencies are based on observations, record reviews, resident and staff interviews for 41 sampled residents.	L 000	The Washington Home makes its best effort To operate in substantial compliance with both Federal and State law. Submission of this Plan of Correction (POC) does not constitute an admission or agreement by any party, its board, officers, directors, employees or agents as to the truth of the facts alleged or the validity of the conditions set forth on the Statement of Deficiencies. The following Plan of Correction constitutes the facility's written credible allegation of compliance. It is prepared and/or executed solely because it is required by Federal and State law.	
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; (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: A.Based on an observation, record review and staff interviews for three (3) of 41 sampled residents, it was determined that the charge nurse failed to develop a care plan with measurable goals and approaches to address	L 051	**L 051** Resident #2 1. Comprehensive care plans will be developed and reviewed quarterly by the interdisciplinary team for all residents diagnosed with mental retardation/mental illness, and/or have a positive PASSR screen. 2. A chart audit will be conducted by the Social Services staff to ensure that: 1) All residents who have been diagnosed with mental illness/mental retardation have a PASSR Level II Screen completed and placed in the chart under the Social Services tab; and 2) All residents with a positive PASSR screen will have a comprehensive care plan which will be reviewed quarterly and as necessary. No other resident was affected by this deficient practice.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0005	A. BUILDING: _____ B. WING _____	02/21/2013

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 051	Continued From page 1 one (1) resident with a positive PASRR [Pre-Admissions Screen/Resident Review for Mental Illness and/or Mental Retardation] Screen; an integrated care plan for hospice services for one (1) resident; and to address a swallowing impairment or potential for aspiration for one (1) resident. Residents #2, #9, and #164. The findings include: 1. The charge nurse failed to ensure that a care plan was developed with measurable goals and approaches to address one (1) resident with a positive PASRR [Pre-Admissions Screen/Resident Review for Mental Illness and/or Mental Retardation] Screen. A record review of the medical record for Resident #2 identified that the resident was admitted to the facility in March 25, 1968. Review of the PASRR [Pre-Admissions Screen/Resident Review for Mental Illness and/or Mental Retardation] Screen dated January 20, 2008, identified the resident as positive for Mental Retardation. Review of the quarterly Minimum Data Set with an ARD [Assessment Reference Date] of November 15, 2012 identified in Section I the following diagnoses: Anemia, Heart Failure, HTN [Hypertension], Hyperlipidemia, Asthma, Sensory Hearing Loss Bilateral, Unspecified Osteoporosis, Dysphagia Oropharyngeal Phase, Vitamin D Deficiency, OBST [Obstructed] Chronic Bronchitis..., Slow transit constipation,	L 051	3. A roster of all residents who have a positive PASSR will be kept by the Director of Social Services. A chart review of all new admissions to the facility will be conducted by the Director of Social Services/Unit Social Worker to identify the need for a PASSR Level II Screen. Upon determination, the social worker will initiate the screening process, and document all related activities in the clinical record. A comprehensive care plan will be developed and then reviewed quarterly, to address the needs/concerns of the resident found to have a positive PASSR. 4. Random chart audits will be conducted by the Director of Social Services to ensure residents have been accurately/appropriately identified and screened for a PASSR level, and that a comprehensive care plan has been developed. All findings of the audit will be reported to the QI Committee quarterly. 5. Date of compliance:	3/22/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0005	A. BUILDING: _____ B. WING _____	02/21/2013

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 051	Continued From page 2 other drug allergy, Unspecified Infantile Cerebral Palsy, Mild Intellectual Disabilities [Mental Retardation]. Review of the "Care Plan Face Sheet" identified that the IDT (Interdisciplinary Team Meeting) was conducted on November 15, 2012. Further review of the care plans lacked evidence of a care plan with goals and approach to address Resident #2's positive screen for Mental Retardation. A face-to-face interview was conducted with Employee #4 on February 14, 2013 at approximately 5:10 PM. After a review of the care plans, he/she acknowledged the findings. The charge nurse failed to develop a care plan with measurable goals and approaches for Resident #2 who had a positive PASRR. 2. The charge nurse failed to initiate an integrated care plan for hospice services for Resident #9. A review of the resident ' s clinical record revealed that the resident was hospitalized in an acute care facility on December 25, 2012 and returned to the facility on January 28, 2013. Review of an" Interim Order Form" revealed two (2) orders. The first order was written by the nurse practitioner and documented the following, " Patient for hospice services as of 1/28/13. " That order was also dated and signed January 28, 2013. The second was a telephone order	L 051	Resident #9 1. Resident #9 suffered no harm. A Care Plan for Hospice Services was initiated during the survey process 2. All residents upon receiving physician orders to receive Hospice Services will be placed on Open Chart Protocol. The Open Chart Protocol will be amended to reflect this standard. All Nurse Managers, Licensed Nurses and Unit Clerks will receive an education session to become aware of the amended Open Chart Protocol. 3. All residents upon receiving physician orders to receive Hospice Services, will within 72 hours of receipt of the order , have a Medical Record review by the Nurse Manager or their designee to ensure a Hospice Services Care plan has been instituted. All Nurse Managers, licensed nurses, and Unit Clerks will receive an education session regarding the review process for ensuring a Hospice Services Care Plan is instituted within 72 hours for all residents with physician's orders for Hospice Services.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0005	A. BUILDING: _____ B. WING _____	02/21/2013

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 051	Continued From page 3 which directed, " Pt. [patient] admitted to Community Hospices under [MD' s name] " was dated January 29, 2013. Further review of the record revealed that the resident was visited by the Hospice nurse on January 29, 2013. According to the admission Minimum Data Set [MDS] with an Assessment Reference Date of February 8, 2013 the resident was coded for Hospice care in Section O. However, review of the care plans failed to reveal a care plan with goals and approaches to address the delivery of Hospice Care to the resident. A face-to-face interview was conducted with Employee #4 on February 20, 2013 at 4:00PM. During the interview the employee acknowledged that no integrated care plan was developed and/or initiated for the resident ' s Hospice care. The clinical record was reviewed on February 20, 2013. 3. The charge nurse failed to develop a care plan for safe swallowing/aspiration for Resident #164 who was identified as requiring mechanical soft meal and nectar thicken liquids. On February 13, 2013 at 9:50 AM a medication administration observation was conduct. Employee # 19 was observed administering oral medications to Resident #164. While at the bedside of the resident, Employee #19 administered medications which included Calcium Carbonate one (1) tablet, Neurontin 100mg two (2) tablets, and Xifaxan one (1)	L 051	4. The Medical Record review of all residents with physician orders for Hospice Services to ensure the residents have a Hospice Services Care Plan will be added as an item for review on the Medical Record Audit Tool completed monthly by Nurse Managers. Nurse Managers will submit the Medical Record Audit Tool monthly to the Quality Improvement Manager. The Quality Improvement Manager will report variances quarterly at the Focus Quality Improvement Committee. 5. Compliance Date <u>Resident # 164</u> 1. Resident # 164 suffered no harm. Immediate education was done with the licensed nurse as to their noncompliance with the resident's need for thickened liquids and a review of the facility Thickened Liquids Policy. A care plan to address the resident's swallowing impaired has been added to the Medical Record.	4/5/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0005	A. BUILDING: _____ B. WING _____	02/21/2013

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 051	Continued From page 4 tablet. The Employee gave Resident #164 approximately 50 ml of cranberry juice in a cup with a straw for the resident to swallow his/her medication. The resident drank the cranberry juice by sipping it from the straw. Observed on Resident #164 ' s over-the-bed table was one (1) packet of Instant Food Thickener and one (1) container of Thick and Easy pre-thickened beverage. At no time did Employee #19 mix the thickener with the cranberry juice that was given to Resident #164 to drink while taking his/her medications. According to the History and Physical dated May 4, 2012 Resident #164 had a diagnosis which Multiple Sclerosis. A review of the physician orders signed and dated February 5, 2013 directed, " Mechanical soft foods-nectar thicken liquids at all meals. " A review of the Functional Maintenance Program-recommendations dated October 22, 2012 revealed, " Referral to restorative nursing for ...cue as needed for adherence to safe swallow strategies/aspiration precautions and required diet/liquid consistencies... " A review of the Nutritional Assessments dated November 12, 2012 and February 13, 2013 revealed, " Current diet order- Mech (mechanical soft, nectar thick, NCS (no concentrated sweets)	L 051	2. Upon receiving a physician's order to have a resident receive Thickened Liquids and or swallowing impairment, the licensed nurse that receives the order will add care plans for both needs in the resident's Medical l Record. All residents requiring Thickened Liquids will have their MAR amended to alert licensed nurses that thickened liquids are to be administered with all medications as well as with all meals. All licensed nurses will receive education regarding the labeling of the MAR of residents receiving thickened liquids and a review of the Thickened Liquids Policy. All licensed nurses will receive education regarding the immediate need to add care plans reflecting swallowing impairment and/or need for Thickened Liquids to residents Medical Record. 3. The facility Thickened Liquids policy will be amended to reflect the labeling of the MAR of all residents receiving thickened liquids. All licensed nurses will receive education regarding the amendment to the Thickened Liquids policy. When a resident receives an order for Thickened Liquids, the licensed nurse receiving the order will label the MAR of the resident to reflect the resident's need for thickened liquids during medication administration as well as during	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0005	A. BUILDING: _____ B. WING _____	02/21/2013

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 051	Continued From page 5 A review of the Care Plans printed by the facility and those located on the active clinical record revealed that there was no care plan with goals and approaches to address the resident ' s swallowing impairment or potential for aspiration. A face-to-face interview was conducted with Employees #3 and #29 on February 19, 2013 at approximately 10:30 AM. They acknowledged that there was no care plan developed to address the resident ' s swallowing impairment or potential for aspiration. The record was reviewed on February 19, 2013. B.Based on record review and staff interview for one (1) of 41 sampled residents, it was determined that the charge nurse failed to ensure that one (1) resident's weight was accurately documented in the clinical record. Resident #98. The findings include: According to the clinical record, Resident #98 was admitted to the facility on October 18, 2012 for Physical Therapy, Occupational Therapy and Speech Therapy. A review of the "Master problem list " revealed resident ' s diagnoses included: Stroke (frontal), History of Stroke (2007); Atrial Fibrillation and Hypertension. A review of the Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of October 25, 2012 revealed Resident #98 was coded under Section K0200 as weighing 160 pounds on admission.	L 051	meals. Within 72 hours following the physician's order for a resident to receive thickened liquids the Nurse Manager or their designee will audit the residents' MAR to ensure the MAR has been labeled to show the resident's need for thickened liquids and to ensure care plans for swallowing impairment and/or thickened liquids has been added to the Medical Record. The Nurse Manager will receive education regarding the audit process of the resident's MAR. 4. The labeling of the MAR of a resident receiving thickened liquids to show the resident must receive thickened liquids during medication administration as well as meals, will be added as an item to the monthly Medical Record Audit Tool completed by Nurse Managers. The addition of care plans for swallowing impairment and/or thickened liquids to the Medical Record will be added as an item to the monthly Medical Record Tool completed by the Nurse Manager. The Nurse Managers will submit the Medical Record Audit Tool to the Quality Improvement Manager on a monthly basis. The Quality Improvement Manager will report variances monthly to the Focus Quality Improvement Committee. 5. Compliance Date	4/5/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0005	A. BUILDING _____ B. WING _____	02/21/2013

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 051	Continued From page 6 The " Physician's Order Sheet and Plan of Care " signed and dated October 19, 2012 directed: " Weight-Weekly x (times) 4; Other: Admission weight, 2nd (second) day weight. " The unit's " Up To Scale Weight Record " revealed the following weights: October 18, 2012- 217.7 pounds October 19, 2012 - 157.8 pounds October 24, 2012- 158 pounds October 31, 2012- 159.6 pounds A review of a printout from Optimus (electronic medical record) titled " Resident ' s Weight On or after 10/18/12 " revealed the following weights: October 18, 2012- 217.7 lbs (pounds) October 24, 2012 - 158 lbs November 7, 2012 - 159 lbs November 14, 2012 - 157.2 lbs An . " Initial Nutrition Risk Assessment " dated October 22, 2012 (no time indicated) revealed: "... Interventions - Monitor weight weekly x 4; on mechanical soft d/t [due to] swallowing deficient, po (by mouth intake) good- 75-100 percent of meals, 217.7 [pounds]. Over wt (weight) but weight loss not an issue at this point due to age, [no] recent labs, no edema, no skin openings. Continue to F/U (follow-up), diet meets needs. " Facility staff failed to document or address the weight variance of 59.7 pounds; which is indicative of a significant weight change from October 18, 2012 to October 19, 2012. A face-to-face interview was conducted with Employee #7 on February 20, 2013 at approximately 3:30 PM. After reviewing the	L 051	**L051 (B)** 1. The weight recorded on October 18 was a scale (mechanical) error, and all other recorded weights from October 19-october 31 were accurate. This incident was addressed by documenting the scale error. Then the resident's weight was monitored to ensure consistency and documentation was put in place. The resident was not negatively affected by the error. 2. A audit of weight records indicated that there were no other residents affected by the practice. 3. The Dietitian and facility staff will use the second day weight (performed by the Weight Team) to insure consistency. The Weight Team will develop a weekly weight report for all residents on weekly weights. Reports will be given to nursing staff and dietitians. Dietitian is responsible for ensuring weights are consistent and will communicate with nursing as needed. The weight team will inform dietitian and nursing of any weight discrepancies within 24 hours, and re-weigh will be done to verify change in weight.	

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0005	A. BUILDING: _____ B. WING _____	02/21/2013

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 051	Continued From page 7 clinical record; he/stated: " The admission weight is not correct, the weight on the second day is correct. " Another face-to-face interview was conducted with Employee #23 on February 21, 2013 at approximately 10:30 AM. Employee #23 acknowledged that he/she failed to look at the 2nd (second) day weight recorded on the weight sheet prior to his/her nutrition assessment written on October 22, 2013. The clinical record was reviewed on February 21, 2013.	L 051	4. Weekly weights will be reviewed weekly and reported and discussed in the weekly Focus QI Meetings. Any variance(s) will be reported to the weekly meetings and monthly QI Committee meetings. 5. Compliance Date	3/22/2013
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;	L 052		

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0005	A. BUILDING: _____ B. WING _____	02/21/2013

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 052	Continued From page 8 (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 (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: A.Based on an isolated observation for one (1) of 41 sampled residents, it was determined that facility staff failed ensure that sufficient nursing time was provided to promote dignity for one (1) resident as evidenced by the observation of a paper towel applied proximal to the resident ' s ear as a skin protectant. Resident #43 The findings include: Facility staff failed ensure that sufficient nursing time was provided to promote dignity for Resident #43. The resident was observed on	L 052	**L052 (A)** Resident# 43 1. Resident sustained no harm. Paper towel used as a skin protectant was removed from the resident's ear 2. A product called E-Z Wrap has been ordered as skin protectant for all residents using tubing that lies proximal to their ears or face. If E-Z Wrap is unavailable nursing staff will be educated to use gauze sponges to wrap tubing lying proximal to residents' ears or face. 3. All nursing staff will be provided education sessions on the use of the product E-Z wrap or gauze sponges as a skin protectant and to promote dignity for residents using tubing that lies proximal to residents' ear or face. 4. All residents using tubing that lies proximal to the resident's ears or face will be monitored daily by the Nurse Manager or their designee, for use of skin protectant (E-Z Wrap or gauze) around the tubing. This item will be added to the Nurse Manager daily Unit Rounds Audit Tool. The audit tool will be submitted monthly to the Quality Improvement Manager and reviewed at the Focus Quality Improvement Committee. 5. Compliance Date	4/5/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0005	A. BUILDING: _____ B. WING _____	02/21/2013

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 052	Continued From page 9 February 20, 2013 at approximately 11:30 AM seated in a wheelchair in the common area of the nursing unit with portable oxygen infusing via nasal cannula. The nasal cannula was applied as prescribed, to the resident ' s nares and secured behind his/her ears. A paper towel was observed resting loosely and unevenly along the tubing of the nasal cannula proximal to the resident ' s right ear. At the time of the observation, Employee #5 was queried as to the purpose of the paper towel observed proximal to the resident ' s ear. He/she stated that the resident had a tendency to have skin break down behind the ears secondary to the oxygen tubing and that the paper towel served to protect the resident ' s skin. He/she added, " 4 x 4 gauze pads are supposed to be used " [instead of the paper towel]. A face-to-face interview was conducted with Employee #17, the licensed staff assigned to Resident #43, on February 20, 2013 at approximately 2:30 PM. In response to a query regarding the paper towel observed proximal to Resident #43 ' s ear, he/she replied that the paper towel served to protect the skin behind the resident ' s ear from breaking down. However, he/she stated that gauze sponges are usually used to protect the skin behind the resident ' s ear from the oxygen tubing rubbing against it. Facility staff failed to promote dignity for Resident #43 as evidenced by the observation of a paper towel applied proximal to the resident ' s ear as a skin protectant. B. Based on observation, record review and staff	L 052		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0005	A. BUILDING: _____ B. WING _____	02/21/2013

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 052	Continued From page 10 interview for seven (7) of 41 sampled residents, it was determined that facility staff failed ensure that sufficient nursing time was provided to ensure that each resident received the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care as evidenced by a failure to: consistently assess and monitor the status of altered skin integrity for two (2) residents; follow through on a physician ' s order for a wound consultation for one (1) resident; identify and implement measures to manage the postural/positioning concerns for one (1) resident; consistently assess pain for two (2) residents receiving " as needed " pain medication; assess intravenous access sites as prescribed for two (2) residents and follow through on a physician ' s order for incentive spirometer treatment for one (1) resident. Residents ' #82, 107, 205, 252, 273, 286 and 292. The findings include: 1. A review of the clinical record for Resident #82 revealed facility staff failed ensure that sufficient nursing time was provided to consistently assess and monitor the status of an alteration in skin integrity and failed to follow through on a physician ' s order for a consultation by the wound care team. A. An electronic entry entitled " Incident details " dated January 2, 2013 at 10:33 PM read: " Resident reported with new open area of inner buttock measure 2.5 cm [centimeter] x 2 cm and cluster of small skin open areas at the same site.	L 052	**L052 (B)** Resident #82 1. Harm did not occur to the resident: documentation in the resident's medical record for Feb. 19 at 11:00am did not show an alteration in the resident's skin. The licensed nurse that failed to document ongoing assessments of the resident's skin received counseling and education as to the process of documenting assessments of resident's skin. 2. All residents with skin conditions will be placed on Open Chart Protocol until the skin condition is resolved. All licensed nurses will receive educational review of the Open Chart Protocol. 3. All residents will have their skin assessed by a licensed nurse weekly and documentation of the assessment placed in the electronic medical record whether the skin is positive or negative for variances in the residents' skin. 4. The weekly skin assessments performed by the licensed nurse and entered into the Electronic Medical Record will be audited weekly by the Nurse Manager or their designee through the use of Administrative Report function of the Electronic Medical Record and a summary forwarded weekly to the Quality	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0005	A. BUILDING: _____ B. WING _____	02/21/2013

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 052	Continued From page 11 [physician named] notified, order given to clean open area with soap and water, pat dry, apply Lantiseptic each shift after each incontinent care. " A nurse ' s entry dated January 3, 2013 at 12:25 AM read, " [family member named] called and was informed of skin impairment to sacral area. " A review of the corrected quarterly Minimum Data Set [MDS] signed January 8, 2013; assessment reference date January 3, 2013 was coded in Section M, Skin conditions that the resident had one (1) Stage 1 pressure ulcer. The clinical record lacked evidence of monitoring and ongoing assessments of the status of the alteration in skin integrity of the " sacral area " and/or " inner buttocks " for Resident #82. There was no evidence of documentation regarding the status of the resident ' s altered skin subsequent to the initial assessment on January 2, 2013. An observation of the resident ' s sacral region on February 19, 2013 lacked evidence of a break in skin integrity. The findings were acknowledged by Employees #4 and #8 during face-to-face interviews conducted on February 20, 2013 at 10AM and 1:00 PM respectively. B. Facility staff failed ensure that sufficient nursing time was provided to follow through on a physician ' s order for wound consultation. An interim physician ' s order dated January 2, 2013 at 9:25 PM directed, " cleanse open area	L 052	Improvement Manager. All Nurse Managers will receive education on the process of using the Administrative Report function of the Electronic Medical Record and the process of summarizing the report for weekly submission to the Quality Improvement Manager. 5. Compliance Date Resident #82 1. No harm occurred to the resident. The Wound Care Team assessed the resident and did not find exacerbation of the resident's skin condition. 2. All residents with skin variances will be placed on Open Chart Protocol until the skin variance is resolved. When a license nurse receives a treatment order for a resident's skin variance the licensed nurse will complete and submit a Skin Care Communication Tool to the Wound Care Team to notify the team to evaluate the resident's skin. The Wound Care Team within 72 hours of receipt of the communication tool will evaluate and document their contact of evaluation of the resident's skin. All licensed nurses and the Wound Care Team will receive education on the use of the Wound Care Communication Tool.	4/5/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0005	A. BUILDING: _____ B. WING _____	02/21/2013

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 052	Continued From page 12 to the right inner buttocks with soap and water, pat dry and apply Lantiseptic after each incontinent care each shift; Evaluate resident by wound care team tomorrow during AM care. " The clinical record lacked evidence that the resident was evaluated by the wound care team as prescribed. A face-to-face interview was conducted with Employee #4 on February 20, 2013 at 10:00 AM who acknowledged that the record lacked evidence of an assessment by the wound care team. The record was reviewed February 20, 2013. 2. Facility staff failed ensure that sufficient nursing time was provided to identify and implement measures to manage the postural/positioning concerns for Resident #107. Resident #107 was observed on February 20, 2013 at approximately 11:00 AM seated at a table in the common area [day/dining room] in his/her wheelchair. The resident was observed excessively leaning to one side without support to maintain an upright position. There was no evidence of needed torso support. Employee #6 who was present during the time of the observation, was queried regarding the lack postural and/or positioning supports for Resident #107. He/she responded that the resident often falls asleep while seated in his/her wheelchair and tends to lean. He/she asked a staff person to obtain a pillow to assist with positioning. Additional observations of positioning/postural concerns were observed during the survey period as follows:	L 052	3. When a license nurse receives a treatment order for a resident's skin variance the licensed nurse will complete and submit a Skin Care Communication Tool to the Wound Care Team to notify the team to evaluate the resident's skin. The Wound Care Team within 72 hours of receipt of the communication tool will evaluate and document their contact of evaluation of the resident's skin. All licensed nurses and the Wound Care Team will receive education on the use of the Wound Care Communication Tool. 4. All licensed nurses and the Wound Care Team will receive education on the use of the Wound Care Communication Tool. The Wound Care Communication Tool will be submitted to the Quality Improvement Manager. Variances will be discussed at the weekly Focus Quality Improvement Committee. 5. Date of Compliance	4/5/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0005	A. BUILDING: _____ B. WING _____	02/21/2013

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 052	Continued From page 13 Observed Resident #107 in the activity area on February 14, 2013 at 10:00 AM and 3:00 PM sitting in a wheelchair. The resident was leaning to his/her right without support to maintain an upright position. Observed February 15, 2013 in the activity area at approximately 9:54 AM, Resident #107 was sitting in a wheelchair at a table; the resident was leaning to one side without support to maintain an upright position. A face-to-face interview was conducted with Employee #37 on February 21, 2013 at 11:00 AM. He/she stated that the resident has a diagnosis of " severe scoliosis " and that a custom wheelchair was provided, however; it is likely that [his/her] condition is declining and additional supports may be indicated. The rehabilitation division had not received a communication from nursing regarding positioning concerns for this resident. He/she stated an evaluation will be conducted. An annual physical therapy (PT) screen dated January 26, 2013 read: " patient was seen today for annual screen. There has been no change of condition or any recent change in safety status. Wheelchair in good condition. PT evaluation not indicated. " Facility staff failed to identify and implement measures to address the postural/positioning concerns for Resident #107. 3. A review of the clinical record for Resident #205 revealed facility staff failed ensure that sufficient nursing time was provided to	L 052	Resident #107 1. The resident did not sustain any harm. A rehabilitative screen for positioning was obtained for the resident. 2. All residents with a need for positioning will have a rehabilitative screen request sent to the Rehabilitative Therapy Department and any recommendations made by the Rehabilitative Therapy Department will be communicated to the resident's care team and entered into the residents care plan. 3. All residents with positioning needs will be monitored every 3 hours and when necessary by the residents' care team and recommendations to correct positioning concerns carried out according to the residents' care plan. Documentation of the follow through will be done on the resident's TAR. 4. Documentation of the residents needs for positioning and changing of position will be an item added to the Nurse Managers Unit Rounds Audit tool (completed by Nurse Managers twice daily). The Nurse Manager Unit Rounds Audit tool will be submitted weekly to the Quality Improvement Manager. Variances and recommendations for variances will be discussed at weekly Focus Quality Improvement Meeting. 5. Compliance Date	4/5/2013

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0005	A. BUILDING: _____ B. WING _____	02/21/2013

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 052	Continued From page 14 consistently assess and monitor the status of an alteration in skin integrity. A nurse ' s entry dated December 31, 2012 read: " New (1st recording) for Site - 352. Present on the Coccyx is a skin tear/laceration. The following findings were documented, general comments: This abnormality was recorded using an assessment other than skin & wound during a body check. " The clinical record lacked evidence of status of the skin alteration of the coccyx initially identified on December 31, 2012. An observation of the resident ' s skin on February 19, 2013 at approximately 11:30 AM lacked evidence of an alteration of the skin of the coccyx. A face-to-face interview was conducted with Employee #4 on February 19, 2013 at approximately 9:30 AM; he/she acknowledged that the record lacked evidence of the status of the resident ' s alteration in skin integrity identified December 31, 2012. However, he/she stated that the resident ' s skin was intact at present. 4A. Facility staff failed ensure that sufficient nursing time was provided to identify the type of device that was inserted for Resident #252 ' s Intravenous access site. The " Central Venous Catheter-Physician Order Sheet " dated and signed by the physician on October 29, 2013 directed, " Device Type: PICC (peripherally inserted central catheter): brand, gauge, and total length " was left blank.	L 052	Resident # 205 1. Resident's skin was intact during survey process. The licensed nurse that failed to document ongoing assessments of the resident's skin received counseling and education as to the process of documenting assessments of resident's skin. 2. All residents with skin conditions will be placed on Open Chart Protocol until the skin condition is resolved. All licensed nurses will receive educational review of the Open Chart Protocol. 3. All residents will have their skin assessed by a licensed nurse weekly and documentation of the assessment placed in the Electronic Medical record whether the skin is positive or negative for variances in the residents' skin. 4. The weekly skin assessments will be audited weekly by the Nurse Manager or their designee using Administrative Report function of the Electronic Medical Record and a summary forwarded weekly to the Quality Improvement Manager. All Nurse Managers will summarize the report for weekly submission to the Quality Improvement Manager. 5. Date of Compliance	4/5/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0005	A. BUILDING: _____ B. WING _____	02/21/2013

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 052	Continued From page 15 There was no evidence that facility staff identified the Device type information (listed above) on the Central Venous Catheter-Physician Order Sheet to identify the type of IV device used for Resident # 252. A face-to-face interview was conducted with Employee #7 on February 21, 2013 at approximately 11:08 AM. He/she acknowledged that the device information was not listed on the " Central Venous -Physician Order Sheet " . The record was reviewed on February 21, 2013. 4B. Facility staff failed ensure that sufficient nursing time was provided to consistently conduct a comprehensive pain assessment for Resident #252 who was in pain and received pain medication. The "Physician ' s Order " dated and signed November 4, 2012 directed, "Oxycodone IR (instant release) 5mg- Take [one] 1 tablet by mouth every [four] 4 hours as needed for mild pain. Oxycodone IR 5mg- Take [two] 2 tablets by mouth every [four] 4 hours as needed for severe pain. " The November 2012 Medication Administration Record (MAR) revealed that Oxycodone IR 5mg one (1) tablet was administered on November 5 (at 5:00 PM and 10:00 PM), 8, 9, 25, and 26 for mild pain. The November 2012 Medication Administration	L 052	Resident # 252 1. The resident sustained no harm. The licensed nursing receiving the physician's order for the PICC line was educated as to how the Central Venous Catheter Physician Order Sheet should be reviewed for completeness. 2. All licensed nurses will receive education as to how the Central Venous Catheter Physician Order Sheet is to be reviewed for completeness once physician orders are received indicating the usage of a PICC line by a resident. 3. All licensed nurses will receive education about Central Line protocol and usage of the Central Venous Catheter Physician Order Sheet. Once a physician order has been obtained designating the need for a Central Line, the Nurse Manager or their designee within 72 hours of the receipt of the order, will audit the Central Line Physician Order Sheet and Central Line TAR for completeness and variances will be corrected. 4. The Central Line TAR and Central Venous Catheter Physician Order Sheet will be listed on the Nurse Manager Medical Record Audit Tool, completed monthly by the Nurse Managers.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0005	A. BUILDING: _____ B. WING _____	02/21/2013

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 052	Continued From page 16 Record (MAR) revealed that Oxycodone IR 5mg two (2) tablets were administered on November 2, 8 (at 3:00 AM and 11:30 AM), 14, 15, 16, 17, 18, 19, 20, 22 (at 11:30 AM and 11:30 PM), 24 26, 29, 30 (at 12:00 AM 5:30 AM, 1:30 PM for severe pain. There was no evidence that facility staff consistently conducted an assessment that included a description of the location of the pain; the intensity of the pain (e.g. numeric scale) before to determined whether to administer one or two tablets of Oxycodone; and there was no evidence that an assessment was completed after the administration of Oxycodone IR 5 mg for mild or severe pain. A face-to-face interview was conducted with Employee #7 on February 21, 2013 at approximately 11:08 AM. He/she acknowledged that the pain assessment was not consistently completed to include the location and the intensity of the pain before the pain medication was administered and after pain medication was administered to determine the effectiveness. The record was reviewed on February 21, 2013. 5. Facility staff failed ensure that sufficient nursing time was provided to consistently conduct a complete pain assessment for Resident #273 who was in pain and received pain medication. The "Physician ' s Order " dated and signed February 8, 2013 directed, "Oxycodone IR (instant release) 5mg- Take [one] 1 tablet by mouth every [four] 4 hours as needed for pain. "	L 052	The Medical Record Audit Tool is submitted monthly to the Quality Improvement Manager: variances will be corrected at the time of the audit and/or discussed at the weekly Focus Quality Improvement Committee. 5. Compliance Date <u>Resident #252 and Resident #273</u> 1. The residents sustained no harm: both received pain medication as per physician orders. The licensed nurse(s) received education on Pain Management Protocol which included the use of a pain scale and using the scale to document the severity of a resident's pain prior to and following the administration of pain medication. 2. During the survey process licensed nurses received education on Pain Management Protocol which included the use of a pain scale and using the scale to document the severity of a resident's pain prior to and following the administration of pain medication. 3. All licensed nurses will receive education on Pain Management Protocol including the use of a pain scale and using the scale to document the severity of a resident's pain prior to and following the administration of pain medication. The use of a pain scale prior to and following the administration of pain medication will	4/5/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0005	A. BUILDING: _____ B. WING _____	02/21/2013

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 052	Continued From page 17 The February 2013 Medication Administration Record (MAR) revealed that Oxycodone IR 5mg was given on February 1, 5, 6, 7, 10, 11, 12 (at 3:00 AM and 4:20 PM), 13, 14 at (4:00 AM and 11:35 PM), 15 (at 2:50 PM and 11:50 PM), 17, 18, and 19 for pain. There was no evidence that facility staff consistently conducted an assessment that included a description of the location of the pain, the intensity of the pain (e.g. numeric scale) before and after the administration of Oxycodone IR 5 mg. A face-to-face interview was conducted with Employee #7 on February 20, 2013 at approximately 10:50 AM. He/she acknowledged the aforementioned findings. The record was reviewed on February 20, 2013. **6. Facility staff failed ensure that sufficient nursing time was provided to measure the arm circumference and the external catheter length for Resident #286 ' s Intravenous access site.** The " Central Venous Catheter -Physician Order Sheet " . dated and signed by the physician on January 23, 2013 directed, " Device Type: PICC (peripherally inserted central catheter): brand, gauge, and total length " was left blank failing to identify the aforementioned information about the device type on the order sheet. Treatment orders: PICC catheters: Measure upper arm circumference (3 in [inches] or 10 cm [centimeters] above insertion site) on admission, with dressing change and PRN [as needed] ... "	L 052	be added to the Nurse Manager Medical Record Audit Tool: the tool is completed monthly and will be submitted to the Quality Improvement Manager 4. Pain Management Protocol will be added to the annual Medication Administration Competency that is part of the facility Quality Improvement initiative: the competency is administered annually to all clinical licensed nurses. The use of a pain scale prior to and following the administration of pain medication will be added to the Nurse Manager Medical Record Audit Tool: the tool is completed monthly and will be submitted to the Quality Improvement Manager 5. Compliance Date <u>Resident # 286</u> 1. The resident did not sustain any harm. The licensed nurse(s) received education as to how follow the Central Venous Line Protocol for PICC lines on the Central Venous Line TAR: including resident arm circumference measurement. 2. All licensed nurses will receive education as to how the Central Venous Line TAR is to be reviewed for completeness.	4/5/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0005	A. BUILDING: _____ B. WING _____	02/21/2013

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 052	Continued From page 18 A review of the January 2013 Central line Catheter Treatment Record and Medication Administration Record revealed that on January26th the Resident's arm circumference was 35 cm and the external catheter length was 10 cm. The " Central Venous Catheter-Physician Order Sheet " dated February 1, 2013 directed, " Device Type: PICC: brand, gauge, and total length was left blank failing to identify the aforementioned information about the device type on the order sheet. Treatment orders: PICC catheters: Measure upper arm circumference (3 in [inches] or 10 cm [centimeters] above insertion site) on admission, with dressing change and PRN [as needed] ... Measure external catheter length on admission, with each dressing change and prn ... " A review of the February 2013 Central line Catheter Treatment Record and Medication Administration Record revealed that on February 2 and 9 Resident ' s arm circumference was not measured. There was no evidence of Resident #286 ' s arm circumference was measured in accordance with the physician ' s order on admission, January 23, 2013 and the arm circumference and the external catheter length on February 2 and 9, 2013. A face-to-face interview was conducted with Employee #7 on February 19, 2013 at approximately 11:45 AM. He/she acknowledged	L 052	3. All licensed nurses will receive education about Central Line protocol and usage of the Central Venous Line TAR. Once a physician order has been obtained designating the need of a Central Line, the Nurse Manager or their designee within 72 hours of the receipt of the order, will audit the Central Line Physician Order Sheet and Central Line TAR for completeness and variances will be corrected. 4. The Central Line TAR and Central Venous Catheter Physician Order Sheet will be an item listed on the Nurse Manager Medical Record Audit Tool completed monthly by the Nurse Managers. The Medical Record Audit Tool will be submitted monthly to the Quality Improvement Manager: variances will be corrected at the time of the audit and/or discussed at the monthly at the Focus Quality Improvement Committee. 5. Compliance Date	4/5/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0005	A. BUILDING: _____ B. WING _____	02/21/2013

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 CORREGTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 19 that the arm circumference and the length of the external catheter were not measured. The record was reviewed on February 19, 2013. 7. Facility staff failed ensure that sufficient nursing time was provided to ensure Resident #292 received the incentive spirometer treatments as prescribed. Resident #292 was admitted to the facility on February 6, 2013 with a diagnosis that included status post CABG (Coronary Artery Bypass Graft). The admission orders signed and dated by the physician on February 8, 2013 directed, " Use the incentive spirometer every 1-3 hours while awake until normal activity is resumed. " A review of the February 2013 Treatment Administration Record revealed that the order, " Use the incentive spirometer every 1-3 hours while awake until normal activity is resumed. " was transcribed for frequency as FYI (for your information). " There was no evidence in the clinical record that facility staff carried out the order for the resident to use the incentive spirometer every one (1) to three (3) hours. A face-to-face interview was conducted on February 20, 2013 at 10:25 AM with Employee #22. He/she stated, " We test the resident ' s oxygen levels each day during therapy. On evaluation [he/she] did the incentive spirometer. We discussed it daily. I instructed [him/her] to do it every commercial break. I made sure [he/she]	L 052	Resident # 292 1. Resident did not sustain any harm and has been discharged from the facility. The licensed nurse received education on proper documentation of a physician treatment order onto the TAR. 2. All licensed nurses will receive education on documentation protocol and transcription of a physician's order onto the residents' TAR to show treatment is administered to residents. 3. The Nurse Manager or designee will audit all resident TARs weekly for accurate documentation of resident treatments. 4. Auditing of accurate documentation on resident TARs will be part of the Nurse Manager Medical Record Audit Tool and the Medical Record Audit Tool will be submitted monthly to the Quality Improvement Manager: variances will be corrected at time of audit and/or discussed monthly at the Focus Quality Improvement Committee. 5. Compliance Date	4/5/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0005	A. BUILDING: _____ B. WING _____	02/21/2013

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 052	Continued From page 20 knew how to do it and understood the instructions." A face-to-face interview was conducted on February 20, 2013 at 11:10 AM with Employee #21. He/she stated, " You could hear the whistling when [he/she] was using it. I was in the room with [him/her] when [he/she] used it. I didn ' t look at the numbers on it [the spriometer]. I didn ' t document him/her using it [the incentive spirometer]. A face-to-face interview was conducted on February 20, 2013 at 11:00 AM with Employee #7. He/she acknowledged that the there was no evidence that the order for the use of the spirometer was carried out. Additionally, at the time of this review the resident had been readmitted to the hospital with Pneumonia. The record was reviewed on February 20, 2013. C. Based on observation, record review and interviews for one (1) of 41 sampled residents, it was determined that facility staff failed ensure that sufficient nursing time was provided to ensure that Resident #164 received adequate services /supervision as to promote safe swallowing during a medication administration observation. The findings include: On February 13, 2013 at 9:50 AM a medication administration observation was conduct. Employee # 19 was observed administering oral medications to Resident #164. While at the bedside of the resident, Employee #19	L 052	**L052 (C)** Resident # 164 1. Resident # 164 suffered no harm, no swallowing difficulties occurred. Immediate education was done with the licensed nurse as to their noncompliance with the resident's need for thickened liquids and a review of the facility Thickened Liquids Policy. A care plan to address the resident's swallowing impairment has been added to the Medical Record. 2. Upon receiving a physician's order to have a resident receive Thickened Liquids and or swallowing impairment, the licensed nurse that receives the order will add care plans for both needs in the resident's Medical I Record. All residents requiring Thickened Liquids will have their MAR amended to alert licensed nurses that thickened liquids are to be administered with all medications as well as with all meals. All licensed nurses will receive education regarding the labeling of the MAR of residents receiving thickened liquids and a review of the Thickened Liquids Policy. All licensed nurses will receive education regarding the immediate need to add care plans reflecting swallowing impairment and/or need for Thickened Liquids to residents Medical Record.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0005	A. BUILDING: _____ B. WING _____	02/21/2013

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 052	Continued From page 21 administered medications which included Calcium Carbonate one (1) tablet, Neurontin 100mg two (2) tablets, and Xifaxan one (1) tablet. The Employee gave Resident #164 approximately 50 ml of cranberry juice in a cup with a straw for the resident to swallow his/her medication. The resident drank the cranberry juice by sipping it from the straw. Observed on Resident #164 ' s over-the-bed table was one (1) packet of Instant Food Thickener and one (1) container of Thick and Easy pre-thickened beverage. At no time did Employee # 19 mix the thickener with the cranberry juice that was given to Resident #164 to drink while taking his/her medications. According to the History and Physical dated May 4, 2012 Resident #164 had a diagnosis which Multiple Sclerosis. A review of the physician orders signed and dated February 5, 2013 directed, · " Mechanical soft foods-nectar thicken liquids at all meals. " A review of the Functional Maintenance Program-recommendations dated October 22, 2012 revealed, " Referral to restorative nursing for ...cue as needed for adherence to safe swallow strategies/aspiration precautions and required diet/liquid consistencies... " A review of the Nutritional Assessments dated November 12, 2012 and February 13, 2013 revealed, " Current diet order- Mech (mechanical soft, nectar thick, NCS (no	L 052	3. The facility Thickened Liquids policy will be amended to reflect the labeling of the MAR of all residents receiving thickened liquids. All licensed nurses will receive education regarding the amendment to the Thickened Liquids policy. When a resident receives an order for Thickened Liquids, the licensed nurse receiving the order will label the MAR of the resident to reflect the resident's need for thickened liquids during medication administration as well as during meals. Within 72 hours following the physician's order for a resident to receive thickened liquids the Nurse Manager or their designee will audit the residents' MAR to ensure the MAR has been labeled to show the resident's need for thickened liquids and to ensure care plans for swallowing impairment and/or thickened liquids has been added to the Medical Record. The Nurse Manager will receive education regarding the audit process of the resident's MAR.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0005	A. BUILDING: _____ B. WING _____	02/21/2013

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 052	Continued From page 22 concentrated sweets)" A review of the Care Plans printed by the facility and those located on the active clinical record revealed that there was no care plan with goals and approaches to address the resident ' s swallowing impairment or potential for aspiration. A face-to-face interview was conducted on February 20, 2013 at 10:02 AM with Employee #19. He/she stated, " I did not give the resident thickener in [his/her] juice. His/her care plan was not updated. The kitchen brings the thickener to him/her. I wanted the doctor to clarify the problem but he/she wasn ' t here that day. The next day I was off (not scheduled to work), I did not give report on it (the use of thickener for Resident #164). I have not spoken to the doctor. I speak with [him/her] today. " facility staff failed ensure that sufficient nursing time was provided to ensure that adequate service/supervision was provided to promote safe swallowing during a medication administration observation. D.Based on record review and staff interview for two (2) of 41 sampled residents, it was determined that facility staff failed ensure that sufficient nursing time was provided to ensure that residents were free from unnecessary drugs as evidenced by: failure to clarify two (2) physician 's orders for pain medication, and failed to determine under which condition/s each	L 052	4. The labeling of the MAR of a resident receiving thickened liquids to show the resident must receive thickened liquids during medication administration as well as meals, will be added as an item to the monthly Medical Record Audit Tool completed by Nurse Managers. The addition of care plans for swallowing impairment and/or thickened liquids to the Medical Record will be added as an item to the monthly Medical Record Tool completed by the Nurse Manager. The Nurse Managers will submit the Medical Record Audit Tool to the Quality Improvement Manager on a monthly basis. The Quality Improvement Manager will report variances monthly to the Focus Quality Improvement Committee. 5. Compliance Date	4/5/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0005	A. BUILDING: _____ B. WING _____	02/21/2013

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 052	Continued From page 23 medication was to be administered for one (1) resident; and facility staff administered an antihypertensive medication outside of the prescribed parameters for one (1) resident. Residents #4 and 286. The findings include: 1. Facility staff failed ensure that sufficient nursing time was provided to determine under which condition/s each pain medication was to be administered to Resident #4. A review of a Physician ' s Order Form for February, 2013 signed and dated January 23, 2013 revealed two orders for pain medications under the heading of " PRN (As needed) medications. The first order was "Acetaminophen 325mg 2 tabs (tablets) (650mg) by mouth every four hours as needed for pain..." The second order was "Oxycodone-APAP (n=Acetyl Para Amino Phenol) 5mg/325mg 2 tabs by mouth every 6 hours as needed for pain..." A review of the Medication Administration Record (MAR) for February 2013 revealed that the Acetaminophen was not administered. The Oxycodone was administered 10 times between February 1 and February 18, 2013; once on February 1, 4, 5, 6, 10, 12, 14 and 18 and twice on February 15, 2013. A review of the back of the February 2013 MAR revealed the nurses' signatures for the administration of the Oxycodone. The nurses documented the sites of the pain in nine (9) of the 10 instances of administration. The level of	L 052	**L052 (D)** Resident # 4 1. Resident sustained no harm. The licensed nurse received education on the facility Pain Management/Pain Assessment Protocol including recommendations to the physician to specify parameters when two different pain medications are ordered for residents. 2. All licensed nurses received education on Pain Management/Pain Assessment Protocol which included recommendations to the physician to specify parameters when two different pain medications are ordered for residents. 3. All licensed nurses will receive education on Pain Management/Pain Assessment Protocol including recommendations to the physician to specify parameters when two different pain medications are ordered for residents. An audit of residents' MARS who receive pain medications will be an item added to the Nurse Managers Medical Record Audit Tool and will be reviewed monthly by the Nurse Managers. The Medical Record Audit Tool will be submitted monthly to the Quality Improvement Manager.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0005	A. BUILDING: _____ B. WING _____	02/21/2013

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 052	Continued From page 24 the pain and the effectiveness were documented in three (3) of the 10 instances when the medication was administered. A review of the "Pain Management" Policy, Item number Six (6) under " Pain Assessment " indicated that " Pain assessment includes quantitative and qualitative rating and description using pain scale with 0 - 5 (zero to five) rating." A face-to-face interview was conducted with Employee #6 at approximately 3:15PM on February 20, 2013. The employee was queried regarding the two orders of pain medications prescribed for the resident and the fact that only one medication has been administered. The employee stated that the resident does not want the Tylenol. The employee added, " We should have notified the physician and asked him/her to discontinue it. " With regard to rating and documenting the level of pain the employee stated, " I will review the Pain Management /Pain Assessment Policy with the Charge Nurses. " The record was reviewed on February 20, 2013. Facility staff failed to determine under which condition/s each pain medication was to be administered and to document the level of the pain prior to administering pain medication and the level of effectiveness after the resident was medicated. 2. Facility staff failed ensure that sufficient nursing time was provided to adminitstered antihypertensive medication outside of the prescirbed parameters for Resident #286. The Admission orders signed and dated January 23, 2013 directed, " Lasix 40 mg one (1) tab	L 052	Pain Management/Pain Assessment Protocol will be added to the annual Medication Administration Competency that is part of the facility Quality Improvement initiative: the competency is administered annually to all clinical licensed nurses. 4. An audit of residents' MARS who receive pain medications will be an item added to the Nurse Managers Medical Record Audit Tool and will be reviewed monthly by the Nurse Managers. The Medical Record Audit Tool will be submitted monthly to the Quality Improvement Manager. The Medical Record Audit Tool will be reviewed at the Focus Quality Improvement Committee. 5. Compliance Date	4/5/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0005	A. BUILDING: _____ B. WING _____	02/21/2013

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 052	Continued From page 25 (tablet) orally daily for heart failure. " The Interim Order dated January 29, 2013 directed, " Hold Lasix for SBP (systolic blood pressure) 110 or less. " A review of the Medication Administration Record for January and February 2013 revealed: The resident ' s blood pressure reading on February 12 was 110/66 and on February 17 the reading was 110/58. On both days the lasix was administered when it should have been held in accordance with the prescribed parameters set by the physician. There was no evidence that facility staff administered Lasix 40mg in accordance with the prescribed parameters for Resident #286. A face-to-face interview was conducted on February 19, 2013 at 11:45 AM with Employee #7. He/she acknowledged that the blood pressure medication was not administrated within the order parameters. The record was reviewed on February 19, 2013.	L 052		
L 056	3211.5 Nursing Facilities Nursing personnel, licensed practical nurses, nurse aides, orderlies, and ward clerks shall be assigned duties consistent with their education and experience and based on the characteristics of the patient load. This Statute is not met as evidenced by: Based on a review of the facility ' s staffing records for the period of February 9 through 11, 2013, it was determined that the facility failed to meet the minimum daily average of direct	L 056		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0005	A. BUILDING: _____ B. WING _____	02/21/2013

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 056	Continued From page 26 nursing care per resident per day for two (2) of three (3) days reviewed. The findings include: A review of the facility ' s staffing records for the period of February 9 through 11, 2013 revealed that the facility failed to meet the required 0.6 hours of direct nursing care provided by registered nurses (RN) or advanced practice registered nurses. On February 9, 2013 it was determined that the facility provided insufficient RN coverage at a rate of 0.34 hours. On February 10, 2013 it was determined that the facility provided insufficient RN coverage at a rate of 0.39 hours. The findings were determined on February 21, 2013 at 11:30 AM during a concurrent review of records with Employee #2. Employee #3 acknowledged the findings and stated that the staffing was reflective of weekend coverage and the facility was currently recruiting qualified staff.	L 056	**L056** Through attrition all licensed nurse positions vacated by Licensed Practical Nurses are converted to Registered Nurse positions. Active recrutiment is in progress to attract qualified Registered Nurses into open positions. Open Houses have been utilized, aggressive advertisement, detailed orientation programs have been designed to attract newly licensed Registered Nurses into open RN positions. 1. Resident care has not been delayed. 2. Resident care has not been delayed. Facility has utilized Open Houses, aggressive advertisement geared toward Registered Nurses has been utilized. 3. The facility has invested in a progressive, detailed orientation program (2 months in length) for newly graduated Registered Nurses: a select qualified, few are admitted to the program quarterly if there is anopen position. 4. Retention of all licensed nurses is monitored quarterly through the Quality Improvement Committee 5. Compliance Date	On-going
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 made during a tour of Dietary Services on February 19, 2013 at approximately 10:15 AM, it was determined that the facility failed to store, prepare and serve food	L 099		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0005	A. BUILDING: _____ B. WING _____	02/21/2013

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 099	Continued From page 27 under sanitary conditions as evidenced by: Four (4) of four (4) hotel pans and 14 of 21 sheet pans that were stored wet and ready for reuse, one (1) of one (1) cutting board was observed with an indentation, and two (2) of two (2) convention ovens were observed soiled. The findings include: The following was observed during a tour of the main kitchen: 1. Four (4) of four (4) 4 inch hotel pans were stored wet and ready for reuse 2. 14 of 21 sheet pans were stored wet and ready for reuse 3. A white cutting board was observed with an indentation in one (1) of one (1) observed 4. Two (2) of two (2) convention ovens were observed with soiled interiors These observations were made in the presence of Employee # 20. Based on observations made during a tour of Dietary Services on February 19, 2013 at approximately 10:15 AM, it was determined that the facility failed to store, prepare and serve food under sanitary conditions as evidenced by: Four (4) of four (4) hotel pans and 14 of 21 sheet pans that were stored wet and ready for reuse, one (1) of one (1) cutting board was observed with an indentation, and two (2) of two (2) convention ovens were observed soiled. The findings include:	L 099	**L099** Hotel pans 1. The four (4) pans were immediately re-washed and dried per policy. 2. No other pans were stored in similar condition. 3. 100% of the staff will be in-serviced on the proper dish room policy. 4. Appropriate hotel pan storage added to the opening and closing checklist. This will be monitored by the director daily. A summary of daily findings will be reported to QI Committee monthly. 5. Date of Compliance Sheet pans 1. Pans were immediately rewashed and dried per policy. 2. These were the only pans identified in cited condition. 3. Appropriate hotel pan storage added to the opening and closing checklist. This will be monitored by the director daily. A summary of daily findings will be reported to QI Committee monthly. 5. Date of Compliance	3/22/2013 3/22/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0005	A. BUILDING: _____ B. WING _____	02/21/2013

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 099	Continued From page 28 The following was observed during a tour of the main kitchen: 1. Four (4) of four (4) 4 inch hotel pans were stored wet and ready for reuse 2. 14 of 21 sheet pans were stored wet and ready for reuse 3. A white cutting board was observed with an indentation in one (1) of one (1) observed 4. Two (2) of two (2) convention ovens were observed with soiled interiors These observations were made in the presence of Employee # 20.	L 099	Cutting board 1. The cutting board was immediately discarded. 2. No other cutting board was identified with an indentation. 3. All staff will be in-serviced to bring damaged cutting boards to management team. 4. Inspection of cutting boards added to Monthly Safety and Sanitation Audit. Audit findings will be reported to QI Committee quarterly. 5. Date of Compliance Ovens 1. Two of two ovens were immediately cleaned and soiled particles removed. 2. No other ovens were observed with soiled particles. 3. Although ovens are not used, they will be added to the weekly cleaning list. 4. Inspection of convention ovens will be added to the opening and closing check list. This will be monitored by Food Services Director weekly and findings reported to QI Committee quarterly. 5. Date of Compliance	3/22/2013 3/22/2013
L 161	3227.12 Nursing Facilities Each expired medication shall be removed from usage. This Statute is not met as evidenced by: Based on an observations during medication storage review, it was determined that facility staff failed to ensure that intravenous (IV) fluids were not stored beyond the expiration date. The findings include: 1. One (1) of six (6) 5% Dextrose and 0.9% Sodium Chloride Injection USP 1000ml had an expiration date of January, 2013 and was stored for use. 2. One (1) of two (2) 10% Dextrose Injections 1000 ml had an expiration date of November, 2012 and was stored for use. These observations were made in the presence	L 161		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0005	A. BUILDING: _____ B. WING _____	02/21/2013

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 161	Continued From page 29 of Employee #7 at 4:15PM on February 15, 2013 on Unit 3B.	L 161	**L161** 1. On 11/29/2012, confirmed that there were 2 bags of Dextrose 10% and 2 bags of 5%Dexrose 0.9% Sodium Chloride in the Omnicell. There were no transactions with these items until 2/18/2013 when one bag of each were removed because they were expired. Therefore, no residents were affected. 2. The Omnicell Technician checked the Omnicell for expired medications. There were no expired medications present in the Omnicell. 3. An Omnicell Technician will continue to check the Omnicell contents for expired medications at least once quarterly. Expired is defined as any medication with an expiration date that is within (4) four months from the date of inspection. When expired medication is identified, the Omnicell Technician will run an "Expiry Inventory Report" from the Omnicell . Once completed, the Omnicell Technician will place all expired medication in an "Omnicare Return to Pharmacy" bag. The Omnicell Technician will locate a Nursing Supervisor to review the findings of the inspection. The Omnicell Technician will sign the "Expiry Inventory Report" and the Nursing Supervisor will sign the form to indicate receipt of the expired	
L 306	3245.10 Nursing Facilities A call system that meets the following requirements shall be provided: (a)Be accessible to each resident, indicating signals from each bed location, toilet room, and bath or shower room and other rooms used by residents; (b)In new facilities or when major renovations are made to existing facilities, be of type in which the call bell can be terminated only in the resident's room; (c)Be of a quality which is, at the time of installation, consistent with current technology; and (d)Be in good working order at all times. This Statute is not.met as evidenced by: Based on observations and staff interview for five (5) of five (5) resident rooms observed, it was determined that facility staff failed to ensure that the call system in five (5) residents' rooms were functioning to allow communication from the residents to the nurses' station. The findings include: 1. Facility staff failed to ensure that the call bell system in the residents' rooms and/or bathrooms were functioning properly.	L 306		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0005	A. BUILDING: _____ B. WING _____	02/21/2013

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 306	Continued From page 30 The call bell in Room #230 did not initiate an audible alarm when tested in one (1) of one (1) resident's room observed on February 14, 2013 at approximately 12:25 PM. Employee #6 stated, "the staff probably pulled the call bed cord to reach where the resident was sitting, and this loosened the cord from the wall outlet." Subsequently, the call bell was removed and re- inserted into the wall outlet, which initiated an alarm to the nursing station. 2. Facility staff failed to ensure that the call bell system in the residents' rooms and/or bathrooms were functioning properly in three (3) of five (5) rooms observed. 2A. A resident room observation was conducted on February 13, 2013 at approximately 3:19 PM on Unit 3A in Room 305. The following was observed: When the residents ' call bell was activated (pressed) in the room, the call bell would not sound at the nurses ' station, nor would the light (outside of the room over the door) light up. When an attempt was made to answer the resident from the nurses ' station, the audible voice was not heard in the room. Employee #31 made an attempt to readjust the call bell, but was still unsuccessful in getting the call bell to function properly. This observation was made in the presence on Employee #30 and Employee #31.	L 306	medications from the Omnicell as well as the facility's responsibility to provide the Omnicare Courier the "Omnicare Return to Pharmacy" bag. The Omnicell Technician will keep the original and a copy will be made for the Facility. Once the contents are verified by the Nursing Supervisor, the Omnicell Technician will seal the bag, both will sign over the seal and the Omnicell Technician will give the bag to the Nursing Supervisor. 4. Upon receipt of the expired medications at Omnicare Pharmacy of Annapolis Junction, the Omnicell Technician will verify the contents with the "Expiry Inventory Report" signed by the Nursing Supervisor and the Omnicell Technician. If there are any discrepancies, the Omnicell Technician will notify the Director of Nursing. The Omnicell Technician will provide a report for the Quarterly Quality Improvement meeting attended by representatives of Omnicare Pharmacy, Annapolis Junction. 5. Compliance Date	3/22/2013

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0005	A. BUILDING: _____ B. WING _____	02/21/2013

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 306	Continued From page 31 2B. A resident room observation was conducted on February13, 2013 at approximately 4:26 PM on Unit 3A in Room #323. The following was observed: When the resident ' s call bell was activated (pressed) in the room, the bell would sound at the nurses ' station. When an attempt was made to answer the resident from the nurses ' station, the audible voice was not heard in the room. When the bathroom call bell was pulled, the red light (over the door outside of the room) would not light up to signal for assistance needed in the bathroom. These observations were made in the presence of Employee #32. 2C. A resident room observation was conducted on February14, 2013 at approximately 10:40 AM on Unit 3A in Room 334. The following was observed: The residents' call bell did not activate in the room when pressed. Employee #30 made an attempt to answer the call bell from the nurses ' station, the voice was not audible in room. Employee #16 was also present at the time of the observation. Employee #30 indicated to Employee #16 that the only way he/she knew the call bell was pressed , is that he/she looked at the system at the front desk and noticed the light blinking, it did not sound at the nurses ' station either.	L 306	**L306** #1 1. Call bell was removed and re- inserted into the wall outlet, which initiated an alarm to the nursing station as of 2/14/13. 2. Clinical leadership to meet with plant operations leadership to delineate responsibilities regarding working conditions of call bells. Maintenance staff repairs system failures once they are reported by clinical staff. 3. Call bells will be tested weekly during multi-disciplinary environmental rounds. 4. Findings to be reported to monthly to QI Committee 5. Date of Compliance #2A 1. Call bell was checked, reinserted and found to be operational as of 02/13/13 2. Call bells inserted incorrectly will prevent activation of bells, lights and audible capabilities from nurse station to resident room and back. Clinical leadership to meet with plant operations leadership to delineate responsibilities regarding working conditions of call bells. Maintenance staff repairs system failures once they are reported by clinical staff.	4/5/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0005	A. BUILDING: _____ B. WING _____	02/21/2013

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 306	Continued From page 32 When the bathroom light was activated, the red light outside of room (over the door) did not light up, although audible in the bathroom when answered. The observation was made in the presence of Employee #16 and #30. 2D. A resident room observation was conducted on February14, 2013 at approximately 11:09 AM on 3A in Room 307. The following was observed: The residents ' call bell did not activate in the room when pressed, when Employee #32 made an attempt to answer the call bell from the front desk, the voice was not audible in room. The resident light did not light up (outside of the room over the door) 2E. A resident room observation was conducted on February14, 2013 at approximately 12:02 PM on Unit 3A in Room #332. The following was observed: When the residents' call bell (cord) was pulled in the bathroom, the light would activate, when Employee #30 answered the call bell from the nurses station, the response was not audible in room 332, the audibility was heard in the room next door to room 332 (334). The observations were made in the presence of Employees #16 and #30.	L 306	3. Call bells will be tested weekly during multi-disciplinary environmental rounds. 4. Findings to be reported to monthly to QI Committee 5. Date of Compliance #2B 1. Call bell repaired as of 02/13/13. 2. Clinical leadership to meet with plant operations leadership to delineate responsibilities regarding working conditions of call bells. Maintenance staff repairs system failures once they are reported by clinical staff. 3. Call bells will be tested weekly during multi-disciplinary environmental rounds. 4. Findings to be reported to monthly to QI Committee. 5. Date of Compliance #2C 1. Call bell repaired as of 2/14/13. 2. Call bells inserted incorrectly will prevent activation of bells, lights and audible capabilities from nurse station to resident room and back. Clinical leadership to meet with plant operations leadership to delineate responsibilities regarding working condition of call bells. Maintenance staff repairs system failures once they are reported by clinical staff.	4/5/2013 4/5/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0005	A. BUILDING: _____ B. WING _____	02/21/2013

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 306	Continued From page 33 Based on observations and staff interview for five (5) of five (5) resident rooms observed, it was determined that facility failed to ensure that the call system in five (5) residents' rooms were functioning to allow communication from the residents to the nurses' station. The findings include: 1. The facility failed to ensure that the call bell system in the residents' rooms and/or bathrooms were functioning properly. The call bell in Room #230 did not initiate an audible alarm when tested in one (1) of one (1) resident's room observed on February 14, 2013 at approximately 12:25 PM. Employee #6 stated, "the staff probably pulled the call bed cord to reach where the resident was sitting, and this loosened the cord from the wall outlet." Subsequently, the call bell was removed and re- inserted into the wall outlet, which initiated an alarm to the nursing station. 2. The facility failed to ensure that the call bell system in the residents' rooms and/or bathrooms were functioning properly in three (3) of five (5) rooms observed. 2A. A resident room observation was conducted on February 13, 2013 at approximately 3:19 PM on Unit 3A in Room 305. The following was observed: When the residents ' call bell was activated	L 306	3. Call bells will be tested weekly during multi-disciplinary environmental rounds. 4. Findings to be reported to monthly to QI Committee 5. Date of Compliance #2D 1. Call bell was repaired as of 2/14/13. Call bells inserted incorrectly will prevent activation of bells, lights and audible capabilities from nurse station to resident room and back. Clinical leadership to meet with plant operations leadership to delineate responsibilities regarding working condition of call bells. 2. Maintenance staff repairs system failures once they are reported by clinical staff. 3. Call bells will be tested weekly during multi-disciplinary environmental rounds. 4. Findings to be reported to monthly to QI Committee 5. Date of Compliance #2E 1. System tested and found to be operational as of 02/14/13. 2. Resident call bells in restrooms do not have the audible function. Call bells in shared resident restrooms sound in either of the shared resident rooms.	4/5/2013 4/5/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0005	A. BUILDING: _____ B. WING _____	02/21/2013

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 306	Continued From page 34 (pressed) in the room, the call bell would not sound at the nurses ' station, nor would the light (outside of the room over the door) light up. When an attempt was made to answer the resident from the nurses ' station, the audible voice was not heard in the room. Employee #31 made an attempt to readjust the call bell, but was still unsuccessful in getting the call bell to function properly. This observation was made in the presence on Employee #30 and Employee #31. 2B. A resident room observation was conducted on February13, 2013 at approximately 4:26 PM on Unit 3A in Room #323. The following was observed: When the resident ' s call bell was activated (pressed) in the room, the bell would sound at the nurses ' station. When an attempt was made to answer the resident from the nurses ' station, the audible voice was not heard in the room. When the bathroom call bell was pulled, the red light (over the door outside of the room) would not light up to signal for assistance needed in the bathroom. These observations were made in the presence of Employee #32. 2C. A resident room observation was conducted on February14, 2013 at approximately 10:40 AM on Unit 3A in Room 334. The following was	L 306	This is the design of the system. No malfunction noted. 3. Call bells will be tested weekly during multi-disciplinary environmental rounds. 4. Findings to be reported to monthly to QI Committee 5. Date of Compliance **L362** 1. Personal refrigerators in resident rooms 229 and 137 were inspected and tagged by maintenance staff as of 2/20/13. 2. Clinical leadership will communicate to maintenance staff when new electrical equipment arrives on units, prior to being placed in service, so that maintenance staff can conduct timely safety/electrical checks. 3. Resident rooms' stands are inspected daily by Environmental Services Team leaders/ Supervisors. Follow-up inspections will be conducted weekly by the Plant Operations Management team. 4. Findings to be reported quarterly to QI Committee. 5. Compliance Date	4/5/2013 4/5/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0005	A. BUILDING: _____ B. WING _____	02/21/2013

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 306	Continued From page 35 observed: The residents' call bell did not activate in the room when pressed. Employee #30 made an attempt to answer the call bell from the nurses ' station, the voice was not audible in room. Employee #16 was also present at the time of the observation. Employee #30 indicated to Employee #16 that the only way he/she knew the call bell was pressed , is that he/she looked at the system at the front desk and noticed the light blinking, it did not sound at the nurses ' station either. When the bathroom light was activated, the red light outside of room (over the door) did not light up, although audible in the bathroom when answered. The observation was made in the presence of Employee #16 and #30. 2D. A resident room observation was conducted on February14, 2013 at approximately 11:09 AM on 3A in Room 307. The following was observed: The residents ' call bell did not activate in the room when pressed, when Employee #32 made an attempt to answer the call bell from the front desk, the voice was not audible in room. The resident light did not light up (outside of the room over the door) 2E. A resident room observation was conducted on February14, 2013 at approximately 12:02 PM	L 306	**L410** A. Finding #1 1. Window blinds in resident rooms #216 and #230 will be replaced. 2. All resident room window blinds were checked for broken blinds and found to be in order. 3. Resident room window blinds are observed and documented weekly during maintenance rounds. Follow-up inspections will be conducted monthly by the Plant Operations Management team. 4. Findings of broken blinds and repair will be reported quarterly to the QI Committee. 5. **Date of Compliance** 04/05/13. Finding #2 1. The damaged door frame to the entrance door of room #216 will be repaired. 2. All doors frames of other resident rooms will be observed and documented for damage. 3. Door frames are observed and documented for damage during weekly maintenance rounds. Follow-up inspections will be conducted weekly by the Plant Operations Management team.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0005	A. BUILDING: _____ B. WING _____	02/21/2013

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 306	Continued From page 36 on Unit 3A in Room #332. The following was observed: When the residents' call bell (cord) was pulled in the bathroom, the light would activate, when Employee #30 answered the call bell from the nurses station, the response was not audible in room 332, the audibility was heard in the room next door to room 332 (334). The observations were made in the presence of Employees #16 and #30.	L 306	4. Findings of damaged and repaired door frames will be reported quarterly to QI Committee. 5. Date of Compliance Finding #3 1. The stained bathroom commode in room #257 was cleaned. 2. All resident room commodes are cleaned daily. 3. Resident rooms are inspected daily to include bathroom commodes, by Environmental Services Team leaders/ Supervisors. Follow-up inspections will be conducted weekly by the Plant Operations Management team. 4. Findings of bathroom commodes and cleaning will be reported quarterly to QI Committee. 5. Compliance Date Finding #4 1. Closet doors in rooms #222 and #223 were repaired as of 03/19/13. 2. All closet doors in resident rooms will be inspected for marrs and scars by maintenance rounds. 3. Resident rooms including inspection of closet doors, are inspected daily by maintenance staff.	4/05/13 4/05/13
L 362	3250.4 Nursing Facilities When food is prepared on the premises, each kitchen area shall be arranged and equipped for the refrigeration, storage, preparation and serving of food, as well as for dish washing, utensil washing, and refuse storage and removal. This Statute is not met as evidenced by: Based on observations made during a tour of Dietary Services on February 19, 2013 at approximately 10:15 AM, and during a tour of the facility, it was determined that the facility failed to ensure that essential equipment was maintained in safe operating condition as evidenced by one (1) of two (2) ovens were observed with a missing bottom panel exposed wires and two (2) of two (2) personal refrigerators that were not deemed to be in safe operating condition prior to use. The findings include: 1. During a tour of Dietary Services on February 19, 2013 at approximately 10:15 AM, it was	L 362		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0005	A. BUILDING: _____ B. WING _____	02/21/2013

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 362	Continued From page 37 determined that the facility failed to ensure that essential kitchen equipment was maintained in safe operating condition as evidenced one (1) of two (2) ovens were observed with a missing bottom panel exposed wires. This observation was made in the presence of Employee #20 who acknowledged the finding. 2. Two (2) of two (2) personal refrigerators were observed "in use" in resident rooms (#229 and 137) in the absence of a mechanical clearance (deeming the refrigerators safe for use) determined by the facility. The observation was made in the presence of Employees #1 and 14 during an environmental tour of the facility on February 20, 2013.	L 362	Follow-up inspections will be conducted weekly by the Plant Operations Management team. 4. Findings and repair will be reported quarterly to QI Committee. 5. Date of Compliance Finding #5 1. The pillar and adjacent wall in room 237 were repaired as of 03/19/13. 2. All resident rooms will be inspected for pillar and wall damage by maintenance staff. 3. Resident rooms are inspected daily by Environmental Services Team leaders/ Supervisors. Follow-up inspections will be conducted weekly by the Plant Operations Management team. 4. Findings and repair will be reported quarterly to QI Committee. 5. Date of Compliance Finding #6 1. The wallpaper on both sides of the hallway between rooms # 226 and #238 was re-glued of 03/19/13. 2. All resident unit common areas will be inspected for peeling wallpaper and re glued by maintenance staff. 3. Resident common areas are inspected for peelling wallpaper	4/5/2013 4/5/2013
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: A.Based on observations made during an environmental tour of the facility on February 13, 2013 at approximately 2:00 PM and on February 14, 2013 at approximately 10:00 AM, it was determined that the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior as evidenced by two (2) of four (4) broken window blinds in two (2) of seven (7) resident rooms; a damaged door frame in one (1) of seven (7) residents' rooms, a stained commode in the bathroom of one (1) of seven (7)	L 410		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0005	A. BUILDING: _____ B. WING _____	02/21/2013

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 410	Continued From page 38 residents rooms, marred and scarred closet doors in two (2) of seven (7) residents rooms, a pillar and an adjacent wall damaged with numerous holes five (5) in one (1) of seven (7) residents rooms, and peeling wallpaper on both sides of the hallway between rooms #226 and #238. The findings include: 1. Window blinds were broken in rooms #216 and #230, in two (2) of seven (7) residents' rooms. 2. The door frame to the entrance door of room #216 was damaged with a hole on the left side of the frame in one (1) of seven (7) resident's rooms. 3. The bathroom commode was stained in room #257, one (1) of seven (7) resident's rooms. 4. Closet doors in two (2) of seven (7) residents' rooms were marred and scarred (rooms #222 and #223). 5. A pillar in room #237 and the adjacent wall were damaged with holes in one (1) of seven (7) resident's rooms. 6. The wallpaper on both sides of the hallway between rooms # 226 and #238 was peeling off the walls in one (1) of three (3) hallways observed and needed to be repaired. These observations were made in the presence of Employee #6 at approximately 2:00 PM on February 13, 2013 and at approximately 10:00 AM on February 14, 2013. He/she acknowledged the findings. B. Based on observations of 39 randomly selected rooms during an environmental tour of the facility on February 20, 2013 at 10:30 AM, it was determined that the facility failed to provide	L 410	daily by Environmental Services Team leaders/ Supervisors. Follow-up inspections will be conducted weekly by the Plant Operations Management team. 4. Findings to be reported quarterly to QI Committee. 5. Date of Compliance 4/5/2013 B. Finding#1 1. All rooms identified will be repaired for surface defects along the wall surfaces. 2. All resident rooms will be inspected by maintenance staff for surface defects along wall surfaces. 3. Resident rooms are inspected daily by Environmental Services Team leaders/ Supervisors. Follow-up inspections will be conducted weekly by the Plant Operations Management team. 4. Findings to be reported quarterly to QI Committee. 5. Date of Compliance 4/5/2013 Finding #2 1. Leaking bathroom faucets in rooms 154, 155 were repaired as of 02/20/13. 2. Resident bathrooms are inspected daily by maintenance staff for leaking spigot.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0005	A. BUILDING: _____ B. WING _____	02/21/2013

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 410	Continued From page 39 housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior as evidenced by defects along wall surfaces in 19 rooms; leaking faucets in two (2) rooms; damaged blinds and/or window screens in six (6) rooms; soiled floor surfaces in four (4) rooms; exhaust vents accumulated with dust in four (4) rooms, one (1) call light was secured with electric tape and one (1) drawer pull was partially detached. The findings include: 1. Nineteen (19) of 39 rooms were observed with surface defects along wall surfaces as follows: Marred areas: Rooms #357, 351, 315, 211, 204, 215, 116 Spackling paste without finishing paint: Rooms: #357, 351, 346, 332, 216, 211, 203 Holes in the wall surfaces: Rooms: #350, 259 Nails and/or hinges protruding from wall surfaces: Rooms: #316, 314, 259 2. Two (2) of 39 bathroom faucets were leaking and would not turn off with spigot: Rooms #154, 155	L 410	3. Resident rooms are inspected daily by Environmental Services Team leaders/ Supervisors. Follow-up inspections will be conducted weekly by the Plant Operations Management team. 4. Findings to be reported quarterly to QI Committee. 5. Date of Compliance Finding #3 1. Identified rooms with damaged blinds and/or screens will be fixed or replaced. 2. All resident rooms are inspected daily for damaged blinds and/or screens by maintenance staff. 3. Resident rooms are inspected daily by Environmental Services Team leaders/ Supervisors Follow-up inspections will be conducted weekly by the Plant Operations Management team. 4. Findings to be reported quarterly to QI Committee. 5. Date of Compliance Finding #4 1. All identified floors have been cleaned as of 2/20/13. 2. All resident room floors have been cleaned for dust, marred or a dull finish.	4/5/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0005	A. BUILDING: _____ B. WING _____	02/21/2013

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 410	Continued From page 40 3. Five (5) of 39 rooms were observed with damaged window blinds and/or screens: Blinds - Rooms #155, 304 Screens - Rooms #249, 229, 250, 227 4. Floor surfaces were soiled with dust, marred and/or observed with a dull finish in four (4) of 39 rooms: Rooms: #315, 313, 356, 358 5. Exhaust vents accumulated with dust in four (4) of 39 rooms: Rooms #325, 345, 345, 358 6. One (1) call light was secured with electric tape in an isolated observation in Room #204. 7. One (1) night stand drawer pull was partially detached in an isolated observation in Room #333. The observations were made in the presence of Employees #1 and 14 during an environmental tour of the facility on February 20, 2013.	L 410	3. Resident rooms floors are inspected daily by Environmental Services Team leaders/ Supervisors. Follow-up inspections will be conducted weekly by the Plant Operations Management team. 4. Findings to be reported quarterly to QI Committee. 5. Compliance Date Finding #5 1. All identified exhaust vents have been cleaned as of 3/19/13. 2. Allexhaust vents are inspected daily and cleaned for dust. 3. Exhaust vents are inspected daily by Environmental Services Team leaders/ Supervisors. 4. Follow-up inspections will be conducted weekly by the Plant Operations Management team. 5. Compliance Date Finding #6 1. Call light cord in room 204 was replaced as of 2/20/13. 2. All call light cords are inspected daily during maintenance rounds. 3. Call light cords are inspected daily by Environmental Services Team leaders/ Supervisors. Follow-up inspections will be conducted weekly by the Plant Operations Management team.	4/5/2013 4/5/2013
L 426	3257.3 Nursing Facilities Each facility shall be constructed and maintained so that the premises are free from insects and rodents, and shall be kept clean and free from debris that might provide harborage for insects and rodents. This Statute is not met as evidenced by: Based on observation and staff interview it was	L 426		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0005	A. BUILDING: _____ B. WING _____	02/21/2013

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 426	Continued From page 41 determined that the facility failed to maintain an effective pest control program to ensure that the facility is free of pests. The findings include: Flying pests were observed as follows: 1. On unit 1-A at the nursing station in the presence of Employee #4 on February 14, 15 and 19, 2013. 2. In room #102 while observing incontinence care, in the presence of Employee #15 on February 19, 2013.	L 426	4. Findings to be reported quarterly to QI Committee. 5. Compliance Date Finding #7 1. Night stand drawer in room 333 was repaired as of 2/20/13. 2. All night stands are inspected daily during maintenance rounds. 3. Night stands are inspected daily by Environmental Services Team leaders/ Supervisors. Follow-up inspections will be conducted weekly by the Plant Operations Management team. 4. Findings to be reported quarterly to QI Committee. 5. Compliance Date **L426** #1,2 1. Facility engaged pest control vendor, and area was serviced on 2/25/13. 2. Pest control vendor inspects/services facility on a weekly and as needed basis. 3. Resident units are inspected daily by Environmental Services Team leaders/ Supervisors. Follow-up inspections will be conducted weekly by the Plant Operations Management team. 4. Findings to be reported quarterly to QI Committee. 5. Date of Compliance	4/5/2013 4/5/2013 4/5/2013