| Health Regulation & Licensing Administration | | | | | | | | | |
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| | | HFD02-0005 | | B. WING 02/21/201 | | | | | |
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| L 000 | 00 Initial Comments | | | L 000 | | | | | |
| L 051 | 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. 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: | | | L 051 | The Washington Home makes its bes To operate in substantial compliance Federal and State law. Submission Plan of Correction (POC) does not on an admission or agreement by any placed by the following plan of the conditions set forth on the State Deficiencies. The following Plan of constitutes the facility's written credit tion of compliance. It is prepared and executed solely because it is require Federal and State law. | with both of this constitute arty, its or agents the validity ement of Correction ole allega- | | | |
| | | | | | L 051 Resident #2 1. Comprehensive care plans will developed and reviewed quarte interdisciplinary team for all residiagnosed with mental retardati illness, and/or have a positive Pacreen. 2. A chart audit will be conducted Social Services staff to ensure 1) All residents who have been diagnosed with mental illness/or retardation have a PASSR Levice Screen completed and placed chart under the Social Services 2) All residents with a positive screen will have a comprehension | rly by the dents on/mental ASSR by the that: en mental rel II in the stab; and e PASSR sive care | | | |
| | interviews for three was determined that | /\ | idents, it led to | | plan which will be reviewed qu and as necessary. No other re was affected by this deficient p | sident | | | |

LABORATORY DIRECTOR OF PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE STATE FORM

If continuation sheet 1 of 42

| Health R | equiation & Licensing | Administration | | | | | |
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| L 051 | Mental Illness and/o an integrated care p (1) resident; and to a impairment or poten resident. Residents: The findings include 1. The charge nurse plan was developed approaches to addressive PASRR [Pre Review for Mental Ill Retardation] Screen A record review of the #2 identified that the facility in March 25, Review of the PASR Screen/Resident Re Mental Retardation] 2008, identified the retardation. Review of the quarte ARD [Assessment R 15, 2012 identified in diagnoses: Anemia, [Hypertension], Hypertension], Hypertension], Hypertension Orophary | n a positive PASRR reen/Resident Review or Mental Retardation] plan for hospice service address a swallowing tial for aspiration for 0 #2, #9, and #164. If failed to ensure that with measurable goal ess one (1) resident well-Admissions Screen/Iness and/or Mental Iness and/or Mental Iness and/or Mental Iness and/or Mental Iness and Januar resident as positive for Mental Illness Screen dated Januar resident as positive for Series Patellowing Heart Failure, HTN erlipidemia, Asthma, Seral, Unspecified Osteologyngeal Phase, Vitamir Obstructed] Chronic Best Phase P | screen; es for one one (1) a care als and with a /Resident of the ed to the ed to the ed with an exember ang sensory opporosis, and D | L 051 | A roster of all residents who he positive PASSR will be kept by Director of Social Services. A review of all new admissions to facility will be conducted by the of Social Services/Unit Social to identify the need for a PASS II Screen. Upon determination social worker will initiate the soprocess, and document all relactivities in the clinical record. comprehensive care plan will be developed and then reviewed to address the needs/concerns resident found to have a positive PASSR. Random chart audits will be concerned to the Director of Social Service ensure residents have been accurately/appropriately identifications accurately/appropriately identification of the will be reported to the QI Communication. Date of compliance: | the chart of the c | 3/22/2013 |

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| L 051 | Palsy, Mild Intellecture Retardation]. Review of the "Care the IDT (Interdisciplic conducted on Nover of the care plans lad with goals and appropositive screen for Market approximately 5:10 plans, he/she acknown The charge nurse farmeasurable goals a who had a positive for that the resident was facility on December facility on January 2 Order Form" reveals order was written by documented the followervices as of 1/28/ | Unspecified Infantile Could Disabilities [Mental Plan Face Sheet" ideinary Team Meeting) mber 15, 2012. Furth sked evidence of a capach to address Residental Retardation. View was conducted worden a caperate of the findings. View disabilities are view of the could be should | entified that was her review re plan dent #2's with of the care e plan with esident #2 e plan with esident #3 e plan with esident #4 e plan with esident e plan | | Resident #9 1. Resident #9 suffered no harm Care Plan for Hospice Service initiated during the survey process. 2. All residents upon receiving proders to receive Hospice Service will be placed on Open Chart The Open Chart Protocol will amended to reflect this stand. Nurse Managers, Licensed N and Unit Clerks will receive an education session to become the amended Open Chart Process of the amended Open Chart Process will within 72 hours of receipt order, have a Medical Reconserview by the Nurse Manager designee to ensure a Hospice Services Care plan has been instituted. All Nurse Manager licensed nurses, and Unit Clereceive an education session regarding the review process ensuring a Hospice Services Plan is instituted within 72 horesidents with physician's ord Hospice Services. | es was ocess ohysician rvices Protocol. be ard. All urses of aware of otocol. ohysician rvices, of the d er or their e. srks will for Care urs for all | |
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| L 051 | which directed, "P Community Hospice dated January 29, 2 Further review of the resident was visited January 29, 2013. Minimum Data Set [Reference Date of F was coded for Hosp However, review of care plan with goals delivery of Hospice A face-to-face interved Employee #4 on Feb During the interview that no integrated cainitiated for the residential record was resident and nectar this on February 13, 20 administration obser #19 was observed at to Resident #164. Tresident, Employee which included Calc | t. [patient] admitted to a under [MD' s name] 013. e record revealed that by the Hospice nurse According to the adm MDS] with an Assess behavior as a care in Section of the care plans failed to and approaches to a Care to the resident. Tiew was conducted worder to the employee acknown the employee acknown are plan was developed and the employee acknown are plan was developed as a failed to develop a capaspiration for Resider as requiring mechanic | the e on ission ment esident D. o reveal a ddress the with 20PM. wledged ed and/or e. The 20, 2013. are plan at #164 al soft cation Employee dications of the dications of the dications l) tablet, | L 051 | 5. | The Medical Record review or residents with physician order Hospice Services to ensure the residents have a Hospice Service Care Plan will be added as an review on the Medical Record Tool completed monthly by Nimanagers. Nurse Managers with submit the Medical Record Autonothly to the Quality Improve Manager. The Quality Improve Manager will report variances quarterly at the Focus Quality Improvement Committee. Compliance Date Resident # 164 Resident # 164 Resident # 164 suffered no has Immediate education was don'the licensed nurse as to their noncompliance with the residence of thickened liquids and review of the facility Thickened Policy. A care plan to address resident's swallowing impaire been added to the Medical Resident R | rs for ne vices n item for d Audit urse vill udit Tool ement ement ement d Liquids s the d has | 4/5/2013 |

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| approximately 50 ma straw for the reside medication. The reby sipping it from the Resident #164 's own packet of Instant Focontainer of Thick a beverage. At no tire thickener with the cracked medications. According to the His 2012 Resident #164 Sclerosis. A review of the physic February 5, 2013 difference to safe some program-recomment october 22, 2012 restorative nursing from adherence to safe some program and requirements. | ree gave Resident #16 of cranberry juice in ent to swallow his/her sident drank the cran e straw. Observed over-the-bed table was od Thickener and one nd Easy pre-thickener e did Employee #19 ranberry juice that waink while taking his/her story and Physical dat had a diagnosis which sician orders signed a rected, "Mechanical iliquids at all meals." | a cup with response to the control of the control o | L 051 | 2. Upon receiving a have a resident reliquids and or swithe licensed nursorder will add caneeds in the resi Record. All resi Thickened Liquids admended to alert thickened liquids administered with well as with all monurses will receive regarding the laboration regarding the laboration regarding and a review of the Policy. All licensed education regarding imparts for Thickened Licensed in thickened liquids will be amended of the MAR of all thickened liquids will receive education and review education regarding imparts for Thickened Licensed in the manded of the manded in thickened liquids will receive education regarding imparts for Thickened liquids will receive education regarding the manded of the manded of the manded of the manded in thickened liquids will receive education regarding the manded of the manded of the manded of the manded in thickened liquids will receive education regarding the manded of the manded in the man | a physician's order receive Thickened vallowing impairm se that receives the replans for both dent's Medical I dents requiring its will have their Mare to be a licensed nurses to are to be a licensed nurses will receive education seling of the MAR ing thickened liquid the Thickened Liquid and the Thickened Liquid its plans reflecting irment and/or need and the residents receiving atton regarding the residents receiving the Thickened Liquid its policity. All licensed nurses atton regarding the Enceiving the order the resident to reflect the laber and in the Thickened Liquid is attonable to reflect the laber attonable to regarding the effect of the resident to reflect the resident to reflect the laber attonable to regarding the effect of the resident to reflect the | ent, e MAR that as d of ds uids eive e d ling ag ses e ids an will |

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| L 051 | Continued From pag | ge 5 | | L 051 | | | i'u a Ala a | T. | |
| L 051 | A review of the Care and those located or revealed that there is approaches to address impairment or poten. A face-to-face interved Employees #3 and #approximately 10:30 there was no care president 's swallowing aspiration. The recording to the claration of 41 samples that the charge nurs resident's weight was clinical record. Resort The findings include According to the clinadmitted to the facilial Physical Therapy. A review of the "Maresident's diagnose History of Stroke (20 Hypertension. A review of the Admit (MDS) with an Asse of October 25, 2012 | e Plans printed by the in the active clinical rewas no care plan with ess the resident 's switial for aspiration. View was conducted witial for aspiration. View was reviewed on aspiration. View was reviewed on aspiration. | ith 013 at edged that ess the ential for February iew for etermined to one (1) inted in the evealed ontal), and Set ete (ARD) 88 was | L US1 | 4. | meals. Within 72 hours follow physician's order for a resider receive thickened liquids the Manager or their designee will the residents' MAR to ensure has been labeled to show the resident's need for thickened and to ensure care plans for swallowing impairment and/or thickened liquids has been as the Medical Record. The Nurs Manager will receive education regarding the audit process or resident's MAR. The labeling of the MAR of a receiving thickened liquids to resident must receive thicken liquids during medication administration as well as mean be added as an item to the managers. The add care plans for swallowing impand/or thickened liquids to the Record will be added as an item monthly Medical Record Tool completed by the Nurse Managers will sub Medical Record Audit Tool to Quality Improvement Manager monthly basis. The Quality Improvement Manager will re | nt to Nurse Il audit the MAR Iliquids I | | |
| | pounds on admission | n. | | | 5. | variances monthly to the Foci Quality Improvement Commit Compliance Date | | 4/5/2013 | |

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| L 051 | Continued From pag | ge 6 | | L 051 | L 051 (R) | |
| | signed and dated Over Weight-Weekly x (time weight, 2nd (second The unit's "Up To revealed the following October 18, 2012-20 October 19, 2012-10 October 24, 2012-10 October 31, 2012-11 A review of a printour medical record) title after 10/18/12 "revealed to the following of the | Scale Weight Recording weights: 17.7 pounds 157.8 pounds 58 pounds 59.6 pounds at from Optimus (elected of Resident's Weight Vealed the following weight and the following weight and the following weight weight weekly x 4; [due to] swallowing dependent of the following weight weekly x 4; [due to] swallowing dependent of the following weight weight but weight due to age, [no] received the following weight weight but weight due to age, [no] received the following weight due to age, [no] recei | dated aled: " on efficient, po of meals, pht loss not ent labs, F/U s the indicative er 18, | | 1. The weight recorded on Octowas a scale (mechanical) erall other recorded weights fro October 19-october 31 were at This incident was addressed documenting the scale error. resident's weight was monitor ensure consistency and documentation was put in plaresident was not negatively a by the error. 2. A audit of weight records incithat there were no other residented by the practice. 3. The Dietitian and facility staff the second day weight (perform the Weight Team) to insure consistency. The Weight Team develop a weekly weights. will be given to nursing staff a dietitians. Dietitian is responsensuring weights are consisted will communicate with nursing needed. The weight team will dietitian and nursing of any discrepancies within 24 hours re-weigh will be done to verify in weight. | ror, and m accurate. by Then the red to ce. The ffected licated lents will use rmed by m will ort for all Reports and ible for ent and g as linform weight s, and |

Health Regulation & Licensing Administration (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED. A: BUILDING: B. WING. HFD02-0005 02/21/2013 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3720 UPTON STREET NW THE WASHINGTON HOME WASHINGTON, DC 20016 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) L 051 L 051 Continued From page 7 4. Weekly weights will be reviewed clinical record; he/stated: "The admission weight weekly and reported and discussed in is not correct, the weight on the second day is the weekly Focus QI Meetings. Any correct. " variance(s) will be reported to the weekly meetings and monthly QI Another face-to-face interview was conducted with Employee #23 on February 21, 2013 at Committee meetings. approximately 10:30 AM. Employee #23 acknowledged that he/she failed to look at the 3/22/2013 5. Compliance Date 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 052 3211.1 Nursing Facilities L 052 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;

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| L 052 | or her own clothing; shall be clean and in (2)Use the dining ro (3)Participate in mea activities; with eating (g)Prompt, unhurried requires or request I (h)Prescribed adapt him or her in eating independently; (i)Assistance, if nee including oral acre; a j)Prompt response thelp. This Statute is not A.Based on an isola sampled residents, staff failed ensure the provided to promote evidenced by the obapplied proximal to protectant. Resident The findings included Facility staff failed ensured the control of the | d and dress or be drest and shoes or slippers in good repair; om if he or she is able aningful social and read; d assistance if he or shelp with eating; live self-help devices the ded, with daily hygien and on activated call below the dignity for one (1) resistency of a paper of the resident 's ear as the #43 | e; and creational creational co assist e, ll or call for at facility ime was sident as towel a skin | L 052 | L052 (A) Resident# 43 1. Resident sustained no harm. Partowel used as a skin protectant weremoved from the resident's ear 2. A product called E-Z Wrap has be ordered as skin protectant for all residents using tubing that lies protected to use gauze sponges werap tubing lying proximal to residents or face. 3. All nursing staff will be provided education sessions on the use of product E-Z wrap or gauze sponas a skin protectant and to promodignity for residents using tubing lies proximal to residents' ear or the resident's ears or will be monitored daily by the Normal to the resident's ears or will be monitored daily by the Normal to the resident (E-Z Wrap or galaround the tubing. This item will added to the Nurse Manager da Unit Rounds Audit Tool. The auwill be submitted monthly to the Quality Improvement Manager are reviewed at the Focus Quality Improvement Committee. 5. Compliance Date | roximal is to idents' fof the nges note g that r face. es or face urse use of auze) Il be aily idit tool | |
| | time was provided to #43. The resident w | o promote dignity for I as observed on | Resident | | | | |

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| | February 20, 2013 a seated in a wheelch | at approximately 11:30 air in the common are table oxygen infusing | ea of the | | | | |
| | resident 's nares an A paper towel was o | vas applied as prescri id secured behind his observed resting loose tubing of the nasal cal lent 's right ear. | her ears. ely and | | | | |
| | queried as to the pu observed proximal to stated that the reside break down behind to oxygen tubing and the protect the resident | servation, Employee rpose of the paper too the resident 's ear. ent had a tendency to the ears secondary to hat the paper towel se's skin. He/she added posed to be used " | wel He/she have skin the erved to d, "4 x 4 | ž | | | |
| | Employee #17, the I Resident #43, on Fe approximately 2:30 I regarding the paper Resident #43's ear towel served to prote s ear from breaking that gauze sponges | PM. In response to a towel observed proxing he/she replied that the ect the skin behind the down. However, he/s are usually used to potent's ear from the o | query mal to he paper e resident ' he stated rotect the | | | | . e |
| | #43 as evidenced by | o promote dignity for F y the observation of a nal to the resident ' s e | paper | | | | |
| | B. Based on observa | ation, record review a | nd staff | | | | |

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| L 052 | was determined that sufficient nursing time each resident receives ervices to attain or physical, mental, an accordance with the and plan of care as consistently assess altered skin integrity through on a physicic consultation for one implement measured postural/positioning consistently assess receiving "as need intravenous access residents and follow for incentive spiromeresident. Residents and 292. The findings include 1. A review of the clipper revealed facility staff nursing time was proposed and monitor the statintegrity and failed to sorder for a consult. A. An electronic endated January 2, 20 Resident reported we buttock measure 2.5 stationary and sufficient resident reported we buttock measure 2.5 stationary and measure 2.5 stati | 7) of 41 sampled resist facility staff failed enter was provided to enter the mean and provided to enter the mean and provided to enter the mean and the highest of psychosocial well-becomprehensive assertied monitor the statut for two (2) residents; an 's order for a wout (1) resident; identify as to manage the concerns for one (1) pain for two (2) resided the mean and medication sites as prescribed for through on a physiciater treatment for one 1 #82, 107, 205, 252 | sure that sure to: so follow and sure sident; ents n; assess or two (2) an 's order sure (1) sure two (2) sure two (2) sure two (2) sure two (3) sure two (4) sure two (4) sure two (5) sure two (6) sure two (7) sure two (7) sure two (8) sure two | L 052 | L052 (B) Resident #82 1. Harm did not occur to the redocumentation in the resident medical record for Feb. 19 adid not show an alteration in resident's skin. The licensed that failed to document ongo assessments of the resident skin received counseling and education as to the process documenting assessments of resident's skin. 2. All residents with skin condition be placed on Open Chart Pruntil the skin condition is resident's educational review of the Operotocol. 3. All residents will have their sassessed by a licensed nurse and documentation of the asplaced in the electronic med whether the skin is positive onegative for variances in the skin. 4. The weekly skin assessment performed by the licensed nurse and the electronic of the ele | nt's t 11:00am the nurse ning 's d of of of of of closs will otocol olved. ve pen Chart skin se weekly ssessment ical record or residents' ts urse and Medical sly by the gnee rative onic nary |

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| L 052 | open area with soap Lantiseptic each shift A nurse 's entry data read, "[family meminformed of skin imp A review of the correset [MDS] signed Jareference date Janu Section M, Skin condition of the clinical record land ongoing assess alteration in skin integrated on the initial assessment and/or "inner butto was no evidence of status of the resident the initial assessment An observation of the February 19, 2013 laskin integrity. The findings were and #8 during face-to February 20, 2013 a respectively. B. Facility staff failed time was provided to sorder for wound conditions. | otified, order given to and water, pat dry, a ft after each incontine ed January 3, 2013 at aber named] called arrairment to sacral area ected quarterly Minimus anuary 8, 2013; asses ary 3, 2013 was code ditions that the reside eulcer. acked evidence of moments of the status of egrity of the "sacral acks" for Resident #documentation regard t's altered skin subsent on January 2, 2013 he resident's sacral reacked evidence of a backed evidence of a backnowledged by Emplo-face interviews conditionally and 1:00 PM diensure that sufficients of follow through on a possibility of the surrection of a possibility of the sacral reacked evidence of a backnowledged by Emplo-face interviews conditionally of the surrection of follow through on a possibility of the sacral reacked evidence of a backnowledged by Emplorate interviews conditionally of the sacral reacked evidence of a backnowledged by Emplorate interviews conditionally of the sacral reacked evidence of a backnowledged by Emplorate interviews conditionally of the sacral reacked evidence of a backnowledged by Emplorate interviews conditionally of the sacral reacked evidence of a backnowledged by Emplorate interviews conditionally of the sacral reacked evidence of a backnowledged by Emplorate interviews conditionally of the sacral reacked evidence of a backnowledged by Emplorate interviews conditionally of the sacral reacked evidence of a backnowledged by Emplorate interviews conditionally of the sacral reacked evidence of a backnowledged by Emplorate interviews conditionally of the sacral reacked evidence of a backnowledged by Emplorate interviews conditionally of the sacral reacked evidence of a backnowledged by Emplorate interviews conditionally of the sacral reacked evidence of a backnowledged by Emplorate interviews conditionally of the sacral reacked evidence of a backnowledged by Emplorate interviews conditionally of the sacral reacked evidence of a backnowledged by Employer interviews conditionally of the sacral reacked evidence of a backnowledged by Employer | pply nt care. " t 12:25 AM nd was a. " um Data sment d in nt had one nitoring f the area " 82. There ling the equent to, . egion on reak in toyees #4 ducted on t nursing ohysician ' | L 052 | 1. | Improvement Manager. All N Managers will receive educat the process of using the Administrative Report functio Electronic Medical Record ar process of summarizing the r weekly submission to the Qu Improvement Manager. Compliance Date sident #82 No harm occurred to the resident and did not find exact of the resident's skin conditio All residents with skin variance be placed on Open Chart Pro until the skin variance is reso When a license nurse receive treatment order for a resident variance the licensed nurse w complete and submit a Skin of Communication Tool to the V Care Team to notify the team evaluate the resident's skin. Wound Care Team within 72 receipt of the communication evaluate and document their of evaluation of the resident's licensed nurses and the Wou Team will receive education of use of the Wound Care | dent. ssed the cerbation n. ces will chocol lved. es a cound to The hours of tool will contact is skin. All and Care | 4/5/2013 | |
| | | | | | | Communication Tool. | | | |

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| L 052 | dry and apply Lantis each shift; Evaluate tomorrow during AIV The clinical record lawas evaluated by the prescribed. A face-to-face interved by the prescribed. A face-to-face interved by the prescribed of an assessment by record was reviewed of an assessment by record was reviewed to measures to manage concerns for Resided Resident #107 was at approximately 11 common area [day/owheelchair. The resident position. The torso support. Employee #6 who we the observation, was postural and/or posi #107. He/she respons as leep while seated to lean. He/she asked pillow to assist with Additional observation. | ttocks with soap and we petic after each incorresident by wound can resident by wound can to an extended evidence that the exound care team as wiew was conducted we bruary 20, 2013 at 10 that the record lacked by the wound care team of February 20, 2013. It densure that sufficient in the postural/position ent #107. The postural position in the postural in his/her wheelchair end a staff person to observed as taff person to observed as taff person to observed a staff person to | ne resident so with 100 AM devidence in the nursing ent ning y 20, 2013 ble in the excessively intain an of needed etime of the lack tesident toften falls and tends otain a stural | L 052 | When a license nurse received treatment order for a resident's variance the licensed nurse we complete and submit a Skin C Communication Tool to the W Care Team to notify the team evaluate the resident's skin. T Wound Care Team within 72 is receipt of the communication to evaluate and document their of evaluation of the resident's licensed nurses and the Wound Team will receive education of use of the Wound Care Communication Tool. All licensed nurses and the W Care Team will receive education the use of the Wound Care Communication Tool. The Wo Care Communication Tool. The Wo Care Communication Tool will submitted to the Quality Improvement Committee. Date of Compliance | s skin ill care cound to the nours of tool will contact skin. All nd Care n the cound tion on cound |

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| L 052 | 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. | | | L 052 | 1 | Resident #107 | | ny harm | |
| | | | | | 2. | A rehabilitative was obtained | lid not sustain and screen for postor the resident. With a need for | | |
| | approximately 9:54 in a wheelchair at a | | | | | positioning will screen reques Rehabilitative and any recon the Rehabilita | I have a rehabili at sent to the Therapy Depart nmendations ma tive Therapy | ment ade by | |
| : | 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. | | | 17 | 3. | the resident's into the resident will be monitor when necessateam and recopositioning coaccording to the side of the resident will be monitor when necessate and recopositioning coaccording to the resident's side of the resident's | with positioning named every 3 hour ary by the reside ommendations to neerns carried one residents' car | needs rs and nts' care to correct out re plan. | 2 3 |
| | 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." | | • 4 | 4. | will be done on Documentation for positioning position will be | n of the follow the the resident's on of the resident and changing of an item added ers Unit Rounds | TAR. ts needs of to the | | |
| | | o identify and impleme s the postural/position nt #107. | | | | tool (complete twice daily). T Rounds Audit weekly to the | ed by Nurse Man he Nurse Manag tool will be subn Quality Improve | nagers ger Unit mitted | |
| | | inical record for Resid f failed ensure that su ovided to | | | 5. | discussed at v Improvement | ions for variance veekly Focus Qu Meeting. | | 4/5/2013 |

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| 6 7 | 2 7/ | | 959 | 19. | _ | 76 | | |
| L 052 | Continued From pag | _ | | L 052 | | Resident # 205 | | |
| | | and monitor the statu | s or an | | 4 | Desidents akin waa intoot du | -laa | |
| | alteration in skin integrity. | | | | 1. | Resident's skin was intact du | - | |
| | A nurse 's entry dated December 31, 2012 read: "New (1st recording) for Site - 352. Present on the | | | | | survey process. The licensed | | |
| | | | | | | that failed to document ongoin | - | |
| | Coccyx is a skin tea | r/laceration. The follo | wing | | | assessments of the resident's | | |
| | | nented, general comm | | | | received counseling and educ | | |
| | abnormality was recorded using an assessment other than skin & wound during a body check." | | | | | to the process of documenting | • | |
| | Ollier than Shin & wo | Julia during a body on | ECN. | | | assessments of resident's ski | | |
| | The clinical record la | acked evidence of sta | tus of the | | 2. | All residents with skin condition | | |
| | skin alteration of the | e coccyx initially identi | | | | be placed on Open Chart Pro | | |
| | December 31, 2012 | | | | | until the skin condition is reso | | |
| | A tion of th | | Fabruary. | | | All licensed nurses will receiv | | |
| | | ne resident ' s skin on mately 11:30 AM lacki | | | | educational review of the Ope | en Chart | |
| | | ation of the skin of the | | | | Protocol. | | |
| | Ovidorioo S. a.i. s | dio | , | | 3. | All residents will have their sk | | |
| | | iew was conducted w | /ith | | | assessed by a licensed nurse | weekly | |
| | Employee #4 on Fel | | 1 10.21 | | | and documentation of the ass | essment | |
| | | AM; he/she acknowle | | 8 | | placed in the Electronic Media | cal | |
| | | vidence of the status on in skin integrity iden | | | | record whether the skin is pos | sitive or | (14) |
| ** | | . However, he/she sta | | it: | | negative for variances in the i | residents' | |
| | | was intact at present. | | | | skin. | | |
| | • | \$ | | | 4. | The weekly skin assessments | s will be |)# |
| | 4A Facility staff fail. | ad analyse that aufficia | ont nurning | | | audited weekly by the Nurse | Manager | |
| | | ed ensure that sufficie o identify the type of c | | | | or their designee using Admir | nistrative | |
| | | sident #252 ' s Intrave | | | | Report function of the Electro | | |
| | access site. | | | | | Medical Record and a summa | | |
| | | | | | | forwarded weekly to the Qual | | |
| | | ous Catheter-Physicia | | | | Improvement Manager. All Nu | • | |
| | | signed by the physici irected, "Device Typ | | | | Managers will summarize the | | |
| | | ed central catheter): br | | | | for weekly submission to the | | |
| | | igth " was left blank. | arra, | | | Improvement Manager | ~ | |
| | 30009-1 | J | | | 5. | Date of Compliance | | 4/5/2013 |
| | | | | | J. | Date of Compilation | | -1/0/2010 |
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| Health Regulation | n & Licensin | q Administration | | | | | |
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| 9 4 | 8 | HFD02-0005 | 22 | B. WING | (4) | 02/21/2013 | |
| NAME OF PROVIDER O | R SUPPLIER | 1985 IC | STREET ADD | RESS, CITY, ST. | ATE, ZIP CODE | € | |
| THE WASHINGTO | ON HOME . | * * * * * * * * * * * * * * * * * * * | | ON STREET | | | |
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| L 052 Contin | ued From pa | ge 15 | | L 052 | Resident # 252 | | |
| the De Centra identify 252. A face- Employ approx that the Centra | vice type info Il Venous Cat If the type of I -to-face interview #7 on Fe simately 11:08 In device infor Il Venous -Ph | nce that facility staff in primation (listed above theter-Physician Order V device used for Review was conducted where the bruary 21, 2013 at BAM. He/she acknown action was not listed sysician Order Sheet don February 21, 20 | e) on the er Sheet to sident # with ewledged I on the " '. The | | The resident sustained no h licensed nursing receiving the physician's order for the PIC was educated as to how the Venous Catheter Physician Sheet should be reviewed for completeness. All licensed nurses will received education as to how the Cer Venous Catheter Physician Sheet is to be reviewed for | ne CC line Central Order or ive ntral | |
| time w. compression who was supposed to the "P Novem (instan every [Oxycoolevery [The Not Record one (1) 5:00 P pain. | 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 | | | | completeness once physicia are received indicating the upiccolor line by a resident. 3. All licensed nurses will received ducation about Central Line and usage of the Central Vencatheter Physician Order Staphysician order has been designating the need for a Cline, the Nurse Manager or designee within 72 hours of receipt of the order, will aud Central Line Physician Order and Central Line TAR for completeness and variances corrected. 4. The Central Line TAR and Covenous Catheter Physician Sheet will be listed on the Manager Medical Record Aucompleted monthly by the Needs will be seed and completed | ive e protocol enous heet. Once obtained Central their the it the er Sheet S will be Central Order Nurse udit Tool, | |

| PREFIX (EACH CORRECTIVE ACTION SHOULD BE COL | ĒD |
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| HFD02-0005 NAME OF PROVIDER OR SUPPLIER THE WASHINGTON HOME STREET ADDRESS, CITY, STATE, ZIP CODE 3720 UPTON STREET NW WASHINGTON, DC 20016 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX CEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE | 13 |
| NAME OF PROVIDER OR SUPPLIER THE WASHINGTON HOME STREET ADDRESS, CITY, STATE, ZIP CODE 3720 UPTON STREET NW WASHINGTON, DC 20016 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY TAG OR LSC IDENTIFYING INFORMATION) TAG COOSS-REFERENCED TO THE APPROPRIATE | 13 |
| NAME OF PROVIDER OR SUPPLIER THE WASHINGTON HOME STREET ADDRESS, CITY, STATE, ZIP CODE 3720 UPTON STREET NW WASHINGTON, DC 20016 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY TAG OR LSC IDENTIFYING INFORMATION) TAG COORSECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE) | 11.5 |
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| THE WASHINGTON HOME WASHINGTON, DC 20016 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX TAG OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE | 9000 <u>†</u> |
| PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE | V2 7 |
| 5 | (X5) DMPLETE 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. 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. | 5/2013 |

| Health R | equiation & Licensing | Administration | | | | | | |
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| L 052 | Record (MAR) reveatives was given on February AM and 4:20 PM), 1 PM), 15 (at 2:50 PM), 19 for pain. There was no evided conducted an assess description of the loc of the pain (e.g. numadministration of Ox. A face-to-face interved Employee #7 on February approximately 10:50 the aforementioned reviewed on February Employee #7 on February Em | Medication Administrated that Oxycodone I ary 1, 5, 6, 7, 10, 11, 3, 14 at (4:00 AM and I and 11:50 PM), 17, note that facility staff comment that included a cation of the pain, the neric scale) before an exycodone IR 5 mg. View was conducted we bruary 20, 2013 at 0 AM. He/she acknown findings. The recording 20, 2013. | R 5mg 12 (at 3:00 111:35 18, and onsistently intensity d after the ith wledged was t nursing ength for en Order an on e: PICC and, ailling to boout the nt orders: imference e insertion | L 052 | 5. | be added to the Nurse Manage Medical Record Audit Tool: the completed monthly and will be submitted to the Quality Improved Manager Pain Management Protocol we added to the annual Medication Administration Competency the part of the facility Quality Imprinitiative: the competency is administered annually to all collicensed nurses. The use pain scale prior to and following administration of pain medical be added to the Nurse Manage Medical Record Audit Tool: the completed monthly and will be submitted to the Quality Improved Manager Compliance Date Resident # 286 The resident did not sustain as The licensed nurse(s) receives education as to how follow the Venous Line Protocol for PIC on the Central Venous Line Tincluding resident arm circum measurement. All licensed nurses will receive education as to how the Central Venous Line TAR is to be for completeness. | ill be on hat is rovement linical e of a ng the tion will ger he tool is e ovement lines ovement lines AR: ference ive | 4/5/2013 |
| | [| | | | | Venous Line TAR is to be | | |

| Healt | n Regulation & Licensin | g Administration | | | | | | |
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| (X4) II PREFI TAG | X (EACH DEFICIENCY MUS | TATEMENT OF DEFICIENCIES IT BE PRECEDED BY FULL REC ENTIFYING INFORMATION) | GULATORY | ID PREFIX TAG | : •: | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE | COMPLETE DATE |
| L 0 | Treatment Record a Record revealed tha arm circumference catheter length was The "Central Vene Sheet" dated Feb Device Type: PICC: was left blank failing information about the sheet. Treatment of upper arm circumfe [centimeters] above with dressing chang Measure external contents each dressing chang A review of the Feb Treatment Record a Record revealed that 's arm circumference There was no evide circumference was the physician 's ord 2013 and the arm of catheter length on Fe A face-to-face intervence Employee #7 on Fe | auary 2013 Central line and Medication Adminiat on January26th the was 35 cm and the exist 10 cm. ous Catheter-Physicia bruary 1, 2013 directed bruary 1, 2013 directed bruary 1, 2013 directed brand, gauge, and to get to identify the aforement device type on the corders: PICC catheters arence (3 in [inches] or a insertion site) on administration and PRN [as needed atheter length on adminiat on February 2 and 9 ce was not measured. Sence of Resident #286 measured in accordant der on admission, January 2013 central line and fer on admission, January 2 and 9, 2013 wiew was conducted were and the secondary 2 and 9, 2013 wiew was conducted were as a secondary 2 and 9, 2013 wiew was conducted were and the secondary 2 and 9, 2013 wiew was conducted were and the secondary 2 and 9, 2013 wiew was conducted were and the secondary 2 and 9, 2013 wiew was conducted were and the secondary 2 and 9, 2013 wiew was conducted were and the secondary 2 and 9, 2013 wiew was conducted were and the secondary 2 and 9, 2013 wiew was conducted were and the secondary 2 and 9, 2013 wiew was conducted were and the secondary 2 and 9, 2013 wiew was conducted were and the secondary 2 and 9 and 2 | istration Resident's Resident's ternal n Order tal length nentioned order 10 cm nission, ad] ission, with e Catheter istration O Resident 's arm nee with uary 23, external 3. | L 052 | | All licensed nurses will receive education about Central Line and usage of the Central Ven TAR. Once a physician order been obtained designating the a Central Line, the Nurse Martheir designee within 72 hours receipt of the order, will audit Central Line Physician Order and Central Line TAR for completeness and variances corrected. The Central Line TAR and Ce Venous Catheter Physician O Sheet will be an item listed on Nurse Manager Medical Reco Tool completed monthly by th Managers. The Medical Reco Tool will be submitted monthly Quality Improvement Manage variances will be corrected at of the audit and/or discussed monthly at the Focus Quality Improvement Committee. Compliance Date | protocol ous Line has e need of nager or s of the the Sheet will be entral rder the ord Audit e Nurse rd Audit y to the r: the time at the | 4/5/2013 |

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| THE WAS | SHINGTON HOME | | | ON STREET I | | * * * * * |
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| L 052 | external catheter we was reviewed on Fe 7. Facility staff failed time was provided to received the incentive prescribed. Resident #292 was a February 6, 2013 with status post CABG of the admission order physician on February 10 physician on Feb | ference and the lengthere not measured. The bruary 19, 2013. The bruary 2014 that sufficie to ensure Resident #25 and the diagnosis that incompared that the object of the control of the co | ent nursing 92 ents as y on cluded lass Graft). by the "Use the e awake order, "burs while was ord that esident to all to three levels [he/she] ed it daily. | L 052 | 1. Resident did not sustain any has been discharged from the The licensed nurse received education on proper documer a physician treatment order of TAR. 2. All licensed nurses will receive education on documentation and transcription of a physicial order onto the residents' TAR treatment is administered to reatment is administered to reatment. 3. The Nurse Manager or design audit all resident TARs weekl accurate documentation of retreatments. 4. Auditing of accurate documer resident TARs will be part of the Nurse Manager Medical Record Tool and the Medical Record Tool will be submitted monthly Quality Improvement Manage variances will be corrected at audit and/or discussed month Focus Quality Improvement Committee. 5. Compliance Date | e facility. Intation of onto the e protocol can's to show esidents. The will be sident entation on the cord Audit Audit y to the er: time of |
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| L 052 | Continued From pag | ge 20 | | L 052 | L052 (C) | 1 | | | |
| | knew how to do it and understood the instructions." | | | | Resident # 164 | | | | |
| | 20, 2013 at 11:10 Al stated, "You could [he/she] was using ir [him/her] when [he/s the numbers on it [th document him/her u spirometer]. A face-to-face interv 20, 2013 at 11:00 Al acknowledged that the order for the use out. Additionally, resident had been re Pneumonia. The re 20, 2013. C. Based on observinterviews for one (1 was determined that sufficient nursing tim Resident #164 recei/supervision as to pre a medication administration observed and the sufficient nursing tim Resident #164 recei/supervision as to pre a medication administration observed and the sufficient nursing tim Resident #164 recei/supervision as to pre a medication administration observed and the sufficient nursing times and the sufficient nu | iew was conducted of M with Employee #7. he there was no evide of the spirometer was at the time of this revealmitted to the hospiecord was reviewed or ation, record review a) of 41 sampled resid facility staff failed enter was provided to enved adequate service formote safe swallowing stration observation. | He/she nen with look at n't n February He/she ence that s carried iew the ital with n February nd ents, it sure that | | Resident # 164 suffered no has wallowing difficulties occurred Immediate education was done the licensed nurse as to their noncompliance with the residence of thickened liquids and review of the facility Thickened Policy. A care plan to address resident's swallowing impairm been added to the Medical Resident's swallowing impairm been added to the Medical Resident receive Thick Liquids and or swallowing impairm the licensed nurse that receive order will add care plans for the needs in the resident's Medic Record. All residents requirity Thickened Liquids will have the amended to alert licensed nuthickened liquids are to be administered with all medicat well as with all meals. All licenses will receive education regarding the labeling of the I residents receiving thickened and a review of the Thickened and a review of the Thickened Policy. All licensed nurses will education regarding the immediated to add care plans reflect swallowing impairment and/o for Thickened Liquids to residental Record. | ed. ne with ent's d a ed Liquids s the nent has ecord. order to eened pairment, es the poth al I ng neir MAR rses that ions as ensed MAR of liquids d Liquids d Liquids fl receive ediate ting r need | | | |

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| L 052 | Carbonate one (1) to tablets, and Xifaxan gave Resident #164 cranberry juice in a content of the cranberry juice in a content of the cranberry juice in the cranberry one (1) container of beverage. At no tin thickener with the cranberry with the cranberry in the cranberry in the cranberry in the cranberry in the cranber with the cranberry in the cranber i | ations which included ablet, Neurontin 100m one (1) tablet. The Exapproximately 50 ml cup with a straw for the edication. The residons in the edication. The residons in the edication of the example of the edication of the example of the edication of the example of the edication of the example of the edication o | ed May 4, ch Multiple and dated a stencies | L 052 | 3. | The facility Thickened Liquids will be amended to reflect the of the MAR of all residents recthickened liquids. All licensed will receive education regarding amendment to the Thickened policy. When a resident receive order for Thickened Liquids, the licensed nurse receiving the clabel the MAR of the resident the resident's need for thicker liquids during medication administration as well as during meals. Within 72 hours follow physician's order for a resider receive thickened liquids the limit Manager or their designee will the residents' MAR to ensure has been labeled to show the resident's need for thickened and to ensure care plans for swallowing impairment and/or thickened liquids has been as the Medical Record. The Nursidened Manager will receive education regarding the audit process or resident's MAR. | labeling ceiving nurses ng the Liquids wes an he order will to reflect ned ing the nt to Nurse II audit the MAR liquids | | |

| | (X3) DATE SURVEY COMPLETED | |
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| (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY TAG (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. 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 Nurse Manager or The Nurse Manager 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. | 4/5/2013 | |

condition/s each

| THE WASHINGTON HOME A STREET ADDRESS, CITY, STATE, ZIP CODE 100 1 | Health R | equiation & Licensing | Administration | | | | | |
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| THE WASHINGTON HOME STREET ADDRESS, CITY, STATE, ZIP CODE 3720 UPTOD STREET NW WASHINGTON HOME PRETTY CONTROLLER TWW WASHINGTON HOME CALL DEPTIFYING INFORMATION) LOS2 Continued From page 23 medication was to be administered for one (1) resident; and facility staff administered an antityperfensive 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 Jaruary 23, 2013 revealed two orders for pain medications under the heading of "PRN (As needed) medications under the heading of "PRN (As needed) medications under the heading of "PRN (As needed) medications was to be active 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 at 9 Edurary 18, 2013, once on February 1, 4, 5, 6, 10, 12, 14 and 18 and twice on February 1, 4, 5, 6, 10, 12, 14 and 18 and twice on February 1, 5, 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 stee of the pain in nine (8) of the Managers Medical Record Audit Tool and will be reviewed monthly to | STATEMENT | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER | | ' ' | | (X | |
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| WASHINGTON HOME WASHINGTON, DC 20016 WASHINGTON, DC 20016 WASHINGTON, DC 20016 PROVIDERS PLANOF CORRECTION (PACH DEPICIENCY MUST BE PRECEDED BY PLAL REGULATORY OR I.S.C IDENTIFIANG INFORMATION) DEPICEMENT OR I.S.C IDENTIFIANG INFORMATION) 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 (biblist) (650mg) by mouth every four 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 to 10 times between February 1 a. 0 February 1 2. 013. 2013. once on February 1, 4, 5, 6, 10, 12, 14 and 18 and twice on February 1, 4, 5, 6, 10, 12, 14 and 18 and twice on February 1, 4, 5, 6, 10, 12, 14 and 18 and twice on February 1 a. 0 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 | NAME OF PR | OVIDER OR SUPPLIER | 21 | | | R S S | i). | |
| L 052 Continued From page 23 medication was to be administered or one (1) resident; and facility staff administered an antitypertensive 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 form 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 1, 4, 5, 6, 10, 12, 14 and 18 and twice on February 1, 4, 5, 6, 10, 12, 14 and 18 and twice on February 1, 4, 5, 6, 10, 12, 14 and 18 and twice on February 1, 4, 5, 6, 10, 12, 14 and 18 and twice on February 1 and 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 | THE WAS | HINGTON HOME | | | | | | an Anga ang |
| medication was to be administered for one (1) resident; and facility staff administered an antihyperfensive 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 1 and February 2013 once on February 1 and February 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 | PREFIX | (EACH DEFICIENCY MUST | BE PRECEDED BY FULL REC | GULATORY | PREFIX | (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A | SHOULD BE | |
| 10 instances of administration. The level of the Quality Improvement Manager. | L 052 | medication was to b resident; and facility antihypertensive me prescribed parameter Residents #4 and 26. The findings included 1. Facility staff failed time was provided to condition/s each pair administered to Residents for pair of "PRN (As need The first order was tabs (tablets) (650m needed for pain" The second order we para Amino Phenol) every 6 hours as need (MAR) for February Acetaminophen was Oxycodone was adrebruary 1 and Feb February 1, 4, 5, 6, February 15, 2013. A review of the backrevealed the nurses administration of the documented the site | e administered for one staff administered andication outside of the ers for one (1) resident 36. If ensure that sufficient of determine under which medication was to be ident #4. Islan's Order Form for ated January 23, 2013 medications under the ed) medications. "Acetaminophen 32 g) by mouth every four as "Oxycodone-APAF 5 5mg/325mg 2 tabs beded for pain" ication Administration 2013 revealed that the standard administered in times the ruary 18, 2013; once are once of the February 2013 in signatures for the edoxycodone. The new ers of the pain in nine (1) | t nursing ich pe February, 3 revealed heading 5mg 2 ur hours as process of (n=Acetyl y mouth). Record heading The petween on the strice of t | | L052 (D) Resident # 4 1. Resident sustained no hicensed nurse received the facility Pain Manage Assessment Protocol in recommendations to the specify parameters whe pain medications are or residents. 2. All licensed nurses received on Pain Management/P Assessment Protocol with recommendations to the specify parameters whe pain medications are or residents. 3. All licensed nurses will education on Pain Mana Assessment Protocol in recommendations to the specify parameters whe pain medications are or residents. An audit of remarks who receive pain will be an item added to Managers Medical Received and will be reviewed medical to will be reviewed medical to will be reviewed medical Tool will be submitted. | d education ement/Paracluding ephysicien two directed education en two directed for exective agement en two directed for exective agement en two directed for exidents of the Nurrord Audionthly by Medical Faitted more entalled for the state of the Nurrord Audionthly by Medical Faitted more entalled for the Nurrord Audionthly by Medical Faitted more | ion on ain ian to ifferent or ucation luded ian to ifferent or it/Pain ations rse it Tool y the Record onthly to |

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| L 052 | three (3) of the 10 in was administered. A review of the "Pain number Six (6) under indicated that " Pain quantitative and quartitative and the resident and the has been administer the resident does not employee added, "physician and asked With regard to rating pain the employee's Management /Pain / Charge Nurses." February 20, 2013. Facility staff failed to condition/s each pain administered and to prior to administering of effectiveness after 2. Facility staff failed time was provided to medication outside of Resident #286. The Admission order | ge 24 ectiveness were documentances when the mean Management" Policyer "Pain Assessment include alitative rating and desir 0 - 5 (zero to five) ration was conducted working and documenting the stated, "I will review Assessment Policy will him/her to discontinution and documenting the stated, "I will review Assessment Policy will review Assessment Policy will record was review to determine under whith medication was to be document the level of grain medication and reference administrated antihy of the prescirbed parameters signed and dated of "Lasix 40 mg one (1) | edication y, Item t " es scription ating." with n February garding ibed for dication tated that The fied the ue it. " e level of the Pain th the wed on ich be f the pain d the level dicated. t nursing rpertensive meters for danuary | L 052 | Pain Management/Pain Ass Protocol will be added to the Medication Administration Competency that is part of to Quality Improvement initiative competency is administered to all clinical licensed nurses 4. An audit of residents' MARS receive pain medications wi item added to the Nurse Material Record Audit Tool at reviewed monthly by the Nuture Managers. The Medical Record Wall be submitted month Quality Improvement Management Management Audit Tool of reviewed at the Focus Quali Improvement Committee. 5. Compliance Date | he facility ve: the I annually s. Who II be an magers and will be rse cord Audit hly to the ger. The will be | 4/5/2013 | |

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| L 052 | Continued From page 2 | :5 | 7. | L 052 | | | | | |
| | (tablet) orally daily for h | eart failure. " | | | | | | | |
| | The Interim Order dated " Hold Lasix for SBP (sy or less. " A review of the Medicat for January and Februa | stolic blood press ion Administratior | sure) 110 n Record | | | | | | |
| | The resident 's blood p 12 was 110/66 and on f 110/58. On both days th when it should have bee the prescribed paramete | ebruary 17 the rene lasix was adminental ending the lasix was adminer accordates. | eading was nistered ance with | | | | | | |
| | There was no evidence administered Lasix 40m prescribed parameters | ng in accordance v | | | | | | | |
| | A face-to-face interview 19, 2013 at 11:45 AM w acknowledged that the was not administrated v The record was reviewe | vith Employee #7. blood pressure movithin the order pa | He/she edication arameters. | | 020 | 9. | e a kasa | * 1 | ** |
| | 195 | 14 | | | | | 4 | | |
| | ₩ | | | | | R | ~ | | |
| L 056 | 3211.5 Nursing Facilitie | es . | | L 056 | | | | | |
| | Nursing personnel, liceraides, orderlies, and waduties consistent with the experience and based opatient load. This Statute is not me | ard clerks shall be neir education and on the characteris | assigned d tics of the | | | | | | |
| | Based on a review of the for the period of Februar determined that the faction minimum daily average | ary 9 through 11, 2 ility failed to meet | 2013, it was | | | | | | |

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| | (3) days reviewed. The findings include A review of the facility period of February 9 that the facility failed of direct nursing car (RN) or advanced processing the facility provided insulo. 34 hours. On February 10, 20 facility provided insulo. 39 hours. The findings were duat 1.1:30 AM-during with Employee #2. Efindings and stated weekend coverage a recruiting qualified served in accordance forth in Title 23, Subsequent in accordance forth in Title 23, Subsequent is not Based on observation in Eased in Eased in Ease Ease Ease Ease Ease Ease Ease Ease | ty 's staffing records through 11, 2013 red to meet the required e provided by register ractice registered nurs it was determined the inflicient RN coverage etermined on Februar a concurrent review of Employee #3 acknowlethat the staffing was reand the facility was cutaff. | for the evealed 0.6 hours red nurses ses. nat the at a rate of that the at a rate of that the effective of t | | L056 Through attrition all licensed nurse positions vacated by Licensed Propositions. Active recrutiment is into attract qualified Registered Nurses are converted to Register positions. Active recrutiment is into attract qualified Registered Nurses have utilized, aggressive advertisement detailed orientation programs have designed to attract newly licensed Registered Nurses into open RN 1. Resident care has not been considered to a tract newly licensed Registered Nurses into open RN 2. Resident care has not been considered advertisement gent toward Registered Nurses have utilized. 3. The facility has invested in a consponent program (2 months in length) newly graduated Registered select qualified, few are adrested to the program quarterly if there anopen position. 4. Retention of all licensed nursemonitored quarterly through the Quality Improvement Commits. Compliance Date | actical red Nurse progress rses into ve been of positions. delayed. delayed. ouses, ared as been for Nurses: a mitted to e is es is the | |

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| L 099 | of four (4) hotel pathat were stored were one (1) cutting boar indentation, and two were observed soile. The findings include. The following was omain kitchen: 1. Four (4) of four (4 stored wet and read 2. 14 of 21 sheet pafor reuse 3. A white cutting board indentation in one (14. Two (2) of two (2) observed with soiled. These observations Employee # 20. Based on observations Employee # 20. Based on observations Employee # 20. Based on observations (4) hotel pans and stored wet and read cutting board was of two (2) of two (2) cosoiled. | itions as evidenced by ns and 14 of 21 she t and ready for reuse, of was observed with a (2) of two (2) converted. bserved during a tour by for reuse ns were stored wet an oard was observed with of one (1) observed convention ovens were stored interiors were made in the present was determined by the prepare and serve to as evidenced by: Found 14 of 21 sheet pans by for reuse, one (1) observed with an inderinvention ovens were | et pans one (1) of an one (1) of an of the were of the were of that an dere esence of ur of ed that the food under of (4) of four of that were one (1) ontation, and | L 099 | L099 Hotel pans 1. The four (4) pans were immed re-washed and dried per polic 2. No other pans were stored in scondition. 3. 100% of the staff will be in-sent the proper dish room policy. 4. Appropriate hotel pan storage the opening and closing check This will be monitored by the director daily. A summary findings will be reported to QI Committ monthly. 5. Date of Compliance Sheet pans 1. Pans were immediately rewash dried per policy. 2. These were the only pans idencited condition. 3. Appropriate hotel pan storage the opening and closing check This will be monitored by the director daily. A summary findings will be reported to QI Committ monthly. 5. Date of Compliance | y similar viced on added to klist. of daily tee hed and added to klist. of daily of daily of daily of daily | 3/22/2013 |
| | The findings include | : : | | | | | |

Health Regulation & Licensing Administration (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: __ HFD02-0005 02/21/2013 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3720 UPTON STREET NW THE WASHINGTON HOME WASHINGTON, DC 20016 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PRÉFIX PREFIX: DATE OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) L 099 L 099 Continued From page 28 Cutting board 1. The cutting board was immediately discarded. The following was observed during a tour of the 2. No other cutting board was identified main kitchen: with an indentation. 1. Four (4) of four (4) 4 inch hotel pans were 3. All staff will be in-serviced to bring stored wet and ready for reuse damaged cutting boards to 2. 14 of 21 sheet pans were stored wet and ready management team. for reuse 4. Inspection of cutting boards added to 3. A white cutting board was observed with an Monthly Safety and Sanitation Audit. indentation in one (1) of one (1) observed 4. Two (2) of two (2) convention ovens were Audit findings will be reported to QI observed with soiled interiors Committee quarterly. 3/22/2013 5. Date of Compliance These observations were made in the presence of Employee # 20. Ovens 1. Two of two ovens were immediately L 161 L 161 3227.12 Nursing Facilities cleaned and soiled particles removed. 2. No other ovens were observed with Each expired medication shall be removed from soiled particles. usage. 3. Although ovens are not used, they will This Statute is not met as evidenced by: Based on an observations during medication storage review, it was determined that facility staff be added to the weekly cleaning list. failed to ensure that intravenous (IV) fluids were 4. Inspection of convention ovens will be not stored beyond the expiration date. added to the opening and closing check list. This will be monitored by The findings include: Food Services Director weekly and 1. One (1) of six (6) 5% Dextrose and 0.9% findings reported to QI Committee Sodium Chloride Injection USP 1000ml had an quarterly. expiration date of January, 2013 and was stored for 5. Date of Compliance 3/22/2013 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

FORM APPROVED Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED IDENTIFICATION NUMBER AND PLAN OF CORRECTION A. BUILDING B. WING HFD02-0005 02/21/2013 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **3720 UPTON STREET NW** THE WASHINGTON HOME WASHINGTON, DC 20016 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE in (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (EACH CORRECTIVE ACTION SHOULD BE PREFIX CROSS-REFERENCED TO THE APPROPRIATE OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY). Continued From page 29 L 161 L161 of Employee #7 at 4:15PM on February 15, 2013 on Unit 3B. 1. On 11/29/2012, confirmed that there were 2 bags of Dextrose 10% and 2 L 306 L 306 3245.10 Nursing Facilities bags of 5%Dexrose 0.9% Sodium Chloride in the Omnicell. There were A call system that meets the following requirements no transactions with these items until shall be provided: 2/18/2013 when one bag of each were removed because they were (a)Be accessible to each resident, indicating signals expired. Therefore, no residents were from each bed location, toilet room, and bath or affected. shower room and other rooms used by residents; 2. The Omnicell Technician checked the Omnicell for expired medications. (b)In new facilities or when major renovations are There were no expired medications made to existing facilities, be of type in which the present in the Omnicell. call bell can be terminated only in the resident's 3. An Omnicell Technician will continue room: to check the Omnicell contents for (c)Be of a quality which is, at the time of installation, expired medications at least once consistent with current technology; and quarterly. Expired is defined as any medication with an expiration date that (d)Be in good working order at all times. is within (4) four months from the date This Statute is not met as evidenced by: of inspection. When expired ... medication is identified, the Omnicell Technician will run an "Expiry" Inventory Report" from the Based on observations and staff interview for five Omnicell. Once completed, the (5) of five (5) resident rooms observed, it was determined that facility staff failed to ensure that the Omnicell Technician will place all call system in five (5) residents' rooms were expired medication in an "Omnicare functioning to allow communication from the Return to Pharmacy" bag. residents to the nurses' station. The Omnicell Technician will locate a Nursing Supervisor to review the The findings include: findings of the inspection. The Omnicell Technician will sign the 1. Facility staff failed to ensure that the call bell "Expiry Inventory Report" and the system in the residents' rooms and/or bathrooms Nursing Supervisor will sign the form

were functioning properly.

to indicate receipt of the expired

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| L 306 | audible alarm when resident's room obse approximately 12:25 staff probably pulled where the resident with the cord from the wabell was removed aroutlet, which initiates station. 2. Facility staff failed system in the reside were functioning prorooms observed. 2A. A resident room February 13, 2013 a Unit 3A in Room 305 When the residents (pressed) in the room at the nurses 'station of the room over the attempt was made to nurses 'station, the the room. Employee #31 macall bell, but was still bell to function proper | ge 30 m #230 did not initiate tested in one (1) of ore tested in one (1) of ore tested on February 14 of PM. Employee #6 of the call bed cord to revas sitting, and this loal outlet." Subsequent of re-inserted into the dan alarm to the nurse of the ensure that the cants' rooms and/or bat operly in three (3) of fine observation was constant approximately 3:19 of the following was the call bell would into any or would the light door) light up. When answer the resident of any other and the end of the ensure that the react of the ensure that the ensur | ne (1) , 2013 at stated, "the reach rosened tly, the call e wall sing all bell hrooms ve (5) ducted on PM on s observed: ted not sound nt (outside en an from the ot heard in lijust the ing the call was made | L 306 | a p " " Co till v Co till | medications from the Omnias the facility's responsibility or ovide the Omnicare Court Omnicare Return to Pharm The Omnical Technician woriginal and a copy will be a he Facility. Once the context of the Facility of the Nursing Support of the seal Omnicell Technician will give of the Nursing Support of the expired medications at Omnicare Phannapolis Junction, the Omfechnician will verify the context of the Nursing Supervisor of the Nursing Supervisor of the Mursing Supervisor of the Nursing Supervisor of the | ty to rier the nacy" bag. It keep the made for ents are ents or, the eal the bag, and the ve the bag. It harmacy of nnicell ontents with rt" signed and the re are any life irector of hnician will arterly ng s of | |

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| L 306 | 2B. A resident room February13, 2013 at | observation was cond t approximately 4:26 F | PM on Unit | L 306 | L306 #1 1. Call bell was removed and re | - inserted |
| | When the resident '(pressed) in the room nurses' station. Wanswer the resident audible voice was not when the bathroom light (over the door of light up to signal for bathroom. These observations Employee #32. 2C. A resident room February14, 2013 at Unit 3A in Room 334 The residents' call be when pressed. Employee was not audible also present at the timployee #30 indicationly way he/she kneethat he/she looked a | s call bell was activated, the bell would sour When an attempt was from the nurses' stated to heard in the room. call bell was pulled, the butside of the room) wassistance needed in were made in the present approximately 10:40. The following was ell did not activate in the ployee #30 made an afform the nurses' state in room. Employee intended to Employee #16 we the call bell was protected to Employee #16 we the system at the from the system at | ed and at the made to ation, the he red vould not the essence of ducted on AM on a observed: the room attempt to ation, the e #16 was an. So that the essed, is put desk | | Call bell was removed and reinto the wall outlet, which initialarm to the nursing station at 2/14/13. Clinical leadership to meet with operations leadership to deling responsibilities regarding work conditions of call bells. Maintestaff repairs system failures of are reported by clinical staff. Call bells will be tested weekly multi-disciplinary environment rounds. Findings to be reported to more QI Committee. Date of Compliance. #2A Call bells was checked, reinsethe found to be operational as of 2. Call bells inserted incorrectly prevent activation of bells, ligit audible capabilities from nurs to resident room and back. Cleadership to meet with plant operations leadership to deling responsibilities regarding work conditions of call bells. Maintestaff repairs system failures of are reported by clinical staff. | ated an s of th plant eate king enance nce they y during tal anthly to 4/5/2013 Ated and 02/13/13 will estation inical eate king enance |

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| L 306 | When the bathroor light outside of room although audible in to the control of the | m light was activated, in (over the door) did not the bathroom when and is made in the presence #30. In observation was condit approximately 11:09 the following was obsected bell did not activate in Employee #32 made in Employee #32 made in Employee #32 made in Employee #36 made call bell from the froudible in room. The result of the room of the call bell (cord) was provided the call bell from the seponse was not audionally was heard in the result of the presected made in the pr | ot light up, nswered. ce of ducted on AM on 3A erved: In the room e an ont desk, resident over the nducted: ndu | L 306 | multi-corounds 4. Finding QI Cor 5. Date of #2B 1. Call be 2. Clinic operative respondent staff respondent 4. Finding QI Cor 1. Call be prever audible to resi leader operative respondent staff respondent | gs to be reported to maintee of Compliance pell repaired as of 02/2 cal leadership to meet ations leadership to de onsibilities regarding itions of call bells. Mai repairs system failures are reported by clinica pells will be tested weed | 3/13. with plant lineate working ntenance sonce I staff. ekly during ntal monthly to 13. / will ghts and se station Clinical t ineate orking enance once they | 4/5/2013 |
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| L 306 | (5) of five (5) resider determined that faci system in five (5) res | ge 33 ons and staff interview nt rooms observed, it- lity failed to ensure the sidents' rooms were fu- tion from the residents | was at the call unctioning | L 306 | 3. Call bells will be tested weekl multi-disciplinary environment rounds. 4. Findings to be reported to make QI Committee 5. Date of Compliance | tal | 4/5/2013 |
| | The findings include 1. The facility failed system in the reside were functioning pro The call bell in Roor audible alarm when resident's room obsapproximately 12:25 staff probably pulled where the resident with the cord from the wabell was removed aroutlet, which initiates station. 2. The facility failed system in the reside were functioning prorooms observed. 2A. A resident room February 13, 2013 a Unit 3A in Room 305 | to ensure that the call nts' rooms and/or bat | an ne (1) , 2013 at stated, "the each osened tly, the call e wall sing I bell hrooms ve (5) ducted on PM on observed | | Call bell was repaired as of 2/ Call bells inserted incorrectly prevent activation of bells, light audible capabilities from nurs to resident room and back. Colleadership to meet with plant operations leadership to deling responsibilities regarding work condition of call bells. Maintenance staff repairs systemilures once they are reported clinical staff. Call bells will be tested weekly multi-disciplinary environment rounds. Findings to be reported to model Committee Date of Compliance #2E System tested and found to be operational as of 02/14/13. Resident call bells in restroom have the audible function. Cashared resident restrooms so either of the shared resident restrooms. | will hts and e station linical eate king tem d by y during tal nthly to e hs do not II bells in und in | 4/5/2013 |

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| THE WASHINGTON HOME CASH DEPARTMENT CASH C | NAME OF PR | OVIDER OR SUPPLIER | | STREET ADD | RESS, CITY, STA | ATE, ZI | P CODE | \$5 | |
| L 306 Continued From page 34 (pressed) in the room, the call bell would not sound at the nurses station, the audible voice was not heard in the room. Employee #31 made an attempt to readjust the call bell to function properly. This observation was conducted on February13, 2013 at approximately 426 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, the audible voice was not heard in the roresed in the presence of Employee #32. When the resident 's call bell was activated (pressed) in the room, the bell would sound at the nurses' station. When an attempt to readjust 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 426 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 February14, 2013 at approximately 10-40 | | * 7 | | | | | | 8 8 4 * | 3 M 3 |
| (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's call bell was activated (pressed) in the resident's call bell was activated (pressed) in the room, the bell would sound at the nurses' station. When the bathroom. These observations were made in the presence of Employee #32. This is the design of the system, No malfunction noted. Call bells will be tested weekly during multi-disciplinary environmental rounds. Findings to be reported to monthly to QI Committee 5. Date of Compliance 4/5/2013 La62 1. Personal refrigerators in resident rooms 229 and 137 were inspected and tagged by maintenance staff as of 2/20/13. La62 1. Personal refrigerators in resident rooms 229 and 137 were inspected and tagged by maintenance staff as of 2/20/13. 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 safetylelectrical checks. 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 to monthly to QI Committee. | PREFIX | (ÉACH DEFICIENCY MUST | FBE PRECÈDED BY FULL REC | GULATORY | PREFIX | - | (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR | BE | COMPLETE |
| Unit 3A in Room 334. The following was | L 306 | (pressed) in the room at the nurses 'station of the room over the attempt was made to nurses' station, the the room. Employee #31 macall bell, but was still bell to function proportion the presence on E #31. 2B. A resident room February13, 2013 at 3A in Room #323. When the resident '(pressed) in the room nurses' station. Vanswer the resident audible voice was not when the bathroom light (over the door of light up to signal for bathroom. These observations Employee #32. | m, the call bell would rion, nor would the light door) light up. When a canswer the resident e audible voice was not deen attempt to read I unsuccessful in gettierly. This observation employee #30 and Employee | It (outside n an a | L 306 | 4. 5. <u>L3</u> 1. 3. | malfunction noted. Call bells will be tested weekly multi-disciplinary environment rounds. Findings to be reported to mor QI Committee Date of Compliance Personal refrigerators in resid rooms 229 and 137 were inspand tagged by maintenance s 2/20/13. Clinical leadership will commute maintenance staff when ne electrical equipment arrives of prior to being placed in service that maintenance staff can contimely safety/electrical checks. Resident rooms' stands are in daily by Environmental Service leaders/ Supervisors. Follow-tinspections will be conducted by the Plant Operations Manateam. Findings to be reported quarte Committee. | ent ected taff as of unicate w . n units, e, so nduct . spected es Team up weekly agement | |

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| L 306 | The residents' call be when pressed. Em answer the call bell voice was not audibell also present at the temployee #30 indicated in the state only way he/she kneethat he/she looked and noticed the light nurses' station eith when the bathroor light outside of room although audible in temployee #16 and #20. A resident room February14, 2013 at in Room 307. The residents' call when pressed, when attempt to answer the voice was not aulight did not light up door) | pell did not activate in the ployee #30 made and from the nurses 'stable in room. Employee time of the observation ated to Employee #16 ew the call bell was preat the system at the frost blinking, it did not so her. In light was activated, in (over the door) did not the bathroom when are smade in the presence. | attempt to attion, the e #16 was n. If that the essed, is ont desk und at the the red ot light up, nswered. The of the red of light up, nswered. The of the room e an ont desk, esident over the the room nducted of the room e an ont desk, esident over the the room nducted the room e an ont desk, esident over the the room nducted | L 306 | L410 A. Finding #1 1. Window blinds in resident roo and #230 will be replaced. 2. All resident room window blinds observed and documented we during maintenance rounds. Finspections will be conducted by the Plant Operations Manateam. 4. Findings of broken blinds and will be reported quarterly to the Committee. 5. Date of Compliance 04/05/13 Finding #2 1. The damaged door frame to the entrance door of room #216 we repaired. 2. All doors frames of other residence of the residen | ds were d found are eekly Follow-up monthly agement repair ae QI 3. the will be dent d ag |
| | | | | | Operations Management tean | n. |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SU | | | | |
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| T BE PRECEDED BY FULL RE | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE | | | |
| 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. 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: | | | 4. Findings of damaged and repaired door frames will be reported quarterly to QI Committee. 5. Date of Compliance | 4/05/13 | | | |
| | | | Finding #3 1. The stained bathroom commode in room #257 was cleaned. 2. All resident room commodes are cleaned daily. | | | | |
| | | | include bathroom commodes, by Environmental Services Team leaders/ Supervisors. Follow-up inspections will be conducted weekly by the Plant Operations Managemen team. | I je | | | |
| n February 19, 2013 at 5 AM, and during a toumined that the facility of all equipment was mained ition as evidenced by observed with a mission and two (2) of two (2) ere not deemed to be in prior to use. | ur of the failed to ntained in one (1) of ing bottom 2) personal in safe | | 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 | 4/05/13 | | | |
| | age 36 age 36 am #332. The following a sight would activate, where the call bell from response was not auditions and the mass and the mass and the mass and removal. The transport of the preparation and seed arranged and equipage, preparation and seed and removal. The transport of the premises, and removal. The transport of the premises and the facility and removal. The transport of the premises are also and the facility and the premises and the facility of the premises and two (2) of two (3) of two (4) of the prior to use. | TATEMENT OF DEFICIENCIES ST BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION) age 36 am #332. The following was be call bell (cord) was pulled in ight would activate, when wered the call bell from the response was not audible in bility was heard in the room next 334). be remade in the presence of d #30. cilities ared on the premises, each be arranged and equipped for the ge, preparation and serving of or dish washing, utensil washing, and removal. It met as evidenced by: ions made during a tour of the mined that the facility failed to ial equipment was maintained in dition as evidenced by one (1) of the observed with a missing bottom es and two (2) of two (2) personal ere not deemed to be in safe in prior to use. | TATEMENT OF DEFICIENCIES ST BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION) age 36 If a call bell (cord) was pulled in ight would activate, when wered the call bell from the response was not audible in bility was heard in the room next 334). Were made in the presence of d #30. Cilities L 362 ared on the premises, each be arranged and equipped for the ge, preparation and serving of or dish washing, utensil washing, and removal. It met as evidenced by: ions made during a tour of the remined that the facility failed to ial equipment was maintained in dition as evidenced by one (1) of observed with a missing bottom es and two (2) of two (2) personal ere not deemed to be in safe a prior to use. | STREET ADDRESS, CITY, STATE, ZIP CODE 3720 UPTON STREET NW WASHINGTON, DC 20018 TATEMENT OF DEPICIENCIES STEPRECEDED BY FULL REGULATORY TAGS TO BE PRECEDED BY FULL REGULATORY TAGS TO CASH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TO QI Committee. 5. Call bell (cord) was pulled in ight would activate, when wered the call bell from the response was not audible in bility was heard in the room next 334). Were made in the presence of d #30. L 362 A 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 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 rounds. | | | |

Health Regulation & Licensing Administration (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED. A. BUILDING: _ B, WING HFD02-0005 02/21/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **3720 UPTON STREET NW** THE WASHINGTON HOME WASHINGTON, DC 20016 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE OR LSÇ IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) L 362 Continued From page 37 L 362 Follow-up inspections will be determined that the facility failed to ensure that conducted weekly by the Plant essential kitchen equipment was maintained in safe Operations Management team. operating condition as evidenced one (1) of two (2) 4. Findings and repair will be reported ovens were observed with a missing bottom panel quarterly to QI Committee. exposed wires. 5. Date of Compliance 4/5/2013 This observation was made in the presence of Employee #20 who acknowledged the finding. Finding #5 2. Two (2) of two (2) personal refrigerators were 1. The pillar and adjacent wall in room observed "in use" in resident rooms (#229 and 237 were repaired as of 03/19/13. 137) in the absence of a mechanical clearance (deeming the refrigerators safe for use) determined 2. All resident rooms will be inspected by the facility. for pillar and wall damage by maintenance staff. The observation was made in the presence of 3. Resident rooms are inspected daily by Employees #1 and 14 during an environmental tour **Environmental Services Team** of the facility on February 20, 2013. leaders/ Supervisors. Follow-up inspections will be conducted weekly L 410 3256.1 Nursing Facilities L 410 by the Plant Operations Management team. Each facility shall provide housekeeping and Findings and repair will be reported 4. maintenance services necessary to maintain the quarterly to QI Committee. exterior and the interior of the facility in a safe. Date of Compliance 4/5/2013 sanitary, orderly, comfortable and attractive This Statute is not met as evidenced by: Finding #6 A.Based on observations made during an environmental tour of the facility on February 13, 1. The wallpaper on both sides of the 2013 at approximately 2:00 PM and on February 14, hallway between rooms # 226 and 2013 at approximately 10:00 AM, it was determined #238 was re-glued of 03/19/13. that the facility failed to provide housekeeping and 2. All resident unit common areas will be maintenance services necessary to maintain a inspected for peeling wallpaper and re sanitary, orderly, and comfortable interior as evidenced by two (2) of four (4) broken window glued by maintenance staff. blinds in two (2) of seven (7) resident rooms; a 3. Resident common areas are inspected damaged door frame in one (1) of seven (7) for peelling wallpaper residents' rooms, a stained commode in the bathroom of one (1) of seven (7)

| 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. 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 the 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 Finding #2 1. All rooms identified will be repaired for surface defects along the wall surfaces. 2. All resident rooms was taloned in rooms 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 #2 1. Leaking bathroom faucets in rooms are inspected by maintenance staff for surface defects along the wall surfaces. 2. All resident rooms are inspected by maintenance staff for surface defects along the wall surfaces. 3. Resident rooms are inspected wall surfaces. 4. Finding#1 5. A pillar in room #237 and the adjacent wall | Health R | egulation & Licensing | q Administration | | VI. | | | | |
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| HFD02-0005 A BIULDING B. WING B. WING DEPOSITE TO PROVIDER OR SUPPLIER THE WASHINGTON HOME STREET NOW WASHINGTON, DC 20016 CACH DEPOSITE TO PRESENT OF DEPOSITE PRESENTED BY FULL RESULATORY OR LSG DENITY WASHINGTON, DC 20016 L410 Continued From page 38 Cach Denity Washington, DC 20016 PROVIDER'S PLAN OF CORRECTION SET OF CROSS REFERENCED TO THE APPROPRIATE DEPOSITE O | | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA | | | | | STRUCTION | | |
| The Washington Home STREET ADDRESS, CITY, STATE, 2IP CODE 3720 UPTON STREET NW WASHINGTON, DC 20016 CACH CORRECTIVE ACTION AND THE PROCEDED BY FULL RESULATORY TAGE (EACH EPICIENCY MUST BE PRECEDED BY FULL RESULATORY TAGE (EACH EPICIENCY MUST BE PRECEDED BY FULL RESULATORY TAGE (EACH EPICIENCY MUST BE PRECEDED BY FULL RESULATORY TAGE (EACH EPICIENCY MUST BE PRECEDED BY FULL RESULATORY TAGE (EACH EPICIENCY) I All 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 darnaged with numerous holes five (5) in one (1) of seven (7) residents rooms, and peeling wellpaper 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) residents' rooms. 4. Closet doors in two (2) of seven (7) residents' rooms. 4. Closet doors in two (2) of seven (7) residents' rooms. 4. Closet doors in two (2) of seven (7) residents' rooms. 4. Closet doors in two (2) of seven (7) residents' rooms. 4. Closet doors in two (2) of seven (7) residents' rooms. 4. Closet doors in two (2) of seven (7) residents' rooms. 4. Closet doors in two (2) of seven (7) residents' rooms. 5. A pillar in room #237 and the adjacent wall were damaged with holes in one (1) of seven (7) residents' rooms were marred and scarred (rooms #222 and #223). 5. A pillar in room #238 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. | ANDILAN | OF CONNECTION | WDEIX. | A, BUILDING: | | | | 1 22 1 2 2 | |
| The Washington Home STREET ADDRESS, CITY, STATE, 2IP CODE 3720 UPTON STREET NW WASHINGTON, DC 20016 CACH CORRECTIVE ACTION AND THE PROCEDED BY FULL RESULATORY TAGE (EACH EPICIENCY MUST BE PRECEDED BY FULL RESULATORY TAGE (EACH EPICIENCY MUST BE PRECEDED BY FULL RESULATORY TAGE (EACH EPICIENCY MUST BE PRECEDED BY FULL RESULATORY TAGE (EACH EPICIENCY MUST BE PRECEDED BY FULL RESULATORY TAGE (EACH EPICIENCY) I All 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 darnaged with numerous holes five (5) in one (1) of seven (7) residents rooms, and peeling wellpaper 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) residents' rooms. 4. Closet doors in two (2) of seven (7) residents' rooms. 4. Closet doors in two (2) of seven (7) residents' rooms. 4. Closet doors in two (2) of seven (7) residents' rooms. 4. Closet doors in two (2) of seven (7) residents' rooms. 4. Closet doors in two (2) of seven (7) residents' rooms. 4. Closet doors in two (2) of seven (7) residents' rooms. 4. Closet doors in two (2) of seven (7) residents' rooms. 5. A pillar in room #237 and the adjacent wall were damaged with holes in one (1) of seven (7) residents' rooms were marred and scarred (rooms #222 and #223). 5. A pillar in room #238 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. | | 73 | | | D MINO | | * 00/04/0040 | | |
| THE WASHINGTON HOME 3720 UPTON STREET NW WASHINGTON, DC 20016 CACH DEPICIENCY WIGST RE PRECEDED BY FILL RESULATORY PRETIX (EACH DEPICIENCY WIGST RE PRECEDED BY FILL RESULATORY TAG) L 410 Continued From page 38 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 wellpaper 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) resident's ro | | 6 26 | HFD02-0005 | CTDEET ADD | | A TE -7 | ID CODE | 02/2 | 1/2013 |
| WASHINGTON HOME WASHINGTON, DC 20016 | 400 | ROVIDER OR SUPPLIER | | | | | IP CODE | æ | |
| Experience of the frame in one (1) of seven (7) residents' rooms. The bathroom commode was stained in room #216 and #223). The bathroom commode was stained in room #227 and the adjacent wall were damaged with holes in one (1) of seven (7) resident walls were damaged with holes in one (1) of seven (7) resident walls were damaged with holes in one (1) of seven (7) resident walls were both sides of the hallway between rooms #226 and #238. L 410 L 410 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. The findings include: The findings include: 1. Window blinds were broken in rooms #216 and #230, in two (2) of seven (7) resident's 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 none (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 1:00 OA Mo or February 14, 2013. He/she acknowledged the findings. | THE WAS | SHINGTON HOME | 8 8 8 8 8 8 | | | | (4 | 78 ^[8] | 39 |
| 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 #2257, one (1) of seven (7) resident's rooms. 4. Closet doors in two (2) of seven (7) resident's rooms. 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 2:00 PM on February 13, 2013 and at approximately 2:00 DM on February 14, 2013. He/she acknowledged the findings. | PREFIX | (EACH DEFICIENCY MUST | BE PRECEDED BY FULL REC | GULATORY | PREFIX | | (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR | BE | |
| 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 02/20/13. Resident bathrooms are inspected daily by maintenance staff for leaking spigot. | L 410 | residents rooms, matwo (2) of seven (7) adjacent wall damagin one (1) of seven wallpaper on both s rooms #226 and #25. The findings include 1. Window blinds #230, in two (2) of s 2. The door frame #216 was damaged the frame in one (1) 3. The bathroom of #257, one (1) of seven 4. Closet doors in rooms were marred #223). 5. A pillar in room were damaged with resident's rooms. 6. The wallpaper of between rooms # 22 walls in one (1) of the needed to be repaired these observations Employee #6 at app 13, 2013 and at app February 14, 2013, findings. B. Based on observooms during an enverted the seven rooms during | arred and scarred clos residents rooms, a pil ged with numerous ho (7) residents rooms, al ides of the hallway beids. were broken in rooms even (7) residents' room to the entrance door of with a hole on the left of seven (7) resident's room two (2) of seven (7) resident's room two (2) of seven (7) reand scarred (rooms ##237 and the adjacen holes in one (1) of seven (3) hallways obseined (3) h | #216 and peeling tween #216 and poms. of room side of s rooms. in room as esidents' 222 and at wall wen (7) Illway and of the rved and sence of a February on a selected a facility on the selected a facility on the selected and the selected an | L 410 | 5. B. 1. 2. 3. 1. | leaders/ Supervisors. Follow-usinspections will be conducted by the Plant Operations Manateam. Findings to be reported quarter Committee. Date of Compliance Finding#1 All rooms identified will be repsurface defects along the wall surfaces. All resident rooms will be inspmaintenance staff for surface along wall surfaces. Resident rooms are inspected Environmental Services Team leaders/ Supervisors. Follow-uinspections will be conducted by the Plant Operations Manateam. Findings to be reported quarter Committee. Date of Compliance Finding #2 Leaking bathroom faucets in respected to the plant of t | weekly gement erly to QI aired for ected by defects daily by weekly gement erly to QI ooms | 4/5/2013 |

| Health Regulation & Licensing Administration | | | | | | | |
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| THE WAS | SHINGTON HOME | # G 70 E | | ON STREET | | 13 | ra . |
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| L 410 | to maintain a sanitar interior as evidenced in 19 rooms; leaking damaged blinds and rooms; soiled floor sexhaust vents accurrooms, one (1) call litape and one (1) dra. The findings include 1. Nineteen (19) of 3 surface defects alon Marred areas: Rooms #357, 351, 3 Spackling paste with Rooms: #357, 351, 3 Holes in the wall sur Rooms: #350, 259 Nails and/or hinges Rooms: #316, 314, 3 | maintenance services ry, orderly, and comfo d by defects along way faucets in two (2) rood/or window screens in surfaces in four (4) roomulated with dust in foight was secured with awer pull was partially e: 39 rooms were observing wall surfaces as followed finishing paint: 346, 332, 216, 211, 20 ffaces: | ortable all surfaces oms; n six (6) oms; our (4) n electric n detached. ved with llows: | L 410 | Resident rooms are inspected Environmental Services Team Supervisors. Follow-up inspect be conducted weekly by the Pl. Operations Management team Findings to be reported quarter Committee. Date of Compliance Finding #3 Identified rooms with damaged and/or screens will be fixed or replaced. All resident rooms are inspected for damaged blinds and/or screens maintenance staff. Resident rooms are inspected Environmental Services Team Supervisors Follow-up inspecti be conducted weekly by the Pl. Operations Management team Findings to be reported quarter Committee. Date of Compliance Finding #4 All identified floors have been as of 2/20/13. All resident room floors have cleaned for dust, marred or a difinish. | leaders/ions will ant ly to QI blinds blinds daily by leaders/ons will ant ly to QI cleaned been | 4/5/2013 |

Health Regulation & Licensing Administration

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE (X2 | ON | | (X3) DATE SURVEY COMPLETED | | |
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| (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 |
|--------------------------|---|-----------------------|---|--------------------------|
| | 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 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 too of the facility on February 20, 2013. 3257.3 Nursing Facilities Each facility shall be constructed and maintained at that the premises are free from insects and rodent 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 | in L 426 | 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. Findings to be reported quarterly to QI Committee. Compliance Date Finding #5 All identified exhaust vents have been cleaned as of 3/19/13. Allexhaust vents are inspected daily and cleaned for dust. Exhaust vents are inspected daily by Environmental Services Team leaders/ Supervisors. Follow-up inspections will be conducted weekly by the Plant Operations Management team. Compliance Date Finding #6 Call light cord in room 204 was replaced as of 2/20/13. All call light cords are inspected daily during maintenance rounds. 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. | 4/5/201 |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/S | | (X1) PROVIDER/SUPPLIER IDENTIFICATION NU | | | STRUCTION | (X3) DATE SURVEY COMPLETED | | |
| AND FLAN | DF CORRECTION | IDENTIFICATION NO | MIDER | A BUILDING: | | | COIVII | FLETED |
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| L 426 | Continued From pag | ge 41 | | L 426 | 4. | Findings to be reported quarte | erly to OI | |
| | | facility failed to mair of program to ensure the ts. | | | 5. | Committee. Compliance Date | iny to Qi | 4/5/2013 |
| | The findings include | : | | | 1 | nding #7 Night stand drawer in room 33 repaired as of 2/20/13. | 33 was | |
| | | oserved as follows: nursing station in the February 14, 15 and 1 | | | 2. 3. | All night stands are inspected during maintenance rounds. | · | |
| | | le observing incontine imployee #15 on Febr | | | | Environmental Services Team leaders/ Supervisors. Follow-uinspections will be conducted by the Plant Operations Manateam. | ıp weekly | |
| . ≅ | × | a * | | | 4. 5. | Findings to be reported quarte Committee. Compliance Date | erly to QI | 4/5/2013 |
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| * 3 | 100 400 | | ß | · · | <u>L4</u> #1, | <u>26</u> | | |
| | × | 8 8 | | es. | | Facility engaged pest control vand area was serviced on 2/25 | | 8 |
| | | * | | • | 2. | Pest control vendor inspects/s facility on a weekly and as nee basis. | | |
| | | | | | | Resident units are inspected of Environmental Services Team leaders/ Supervisors. Follow-uninspections will be conducted by the Plant Operations Manateam. | up weekly gement | |
| | | | | | 4.5. | Findings to be reported quarte Committee. Date of Compliance | пу ю ЦГ | 4/5/2013 |

Health Regulation & Licensing Administration