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	095005	A. BUILDING _____ B. WING _____	02/02/2011

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THE WASHINGTON HOME	3720 UPTON STREET NW WASHINGTON, DC 20016

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F 386	Continued From page 60 polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview for two (2) of 27 sampled residents, it was determined that the physician failed to review the total program of care for one resident ' s diagnosis of anemia and one resident ' s pain management. Residents #7 and 17. The findings include: 1.Facility staff failed to stipulate parameters associated with pre-medication administration before wound treatment. Resident #7 At the start of a dressing change observation conducted on January 31, 2011 at 11:00 AM with Employee #20, he/she indicated that the resident has an order for pain medication of Oxycodone IR 5 mg tablet prior to the dressing change and that pain medication was given at 9:00 AM. A query was made " if the resident required additional medication, given the time of the dressing change, was there a physicians ' order to cover that " Employee #20 indicated that the resident also had an order for " Oxycodone IR 5 mg tablet: give 1 tab by mouth every 8 hours as needed for pain " A query was also made as to " how far in advance is pain medication given prior to the wound treatment? " After review of the physician ' s orders he/she acknowledged that parameters to administer pain medications prior to the wound treatment was not identified. Facility staff failed to stipulate parameters associated with pre-medication administration	F 386	2.Inspection identified no other expired fruit plates. 3.Dietary staff was re-in-serviced on correct dating of food items, using pre-printed labels identifying day of week item is placed in storage and day the item expires. Food storage dates are audited/reviewed daily by Dietary management. 4Dietary management will report results of food item date audits, with corrective actions and identification of trends, to QI Committee monthly. F371 – 7 1. Air curtain refrigerator door handles were repaired and the door gasket was replaced. 2.An inspection of the kitchen identified no other equipment in need repair. 3.The sanitation and equipment inspection form was implemented that includes the air curtain refrigerator. Daily rounds by Dietary management is done to identify condition of kitchen equipment. 4.Dietary management reports outcome, corrective actions, and trends identified by sanitation and equipment inspections to QI Committee monthly. F371 - 8 1.Refrigerator temperatures were checked immediately and temperatures recorded.. 2.Dietary staff was re-in-serviced on appropriate documentation of all kitchen quality control measurements. 3.Dietary management will review temperature logs daily for accurate, real-time documentation of temperatures.	

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F 386	Continued From page 61 before wound treatment for Resident #7. The record was reviewed on January 31, 2011. 2. A review of the clinical record for Resident #17 revealed the physician failed to consistently review the total plan of care related to the status of the resident ' s anemia diagnosis. The history and physical examination dated March 16, 2010 revealed Resident #17 ' s diagnoses included Anemia, Hypertensive Cardiovascular Disease, Hypothyroidism, Diabetes Mellitus, Depression and status-post Cerebrovascular Accident. A review of interdisciplinary progress notes dated January 21, 2011 at 10:00 AM revealed Resident #17 was hospitalized January 2 - 20, 2011. Upon admission to the acute care facility, he/she was found to be " severely anemic and responded well to 4 units of PRBC ' s " [packed red blood cells - blood transfusion]. According to the hospital discharge summary dated January 20, 2011, the patient was diagnosed with Upper GI bleed, non-STEMI [ST elevation myocardial infarction] secondary to demand ischemia and urinary tract infection. A review of interdisciplinary progress notes for the period of July 2010 thru January 1, 2011 lacked documented evidence that the medical staff documented an account of the status of the resident ' s anemia. A review of nutrition progress notes for the period of July 2010 thru December 2010 revealed the dietician documented " Dx (diagnosis) of anemia, MD monitoring. " A review of laboratory reports revealed the most recent complete blood count [CBC] was assessed February 17, 2011.	F 386	4.Dietary management will report outcome of daily temperature log documentation to QI Committee monthly. 5. Date of Compliance F386 – 1 1. Pre-medication administration parameter prior to wound treatment was obtained. 2. Pre-medication prior to wound treatment orders were reviewed to ensure all residents in this category have medication parameters. 3. Nursing and Medical Staffs were in-serviced to ensure orders in this category include a pre-medication administration parameter. Nurse Managers will review new pre-medication orders to ensure a parameter is included. Medical Director will meet and discuss (education session) with the Medical Staff to document monitoring of chronic anemia. 4. Nurse Managers will audit residents in this category and report outcomes, corrective actions, and trends identified to QI Committee quarterly. 5. Date of Compliance	4/8/2011 4/8/2011

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F 386	Continued From page 62 A face-to-face interview was conducted with Employee #11 on January 31, 2011 at approximately 2:30 PM. He/she stated the resident had a chronic history of anemia and the recent hospitalization was secondary to an acute onset GI bleed. The record was reviewed January 28, 2011.	F 386	F386 - 2 1. Resident's anemia was treated in the hospital and resident returned to the facility. 2. All residents with diagnosis of chronic anemia were reviewed for appropriate monitoring documentation. 3. Registered Dietitian and Nutritionist will document actual communication between nutrition and physicians in a nutrition progress note, for clinical nutrition follow-up of chronic medical conditions, such as anemia. Medical Director will remind Medical Staff to document monitoring of chronic anemia. Medical Director will meet and discuss (education session) with the Medical Staff to document monitoring of chronic anemia. 4. Registered Dietitian and/or Nutritionist will audit communication documentation for residents with chronic anemia and report outcome, corrective action, and trends to QI Committee quarterly. QI will audit Medical Staff documentation in the medical record of monitoring chronic anemia. 5. Compliance Date	4/8/2011
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of _ supplemental residents, it was determined that the facility failed to ensure that routine medication was received from the	F 425		

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F 425	Continued From page 63 pharmacy and available to be administered to the Resident#F1. The findings include: The Physician ' s Order Form dated January 2011 and signed by the physician on January 10, 2011 directed, " Lidocaine HCL 5% Ointment, apply to legs from knee down twice daily for pain, pt (patient) may refuse. " A review of the Medication Administration Record for January 2011 revealed that on January 9 and 20, 2011 nurses initials were circled indicating that Lidocaine was not given. A review of the reverse side of the MAR for January 2011 revealed that facility staff documented " not available from pharmacy " as the reason that Lidocaine was not administered. A face-to-face interview was conducted with Resident #F2 on January 31, 2011 at 9:40 AM. He/she stated, " I was told that my medication [resident was point to his/her legs] ran out. " There was no evidence that the facility ensured that Lidocaine was received from the pharmacy in a timely manner to be administered to the resident in accordance with the physician's order. A face-to-face interview was conducted on February 1, 2011 at 12:50 PM with Employee #7. He/she acknowledged that the medication was not given as it was not available from pharmacy. The record was reviewed on February 1, 2011.	F 425	F425 1. Lidocaine was ordered and received for Resident #F2. 2. A report was obtained from Omnicare Pharmacy reviewing all residents on lidocaine 5% ointment to ensure delay in therapy did not occur. Nurse managers, supervisors and pharmacist will review pharmacy fax cut-off times, refill cut-off times and requests for STAT deliveries with nursing staff to ensure the facility receives orders to the pharmacy in a timely fashion for scheduled deliveries. Fax and refill cut-off times will be posted on each unit. Nurse managers and supervisors will also review the process if cut-off times are missed, e.g., request STAT delivery. Nursing staff will be instructed to notify nurse managers or supervisors if medication does not arrive with the anticipated delivery. 3. Nurse managers, supervisors and pharmacist will review electronic refill listing with nursing staff. The nurse managers, house supervisors and pharmacist will be instructed to use our consulting pharmacy, Omnicare real time, on-line tool, Issue Resolution Protocol, to document and report delay in delivery of medication and track consulting pharmacy Omnicare's response to reported delays in delivery. An information sheet was provided to all of the unit managers to share with the nursing staff on the respective units in a highly visible, conspicuous location. The information sheet contained the pharmacy telephone and fax numbers,	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of	F 431		

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F 431	Continued From page 64 a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: A. Based on observations, record review and interview for three (3) of 27 records reviewed, it was determined facility staff failed to ensure safe storage of medications for residents that	F 431	Phone hours of operation, contact information for various pharmacy personnel, pharmacy cut-off times for new orders and refills as well as delivery times. Pharmacy cut-off times are also reviewed during clinical orientation. 4. Negative outcomes will be reported to quarterly Quality Improvement committee. 5. Compliance Date F431 – A1,2,& F1 1. Residents #1, #18 and #FI received assessments to ensure they were safe to administer medications. The facility purchased and gave residents a lock boxes with a pad lock and key (nurse also given a second key for box) in order that residents can safely secure the medications they self-administer. 2. The Nurse Managers conducted a sweep of all other residents on their units to ascertain if there were other residents self administering medications: no other residents were found. The Self-Administration of Medication policy has been amended to include a safety assessment of each resident desiring to administer their medications.	4/8/2011

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F 431	Continued From page 65 self-administered medications. Residents #1, #18 and #F1. The findings include: 1. An observation of Resident #1 on January 25, 2011 revealed several medications were stored in manufacturer ' s containers on the bedside table proximal to the resident ' s bed. Facility staff acknowledged that the resident self-administered " natural " medications in accordance with physician ' s orders. There was no evidence that the facility offered provisions to store the medications safely and in a manner to protect against access by vulnerable or unauthorized individuals. The findings were reviewed and acknowledged during a face-to-face interview with Employee #3 on January 31, 2011 at 3:30 PM. 2. Facility staff failed to ensure safe storage of medications for Resident #18 that self-administered her eye ointment. The findings include: An observation of Resident #18 on January 24, 2011 revealed an eye ointment was stored in resident ' s bedside table. There was no evidence that the facility offered provisions to store the medication safely and in a manner to protect against access by unauthorized individuals. The finding was reviewed and acknowledged	F 431	The assessment will be done for an initial review, quarterly at the time of review of the interdisciplinary care plan and when a significant change occurs to the resident. 3. Upon admission to the facility the resident will be queried to determine if they want to self-administer their medications. If an affirmative answer is given, the Self-Administration of Medications policy will be implemented. Nursing staff were educated regarding the Self-Administration of Medication Policy and the amendments made to the Self-Administration of Medications Policy. 4. Nurse Managers will conduct an audit of the implementation of the Self-Administration policy quarterly and report outcome trends and corrections to the Quality Improvement Committee quarterly. 5. Compliance Date F431 - B 1. The thermometer used to take the refrigerator temperature was removed. 2. One thermometer will be used consistently to measure refrigerator temperatures on all nursing units. Night staff re-educated to take & log unit refrigerator temperatures nightly.	4/8/2011

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F 431	Continued From page 66 during a face-to-face interview with Employee #6 on January 24, 2011 at 1:30 PM. The clinical record was reviewed on January 24, 2011 3. Facility staff failed to ensure safe storage of medications for Resident #F1 who was observed to have medication at his/her bedside. On January 26, 2011 at 3:00 PM a tour of Resident F1 ' s room was conducted. A can of Cetacaine spray was observed on the night stand (on left side of the bed). At that time Employee #16 was present and acknowledged that the medication was on the resident's night stand. Employee #16 stated, " [He/she] self administers the spray to [his/her] throat. " Additionally, Resident F1 wrote the following on his/her communication board, " I spray it in my mouth. " The Physician Order Form dated January 2011 and signed by the physician on January 10, 2011 directed, " Cetacaine Spray 2 sprays every 3 hours as needed for pain-may keep at bedside to use as needed. " There was no evidence that the facility offered provisions to store the medications safely and in a manner to protect against access by vulnerable or unauthorized individuals. The findings were reviewed and acknowledged during a face-to-face interview with Employee #16 on January 26, 2011 at 3:00 PM	F 431	3. Night House supervisors will audit temperature logs daily. Nurse Managers will report outcome trends and corrections to the Quality Improvement Committee quarterly. 4. Director of Nursing will report outcome to the Quality Improvement Committee quarterly. 5. Compliance Date F431 - C 1. Missing audits cannot be created retrospectively. 2. Re-education of House nursing supervisors was conducted to complete audits consistently. House Nursing Supervisors to complete audit consistently each night and forward to the Director of Nursing. No residents were adversely affected. 3. House Nursing supervisors to complete audit consistently each night, and forward to Director of Nursing . Re-education of House Nursing Superviosrs was conducted to complete audits consistently. 4. Director of Nursing will report outcome to the Quality Improvement Committee quarterly. 5. Compliance Date	4/8/2011 4/8/2011

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F 431	Continued From page 67 B. Based on observations and interview, it was determined that facility staff failed to ensure that medications were stored under proper temperature controls in an isolated observation. The findings include: Observations of the medication storage refrigerator on unit 1-A revealed a temperature of 21 degrees Fahrenheit (F) on February 1, 2011 at approximately 10:30 AM. A subsequent observation approximately two (2) hours later yielded a temperature of 32 degrees (F). The observations were made in the presence of Employee #3 and the temperature was obtained via the facility ' s refrigerator thermometer. The medications that were stored in the refrigerator included various brands of Insulin and Travatan ophthalmic solution. According to the facility ' s pharmaceutical provider, Omnicare Inc., " Recommended Minimum Medication Storage Parameters (based on manufacturer package inserts) " refrigerated insulin vials were to be stored at temperatures between 36°F to 46°F and Travatan stored between 36° to 77°F. The refrigerator temperatures were below the recommend parameters for the medications stored. The findings were confirmed with Employee #3 at the time of observation. C. Based on a review of the Omni cell inventory records and staff interview, it was determined that facility staff failed to ensure that control drugs were reconciled every shift, every day. The findings include:	F 431	F431 – D1, 2 1. All expired medications were removed from both nursing units.No residents had negative outcomes from this occurrence. 2. Resident S1—nurse re-educated to use standard principles of medication administration (examine medications for expiration date before giving). Nurse Managers to conduct weekly inspection of medication refrigerator for expired drugs to ensure safety for all residents. No residents were adversely affected. 3. Infection Control Nurse to conduct a monthly environmental infection control round (to include medication carts & medication refrigerator). 4. Infection Control Nurse will report outcome trends and corrections to the Quality Improvement Committee quarterly. 5. Compliance Date	4/8/2011

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F 431	Continued From page 68 The Omni Cell inventory records from December 14, 2010 through January 29, 2011 revealed that on December 15, 16, 17, 18, 20, 22, 24, 25, 27, 29, and 31, 2010; January 3, 6, 9, 10, 13, 14, 15, 17, 19, 22, 23, 25, and 27, 2011 facility staff failed to reconcile the schedule II medications stored in the Omni Cell. A face-to-face interview was conducted on February 1, 2011 at approximately 5:00 PM with Employees #2, 3, 4, 5, 6 , and 7. They stated that the practice is to reconcile the schedule II medications every shift on a daily bases. Additionally, the staff acknowledged that the schedule II medications stored in the Omni Cell were not reconciled on a daily and shift-to-shift basis. D. Based on observation and staff interview it was determined that facility staff failed to remove expired medications from use. The findings include: 1. Facility staff failed to remove expired Acetaminophen tablets from one (1) of two (2) medication carts. During a check of the medication carts on January 31, 2011 at 1:50 PM it was identified that 18 of 33 regular strength Acetaminophen 325mg tables belonging to resident S1 had expired December 2010. The expired medications were in the same container as the unexpired medications. A face-to-face interview was conducted on January 31, 2011 at 2:00 PM with Employee # 4 and #32. After review of the above findings neither had an explanation as to how the medications ended up in same the box. A telephone interview was conducted with Employee #34 from pharmacy services. After review of the above findings he/she indicated that boxes are packed 1 lot number at a time and in	F 431		

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F 431	Continued From page 69 large quantities and that expired and unexpired medications are not packed in the same box. Facility staff failed to remove expired Acetaminophen tables from the medication cart. The observation was made on January 31, 2011. 2. . Facility staff failed to ensure that expired Pneumococcal Vaccine was not removed from medication refrigerator. An observation of the medication refrigerator on unit 3-A on January 25, 2011 at 9:16 AM revealed the following immunization was stored beyond expiration date: one (1) of one vial of pneumococcal vaccine unopened. Expiration date: December 3, 2010. The observation was made in the presence of Employee #6. During a medication pass on January 24, 2011 at 10:00 AM for Resident #10, Employee #15 was observed leaving Resident #10 ' s room to obtain gloves and a box of tissues from another room for eye drop administration. The Employee left medicine unattended. The observation was made January 24, 2011.	F 431		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility;	F 441		

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F 441	Continued From page 70 (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: A. Based on observations, record review and interview for six () of 27 sampled residents and 12 supplemental residents, it was determined that facility staff failed to maintain proper infection control practices during wound care treatments for four (4) residents, during assistance with dining, food preparation for one (1) and/or medication pass for one (1) resident. Residents #6, 7, 10, 15, K1, and M1 . The findings include: 1. A wound care treatment observation for	F 441		

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F 441	Continued From page 71 Resident #6 was conducted on January 26, 2011 at 9:30 AM. During the observation, it was determined that licensed staff failed to utilize proper hand hygiene practices consistent with CDC [Center for Disease Control] guidelines and facility policy. Hand wash techniques observed, revealed staff washed with soap and water for a period of 3 seconds in one instance and 8 seconds or less when washing hands during the course of the procedure. Additionally, staff failed to sanitize hands prior to donning new gloves intermittently during the course of the procedure. Staff failed to sanitize hands prior to donning new gloves between the cleansing the wound and the application of treatment to the wound site. The resident ' s pillow dropped onto the floor and was replaced onto the bed. The pillow linen that contacted the floor surface was not removed. 2. Facility staff failed to decrease the spread of infection during a wound treatment. Resident #7 A wound treatment observation was made on January 31, 2011 at 11:00 AM with Employee #20, Employee # 21 was assisting. The treatment order was to " cleanse right heel ulcer with soap and water rinse off with saline, pat dry apply skin prep to periwound, bacitracin to wound bed, secure with gauze and kling daily. " The original date was December 14, 2010. After Employee #20 created the sterile field, an ointment tube fell to the floor, Employee #21 picked up the tube and replaced it on top of the corner of sterile field. During the observation Employee #21 exited the room to retrieve an item, after placing the item down he/she placed on a pair of gloves without washing his or her hands. A face-to-face interview was conducted on February 1, 2011 at 1:00PM with Employees #20 and #21, after review of the observations both	F 441	F441 – A 1,2,3,4, & 5 1. Staff re-educated about hand hygiene during unit meetings. 2. During orientation and annually the Education Department will conduct Hand Hygiene in-service classes. During random daily unit rounds conducted by Nurse Managers staff were observed following hand hygiene procedures: where staff were found not to follow procedures, on-the-spot reminders (education) were given to staff. No residents were adversely affected due to improper hand hygiene of staff. 3. By April 8, 2011 the Education Department will conduct role play hand hygiene in-service classes across all shifts. 4. The Education Department will report attendance at in-service classes quarterly to the Quality Improvement Committee. 5. Compliance Date	4/8/2011

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F 441	Continued From page 72 acknowledged the findings. 3. Facility staff failed to decrease the spread of infection prior to administration of eye drops for Resident #10. During a medication pass observation on January 24, 2011 at approximately 9:30 AM , Employee #15 obtained a box of tissues and gloves from another resident ' s room prior to administration of Resident ' s #10 ' s eye drops. 4. Facility staff failed to clean the over bed table after wound care procedure for Resident #15. During a treatment observation conducted on January 31, 2011 at 10:55AM of Resident #15 ' s Stage three (3) left lower leg wound, it was observed that the nurse failed to clean the over bed table upon completion of the dressing change procedure. The nurse used the over bed table for his/her wound care supplies. After the dressing change was completed Employee #22 removed the table barrier and wound care supplies and failed to clean the over bed-table. A face-to-face interview was conducted on January 31, 2011 at approximately 11:10 AM with Employees #22. He/she acknowledged that the over bed table should have been sanitized after the wound treatment. The treatment was observed on January 31, 2011 at 10:55AM. 5. An observation of the breakfast meal on January 25, 2011 revealed facility staff failed to consistently utilize proper hand hygiene practices during dining. Employee #39 transported a chair across the room in order to assist Resident #K1	F 441	F441 - B 1. Drain lines from ice machines located in the pantries of units 1A, 3A and 3B were corrected by maintenance staff to the required distance between the line and the drain 01/28/11. 2. All drain lines were observed for proper drain line to drain distance. No other areas of concern were noticed. 3. The maintenance technicians were trained on the correct distance required between the drain lines and drains. These conditions are observed monthly during maintenance rounds conducted by the maintenance technicians. 4. Drain lines will be monitored daily by engineer/maintenance and reported to supervisory staff. Compliance Date	04/8/2011

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F 441	Continued From page 73	F 441		

with meal consumption then proceeded to assist the resident with dining utilizing bare hands to butter bread and manipulate food. He/she failed to wash/sanitize hands immediately prior to manipulating the resident ' s food with bare hands.
6. Facility staff failed to clean the over bed table after wound care procedure for Resident #M1,

During a treatment observation conducted on January 31, 2011 at 12:30AM of Resident #M1's left buttock wound care, it was observed that the nurse failed to clean the over bed table after the wound care procedure.

The nurse used the over bed table for his/her wound care supplies. After the dressing change was completed Employee #23 removed the table barrier and wound care supplies and failed to clean the over bed-table.

A face-to-face interview was conducted on January 31, 2011 at approximately 12:45 AM with Employees #23. He/she acknowledged that the over bed table should have been sanitized after the wound treatment. The treatment was observed on January 31, 2011 at 12:30AM.

B. Based on observations made during the environmental tour of the facility from January 26 thru January 28, 2011, it was determined that the facility failed to provide a safe, sanitary and comfortable environment as indicated by insufficient air gap to drain on three (3) of five (5) ice machines. The findings include:
1. Drain lines from ice machines located in the pantries of units 1A, 3A and 3B did not provide

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F 441	Continued From page 74 sufficient air gap to drains. These observations were made in the presence of employee # 8 and #37 who acknowledged these findings during the survey.	F 441		
F 456 SS=D	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observations made during the environmental tour of the facility from January 26 thru January 28, 2011, it was determined that the facility failed to maintain resident call system as evidenced by call bells that were not properly cared for in four (4) of 52 rooms. The findings include: 1. Call bell covers were loose in rooms #153 and 338 and call bell pull cords were too short and needed to be extended in the resident ' s bathroom on unit 2A and the tub room on unit 3B. These observations were made in the presence of employee # 37 who acknowledged these findings during the survey.	F 456	F456 1. Loose call bell covers in rooms #153 and #338 were tightened or replaced by the maintenance technicians. Call bell pull cords that were too short and needed to be extended in the resident bathroom on unit 2A and the tub room on unit 3B drain were removed and longer cords were put in place by the maintenance technicians 2. Call bell covers and cords throughout the facility were inspected for proper functioning. No other areas of concern were noticed. 3. The maintenance technicians were retrained on observing and replacing loose call bell covers. Maintenance technicians were retrained on reporting and, where necessary, verifying with supervisors whether call bell cord lengths are appropriate. These conditions are observed monthly during maintenance rounds conducted by the maintenance technicians. 4. Conditions of call bells will be monitored daily by engineer/maintenance and reported to supervisory staff. 5. Compliance Date	01/28/11. 4/8/2011
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced	F 463	F463 1. Call bells in rooms #204, 233, 254 and 356 that failed to operate as required and, when activated, did not consistently alert the nursing staff were replaced by maintenance technicians.	01/28/11

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F 463	Continued From page 75 by: Based on observations made during the environmental tour of the facility from January 26 thru January 28, 2011, it was determined that the facility failed to maintain resident call system as evidenced by the failure of the call bell system to operate as intended in four (4) of 48 resident ' s rooms. The findings include: 1. Call bells in rooms #204, 233, 254 and 356 failed to operate as required and, when activated, did not consistently alert the nursing staff. These observations were made in the presence of employee # 37 who acknowledged these findings during the survey.	F 463	2. Call bells throughout the facility were observed for functionality. No other areas of concern were noticed. No residents were negatively affected. 3. The maintenance technicians were retrained on replacing, installing and testing call bells. These conditions are observed daily by nurse staff and monthly by maintenance technicians during maintenance rounds. 4. Conditions of call bells will be monitored daily by engineer/maintenance and reported to supervisory staff. 5. Compliance Date	4/8/2011
F 490 SS=C	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview it was determined that facility staff failed to code the 672 [Resident Census and Conditions of Residents] and 802 [Roster Sample Matrix] forms to represent the current condition of residents in the facility. The findings include: On January 24, 2011 at 9:30 AM, Employee #2 presented the surveyor with the 672 and the 802 forms. A review of the 672 revealed that	F 490	F490 1. Director of Nursing at monthly Nurse Manager meeting reviewed instruction sheets for completion of 672/802 2. Nurse Managers corrected coding errors for the 672/802 comparing the 802 with the 672 for match up accuracy of both forms. No residents were adversely affected. 3. Nurse Managers will complete 672/802 weekly matching data for accuracy.	

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F 490	Continued From page 76 information contained was not consistent with the information provided by the facility on the 802 form(s). A face-to-face interview was conducted with Employee #2 at the time of the review. He/she acknowledged the differences. Additionally, a review of the " General Instructions and Definitions " form was conducted with Employee #2. The forms were returned to the facility to make the necessary modifications/changes. On January 26, 2011 at 9:00 AM, Employee #2 resubmitted the 672 and the 802 forms to the surveyor. Upon review of the 802 form(s) it was found that while changes had been made to correct the previously identified areas of concern, other discrepancies were identified. The forms were return to Employee #2 to make the additional modifications and/or changes to the forms. On January 28, 2011 at approximately 3:00 PM the third revision of the 672 and 802 forms were accepted.	F 490	The Director of Nursing or their designee will review instruction sheets or completion of the 672/802 with the Nurse Managers weekly, prior to completion of both documents to ensure accuracy. 4. Director of Nursing will review total compilation of 672/802 data for the facility, matching forms for accuracy and querying nurse managers to correct identified variances. Outcomes will be reported to the Quality Improvement Committee quarterly. 5. Compliance Date	4/8/2011
F 492 SS=F	483.75(b) COMPLY WITH FEDERAL/STATE/LOCAL LAWS/PROF STD The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. This REQUIREMENT is not met as evidenced by: A. Based on observation, record review and staff	F 492		

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F 492	Continued From page 77 interview for three (3) of 27 sampled residents, it was determined that the social worker failed to perform quarterly assessments for two (2) residents; facility staff failed to notify the state agency of an unusual incident for one (1) resident. Residents #1, #4 and #17. The findings include: According to 22 DCMR (District of Columbia Municipal Regulations) 3229.5, "The social assessment and evaluation, plan of care and progress notes, including changes in the resident's social condition, shall be incorporated in each resident's medical record, reviewed quarterly, and revised as necessary." 1. The social worker failed to document in Resident #1 ' s record every 90 days. A review of Resident #1 ' s clinical record revealed the most recent social services assessment was documented October 10, 2010. There were no social work entries subsequent to this date. The record lacked evidence of a quarterly social work assessment for January 2011. The record was reviewed January 25, 2011. 2. The social worker failed to document in Resident #4 ' s record every 90 days. A review of Resident #4 ' s clinical record revealed the following quarterly assessments: January 19, 2010, June 29, 2010, September 21, 2010, and December 10, 2010. The record lacked evidence of a quarterly social work assessment for April 2010. A face-to-face interview was conducted with Employees #6 and #13 on January 25, 2011 at approximately 2:00 PM. Both acknowledged that the clinical record did not have a quarterly	F 492	F492 1. The quarterly assessment for Resident #1 has been completed and entered into the chart. The quarterly assessment for Resident # 4 could not be corrected as there was a lapse in time between the hiring of the current social worker and the resignation of the previous social worker; thus, subsequent documentations have been entered. 2. The social services staff completes quarterly assessments per the MDS schedule. The Director of Social Services will review charts weekly to ensure timely documentation. Any chart found to be deficient will be corrected immediately. There were no negative outcomes to any resident. 3. The social services staff completes quarterly assessments per the MDS schedule. The Director of Social Services will review & discuss with(educate) the Social Work staff the process timely documentation, according to standards & policy, in the resident medical record. 4. Outcomes will be reported to the Quality Improvement Committee quarterly. 5. Compliance Date 1. An unusual incident report was completed 2/2/2011 for the 911 transfer of Resident #17. 2. All unusual incidents will be documented and reported according to 22 DCMR 3232.4.	4/8/2011 4/8/2011

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F 492	Continued From page 78 assessment for April 2010. The record was reviewed January 25, 2011. 3. Facility staff failed to notify the state agency of an unusual incident. According to 22 DCMR (District of Columbia Municipal Regulations) 3232.4: Each incident shall be documented in the resident's record and reported to the licensing agency within forty-eight (48) hours of occurrence, except that incidents and accidents that result in harm to a resident shall be reported to the licensing agency within eight (8) hours of occurrence. A review of nurse ' s notes dated January 2, 2011 at 11:00 AM revealed Resident #17 was assessed as unresponsive and hypotensive, transferred to the nearest emergency department via 911 and hospitalized for approximately 19 days. There was no evidence that the facility documented and unusual incident report and notified the state agency regarding the incident. A face-to-face interview was conducted with Employee #3 on January 31, 2011 at approximately 11:00 AM. He/she stated an incident summary was completed on January 25, 2011 following this surveyor ' s request to review the report during the orientation tour of the unit. B. Based on observations made during the environmental tour of the facility from January 26 thru January 28, 2011, it was determined that the facility failed to provide a safe, sanitary and comfortable environment as indicated by insufficient air gap to drain on three (3) of five (5) ice machines. The findings include: According to 22 DCMR (District of Columbia Municipal Regulations) 3236.2 There shall be no cross-connection between the potable safe water supply and each water supply that is non-potable, or any source of pollution through which a safe	F 492	The Director of Nursing or their designee will daily review the 24 hour and Acute Care Report. Any usual incident should warrant a incident report attached to the reports. If an incident report is lacking, The Director of Nursing will ensure an incident report is completed and promptly forwarded to the Department of Health. Variances of documentation not recorded in the medical record will be promptly corrected. Nursing staff failing to follow the procedure for documentation of an unusual occurrence will result in d isciplinary counseling up to and including suspension and or termination. 3. All staff will review the regulation, 22 DCMR 3232.4 on the reporting time frame for an unusual incident and comply. 4. Daily monitoring of facility incident reports will be completed by Nursing Home Administration, Nursing Administration or designee. Unusual incidents will be reported to the licensing agency. Negative outcomes will be reported to Quality Improvement. 5. Compliance Date 1. Drain lines from ice machines located in the pantries of units 1A, 3A and 3B were corrected by maintenance staff to the required distance between the line and the drain 2. All drain lines were observed for proper drain line to drain distance. No other areas of concern were noticed.	4/8/2011 4/8/2011 4/8/2011 01/28/11.

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F 492	Continued From page 79 supply might become contaminated. 1. Drain lines from ice machines located in the pantries of units 1A, 3A and 3B did not provide sufficient air gap to drains. These observations were made in the presence of employee # 8 and #37 who acknowledged these findings during the survey.	F 492	3. The maintenance technicians were trained on the correct distance required between the drain lines and drains. These conditions are observed monthly during maintenance rounds conducted by the maintenance technicians. 4. Drain lines will be monitored daily by engineer/maintenance and reported to supervisory staff and QI Committee.	
F 497 SS=D	483.75(e)(8) NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on employee record review and staff interview for one (1) of four (4) Certified Nurse Aides (CNA), it was determined that facility staff failed to ensure that performance reviews were conducted for CNAs at least once every 12 months. The findings include: A review of the Certified Nurse Aides employee	F 497	5. Compliance Date F497 1. The employee whose evaluation was deficient was completed during the week of February 2, 2011; 2. The HRIS Analyst informs managers of all delinquent (over a month) evaluations on a monthly basis. The delinquent list is also forwarded to the Director of Human Resources and the CEO. The manager is responsible for completing all delinquent evaluations during the notified period (end of the month). Failure to comply, will result in disciplinary action up to and including suspension; No residents were adversely affected as a result. 3. In order for the deficient practice of delinquent performance evaluations, to not recur Human Resources will be responsible for the following: a. Educating the managers and line staff about the importance of performance evaluations and how to schedule the appropriate time to complete and review the evaluation;	4/8/2011

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F 497	Continued From page 80 records revealed the following: Employee #37 - Employee date of hire December 14, 2009, the Competencies were signed as completed on June 9, 2010. There was no evidence that the facility conducted a performance review for Employee #37 [CNA] at least once every 12 months. A face-to-face interview was conducted with Employee # 10 on January 31, 2011 at approximately 2:00 PM. He/she acknowledged that the performance review was not conducted at least once every 12 months for the aforementioned CNA.	F 497	b. Reviewing the Performance Evaluation policy; b. The CEO and Director of Human Resources will emphasize the importance of adhering to the monthly schedules, as well as the during scheduled Town Hall Meetings during the month of May; Complete and present monthly progress reports to all department heads, which will highlight the percentage of performance evaluations completed, during Senior Management meetings 4. Annual Performance Evaluations will be monitored as follows: a. Completed evaluations will be data entered into Human Resources performance evaluation database within 72-hours of receipt. b. Based upon the evaluations entered, a monthly progress and delinquent report will be completed and distributed to department heads; c. Managers who continue to be delinquent will receive a formal disciplinary action up to and including termination; d. The timeliness in completing performance evaluations will be a standard that all managers will be evaluated on. 5. Compliance Date	4/8/2011
F 514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview of four (4) of 27 sampled residents it was determined that facility staff failed to document quarterly assessments for one (1) resident, failed to	F 514		

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F 514	Continued From page 81 accurately transcribe wound treatment orders for one (1) resident, failed to document behavioral monitoring for two (2) residents, failed to write a verbal order and document a concern for one (1) resident, and failed to maintain dental examinations on active medical record. Residents #4, #6, #10 and #22. The findings include: 1a. Facility staff failed to consistently document Resident #4 ' s behavior on the behavioral monitoring tool. for Resident #4. Resident #4 had a current physician's order dated January 7, 2011 for Lexapro 10mg every day for depression and Trazadone 50mg at bedtime for insomnia. A review of the clinical record revealed behavioral monitoring sheets completed for August and September 2010. There were no behavioral monitoring sheets for October, November, December 2010 and January 2011. An interview was conducted with Employee #6 on January 25, 2011 at approximately 10:30 AM; he/he stated that the staff had failed to initiate the monitoring sheet for October, November, December 2010, and January 2011. The clinical record was reviewed on January 25, 2011. 1b. Facility staff failed to maintain dental evaluations in Resident #4 ' s active medical record. According to the physician orders dated January 7, 2011 revealed, " Annual Dental Consult " ...order initiated March 12, 2010.	F 514	F514 – 1a 1. Behavioral monitoring tool cannot be corrected retrospectively. 2. Nurse re-educated to match documentation of behavior monitoring tool with actual resident behavior occurrences 3. QI will assist Nurse Managers to audit antipsychotics and anti-anxiety medications monthly to monitor behavior monitoring tool coding accuracy. 4. QI will report outcome trends and corrections to the Quality Improvement Committee quarterly. 5. Compliance Date F514 – 1b Resident #4 - An annual dental consult was conducted on Resident #4 and placed into the medical record. The dates were April 10, 2010 and October 9, 2010. 2. All residents will have an annual dental consult documented in their medical record. Quality Improvement Nurse using pharmacy consult reports (antipsychotics, anti-anxiety medications) to conduct monthly audit of behavior monitoring tool coding accuracy. No residents were negatively impacted.	4/8/2011 4/8/2011

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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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) COMPLETION DATE
F 514	Continued From page 82	F 514		

A review of Resident #4 ' s record revealed no dental evaluation. There was no evidence that an annual dental screen was completed for 2010.

A face-to-face interview was conducted with Employee #6 on January 25, 2011 at approximately 11:30 AM. He/she acknowledged that there was no dental evaluation on Resident #4 ' s active clinical record. Dental evaluations were received via fax from the [Dental MD] revealing a dental evaluation was conducted on April 10, 2010 and October 9, 2010. The record was reviewed on January 25, 2011.

2. A review of the clinical record for Resident #6 revealed facility staff failed to accurately transcribe wound treatment orders onto the January 2011 Medication Administration Record [MAR]. The transcribed orders lacked evidence of a "frequency " to perform the treatment.
A review of physician ' s orders dated January 3, 2011 revealed the wound treatment was prescribed daily [frequency].
The findings were reviewed and confirmed during an interview with Employee #3, January 26, 2011 at approximately 11:00 AM.
3a. Facility staff failed to write an order to flush right eye after administration of eye drop to wrong site for Resident #10.

Physician ' s orders dated January 7, 2011 directed Cosopt Ocumeter Plus, instill one (1) drop in left eye every 12 hours for glaucoma.

During a medication pass observation on January 24, 2011 at approximately 9:30 AM, Employee #15 instilled one drop in right eye. After instilling the drop, Resident #10 state, " It ' s burning; I had cataract surgery ... ." Employee #15

Provider's plan of correction (F 514):

3. A letter will be sent to the Dentist outlining the deficiency and the regulation. Unit secretaries will audit open resident records for documentation of the annual dental consult. — 4/8/2011
4. Negative outcomes from the audit will be reported to the Dentist, the Nurse Manager and trended for Quality Improvement. — 4/8/2011
5. Compliance Date — 4/8/2011

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1. Resident #6 - Incomplete order was corrected. Missing order transcribed.
2. Nurse Managers to conduct unit meetings reviewing standards for transcription of physician orders. The Nurse Managers audited 10% of charts on their units to ascertain if standards of order transcription were followed: no negative outcomes for other residents were seen
3. Staff nurses re-educated regarding documentation standards for order transcription. All nurses will receive a medication update training session to include standards of transcribing orders.
4. Nurse Managers to forward documentation of unit meetings to Director of Nursing. Director of Nursing will forward reports to Quality Improvement Nurse. Attendance will be reported quarterly to Quality Improvement Committee.
5. Compliance Date — 4/8/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095005	A. BUILDING _____ B. WING _____	02/02/2011

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F 514	Continued From page 83 proceeded to inform [NP]. Verbal order given by [NP] to " flush right eye. " A review of the clinical record lacked evidence that an order was written to flush right eye. This was acknowledged in the presence of Employee #6 on January 24, 2011 at approximately 11:00 AM. The clinical record was reviewed on January 24, 2011. 3b. Facility staff failed to document resident ' s " voiced concern " regarding burning in right eye after administration of eye drop. Resident #10. Physician ' s orders dated January 7, 2011 directed Dorzolamide HCl 2%-0.5 %(Cosopt Ocumeter Plus), instill one (1) drop in left eye every 12 hours for glaucoma. During a medication pass observation on January 24, 2011 at approximately 9:30 AM, Employee #15 instilled one drop in right eye. After instilling the drop, Resident #10 stated, " It ' s burning; I had cataract surgery ... . " A review of the " Medication Occurrence Report " dated January 24, 2011 revealed, Dorzolamide 1 drop instilled in wrong eye (right). Resident has no complain of pain. " According to Nurses Notes dated 1/24/11 at 11:30 AM revealed, " AM medication pass this AM, writer instilled Cosopt in resident right eye, Resident states it does not burn. NP made aware. " The clinical record lacked evidence that resident voiced concern that right eye was burning. This was done in the presence of Employee #15	F 514	1. Resident #10-Nurse documentation of resident eye not burning following administration of eye drops was an error in documentation. Note corrected. Verbal order of nurse practitioner to flush resident's eye recorded as late entry. 2. Nurse re-educated concerning 5-Rights of Medication administration. Nurse instructed to use Lippincott Manual to review the procedure for administering eye drops to resident. Nurse Manager conducted a follow up Medication Administration Observation with individual nurse. During the medication administration observation, no negative effects were seen with other residents receiving eye drops. 3. Follow up medication administration observation completed with nurse. All nurses, during unit meetings were instructed to review the procedure in the Lippincott manual, for administering medications (eye drops). The 5-Rights of Medication Administration were reviewed during the same unit meetings.	

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F 514	Continued From page 84 immediately after the eye drop was instilled in right eye. The clinical record was reviewed on January 24, 2011. 4.. A review of the clinical record for Resident #22 revealed facility staff failed to consistently document the resident ' s behavioral status on the facility's Behavior Monitoring Flow Record. According to physician ' s orders dated January 1, 2010, the resident ' s medication regimen included the following psychotropic medications that were initiated November 8, 2010: Ativan 1mg PO daily at bedtime as needed for agitation; Seroquel 25mg by mouth every evening for psychosis/ for agitation and Lexapro 20mg by mouth every day for depression. A review of the Behavior Monitoring Flow Records for the months of November and December 2010, and January 2011 revealed that licensed staff inconsistently documented episodes of targeted behaviors. A face-to-face interview was conducted with Employee #5 on January 26, 2011 at 1 PM. He/she stated that the behavior monitoring records were initiated to monitor episodes of scratching, biting, refusing blood sugar check and insulin coverage and jittering and nervousness in addition to assessing the effectiveness of psychotropic medication. Inconsistencies in the documentation of episodes of behaviors on the monitoring record were acknowledged. The record was reviewed January 26, 2011.	F 514	4. By April 8, 2011 Nurse Managers or their designee will conduct a random medication administration observation with one nurse. Once per month Nurse Managers or their designee will conduct a random medication administration with one nurse on each shift. Nurse Managers received an education. session presented by the pharmacy, on how to conduct Medication Administration Observations. Negative trends and corrections will be reviewed during the facility QI monthly Meeting. 5. Compliance Date	4/8/2011