Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0005	A. BUILDING: _____ B. WING _____	04/22/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 000	Initial Comments The annual licensure survey was conducted at your facility on April 14, 2014 through April 22, 2014. The following deficiencies are based on observations, record reviews, resident and staff interviews for 46 sampled residents. The following is a directory of abbreviations and/or acronyms that may be utilized in the report: Abbreviations AMS - Altered Mental Status ARD - assessment reference date BID - Twice- a-day B/P - Blood Pressure cm - Centimeters CMS - Centers for Medicare and Medicaid Services CNA- Certified Nurse Aide CRF - Community Residential Facility D.C. - District of Columbia D/C discontinue Dl - deciliter DMH - Department of Mental Health EKG - 12 lead Electrocardiogram EMS - emergency medical services (911) g-tube Gastrostomy tube HVAC - Heating ventilation/Air conditioning ID - Intellectual disability IDT - interdisciplinary team L - Liter Lbs - pounds (unit of mass) MAR - Medication Administration Record MD- Medical Doctor MDS - Minimum Data Set Mg - milligrams (metric system unit of mass) mL - milliliters (metric system measure of	L 000	The Washington Home makes its best effort. To operate in substantial compliance with both Federal and State law. Submission of this Plan of Correction (POC) does not constitute an admission or agreement by any party, its board, officers, directors, employees or agents as to the truth of the facts alleged or the validity of the conditions set forth on the Statement of Deficiencies. The following Plan of Correction constitutes the facility's written credible allegation of compliance. It is prepared and/or executed solely because it is required by Federal and State law.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0005	A. BUILDING: _____ B. WING _____	04/22/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 000	Continued From page 1 volume) mg/dl - milligrams per deciliter mm/Hg - millimeters of mercury Neuro - Neurological NP - Nurse Practitioner PASRR - Preadmission screen and Resident Review Peg tube - Percutaneous Endoscopic Gastrostomy PO- by mouth POS - physician ' s order sheet Prn - As needed Pt - Patient Q- Every QIS - Quality Indicator Survey Rp, R/P- responsible party TAR - Treatment Administration Record	L 000		
L 051	3210.4 Nursing Facilities A charge nurse shall be responsible for the following: (a)Making daily resident visits to assess physical and emotional status and implementing any required nursing intervention; (b)Reviewing medication records for completeness, accuracy in the transcription of physician orders, and adherences to stop-order policies; (c)Reviewing residents' plans of care for appropriate goals and approaches, and revising them as needed; (d)Delegating responsibility to the nursing staff for direct resident nursing care of specific residents;	L 051		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0005	A. BUILDING: _____ B. WING _____	04/22/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 2 (e)Supervising and evaluating each nursing employee on the unit; and (f)Keeping the Director of Nursing Services or his or her designee informed about the status of residents. This Statute is not met as evidenced by: Based on record review and staff interview for three (3) of 51 sampled residents, it was determined that facility staff failed to develop care plans with goals and approaches for the management of a Nephrostomy tube for one (1) resident, one (1) resident receiving hospice services and for the use of compression stockings for one (1) resident with edema. Residents # 207, #211 and #252 The findings include 1. Facility staff failed to develop a care plan with goals and approaches to address resident#207 ' s use of a Nephrostomy tube. This was a closed record review. A review of the physician " history and physical " signed and dated December 14, 2013 revealed, " ... Nephrostomy tube placement secondary to acute renal failure. " A review of Physician ' s order sheet and plan of care dated and signed December 18, 2013 directed: Change Nephrostomy bag every week and as needed. Change dressing to Nephrostomy tube every three days and as needed. ... Flush Nephrostomy tube every 8hrs [hours] with 30ml [milliliters] water. Measure output every shift. "	L 051	L051(Resident #207) 1. Resident record is closed. Care plans cannot be added. 2. No other residents were found to be presently affected. 3. Within 72 hours of any admission to a nursing unit, the Clinical Manager will complete the Admission Chart Audit Tool which includes an audit of appropriate care plans for the needs of a resident. The Clinical Manager will monthly audit 10% of all resident(s) medical records utilizing the Chart Audit Tool: audit includes review of care plans. The monthly Chart Audit tools are submitted to the Director of Nursing for review and following review are forwarded to the QI Manager. 4. The findings of the monthly Chart Audit Tools completed by the Clinical Manager are reported quarterly by the QI Manager to the QI Committee. 5. Compliance Date:	6/6/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0005	A. BUILDING: _____ B. WING _____	04/22/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 3 A review of the care plan section lacked evidence that a care plan with goals and approaches were developed to address Resident #207 ' s Nephrostomy tube management. A face-to-face interview was conducted on April 15, 2014 at approximately 11:20 AM with Employee #7. He/she acknowledged the findings after reviewing the record. The record was reviewed April 15, 2014. 2. Facility staff failed to develop a jointly coordinated care plan with goals and approaches between the facility and the hospice services for Resident #211. A review of the " Physician Order Sheet and Plan of Care " revealed that the resident was admitted to the facility on February 21, 2014 with the following diagnosis: Adenocarcinoma of the Esophagus, Hx [history] [of] Upper Gastrointestinal bleed secondary to Adenocarcinoma of [the] esophagus. According to the Interdisciplinary Progress Note dated February 24, 2014, no time indicated, " 81 year old woman with Esophageal Adenocarcinoma admitted to [facility name] 2/21/14 [February 21, 2014] DNR/DNI [Do Not Resuscitate/Do Not Intubate] in Hospice. " Review of the " Progress Notes by Resident " progress notes identified that hospice care had been conducted February 22, 2014 through	L 051	L051 (Resident #211) 1. Resident record is closed. Care plans cannot be added. 2. No other residents were found to be presently affected. 3. Within 72 hours of admission of a resident to Hospice Services, the Clinical Manager will audit the resident's medical record to ensure an integrated Long Term Care/Hospice Care plan is a part of the medical record and collaborate with Hospice Services if integrated care plan is not available. Within 72 hours of any admission to a nursing unit, the Clinical Manager will complete the Admission Chart Audit Tool which includes an audit of appropriate care plans for the needs of a resident. The Clinical Manager will monthly audit 10% of all resident(s) medical records utilizing the Chart Audit Tool: audit includes review of care plans. The monthly Chart Audit tools are submitted to the Director of Nursing for review and following review are forwarded to the QI Manager. 4. The findings of the monthly Chart Audit Tools completed by the Clinical Manager are reported quarterly by the QI Manager to the QI Committee. 5. Compliance Date:	6/6/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0005	A. BUILDING: _____ B. WING _____	04/22/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 4 March 12, 2014. Review of the resident ' s care plans lacked evidence of a jointly coordinated care between the hospice services and the facility. A face-to-face interview was conducted with Employee #32, after review of the medical record he/she acknowledged that the resident's record lacked evidence of a jointly coordinated care plan between the hospice service and the facility. Facility staff failed to initiate an integrated care plan with goals and approaches to reflect the resident ' s current status. 3. Facility Staff Failed to develop a care plan with goals and approaches to address resident#252 ' s use of compression stockings for edema. This was a closed record review. A review of the physician " history and physical " signed and dated February 5, 2014 revealed, " ... (4) CHF [Congested Heart Failure]: compensated, EF [Ejection Fraction] 58; continue Metoprolol [antihypertensive]; off Lasix [diuretics] due to dehydration. Start compression stockings. " A review of Physician ' s order sheet and plan of care dated and signed February 5, 2014 directed: " Bilateral knee, apply skin prep every shift. Compression stocking B/L [bilateral] lower legs on 8AM [morning] off 8PM [night]. "	L 051	L051 (Resident #252) 1. Correction has been made: care plan for compression stockings added to medical record. 2. No other residents were found to be presently affected. 3. The Clinical Manager using the Chart Audit Tool will conduct an audit of 10% of all resident medical records: audit includes review of care plans to meet the resident(s) needs. The Clinical Manager will monthly audit 10% of all resident charts. Chart Audit Tools are submitted to the Director of Nursing for review and following review are forwarded to the QI Manager. 4. The findings of the monthly Chart Audit Tools completed by the Clinical Manager are reported quarterly by the QI Manager to the QI Committee. 5. Compliance Date:	6/6/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0005	A. BUILDING: _____ B. WING _____	04/22/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 5 A review of the care plan section lacked evidence that a care plan with goals and approaches were develop to address Resident #252 ' s use of Compression stockings. A face-to-face interview was conducted on April 15, 2014 at approximately 11:20 AM with Employee #7. After the review of the care plan, he/she acknowledged the findings. The record was reviewed April 15, 2014.	L 051		
L 052	3211.1 Nursing Facilities Sufficient nursing time shall be given to each resident to ensure that the resident receives the following: (a)Treatment, medications, diet and nutritional supplements and fluids as prescribed, and rehabilitative nursing care as needed; (b)Proper care to minimize pressure ulcers and contractures and to promote the healing of ulcers; (c)Assistants in daily personal grooming so that the resident is comfortable, clean, and neat as evidenced by freedom from body odor, cleaned and trimmed nails, and clean, neat and well-groomed hair; (d) Protection from accident, injury, and infection; (e)Encouragement, assistance, and training in self-care and group activities; (f)Encouragement and assistance to:	L 052		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0005	A. BUILDING: _____ B. WING _____	04/22/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 6 (1)Get out of the bed and dress or be dressed in his or her own clothing; and shoes or slippers, which shall be clean and in good repair; (2)Use the dining room if he or she is able; and (3)Participate in meaningful social and recreational activities; with eating; (g)Prompt, unhurried assistance if he or she requires or request help with eating; (h)Prescribed adaptive self-help devices to assist him or her in eating independently; (i)Assistance, if needed, with daily hygiene, including oral acre; and j)Prompt response to an activated call bell or call for help. This Statute is not met as evidenced by: Based on observations, record review and staff interview for ten (10) of 51 sampled residents, it was determined that facility staff failed to ensure that each resident received necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care as evidenced by a failure to: administer medications in accordance with physician's orders for three (3) residents; assess oxygen saturation levels for one (1) resident as prescribed; consistently conduct monitoring and assessments for one (1) resident with a respiratory disorder; provide end of life services and implement end of life policies	L 052		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0005	A. BUILDING: _____ B. WING _____	04/22/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 7 for three (3) residents identified as receiving palliative care; assess oxygen saturation levels as prescribed for one (1) resident; obtain physician's orders for one (1) resident who received hospice services and assess the level of pain for one (1) resident prescribed more than one (1) analgesic for pain. Residents #78, #95, #98, #106, #153, #182, #211, 213, #291, #305. The findings include: The facility ' s policy entitled; " Medication Administration, " Policy No: TC-00003.12, page 5 of 6 stipulates: " Prior to infusion of a feeding and/or before administering medications via a feeding tube, the feeding tube must be checked for placement each time. To accomplish this task do the following: Remove the plug from the end of the tube, Attach a 50-60 ml. syringe to the end of the tube, Place a stethoscope over the abdomen approximately 3cm below the sternum. Unclamp tube and inject 10 ml of air into the stomach: listen for a gurgling sound- gurgling equals probable proper placement of tube, As a second check, draw back on the syringe and aspirate stomach contents: ... ... " The American Academy of Hospice and Palliative Medicine (AAHPM) www.aahpm.org <http://www.aahpm.org> Clinical Practice Guidelines for Quality Palliative Care Statement: The goal of palliative care is to prevent and relieve suffering, and to support the best possible quality of life for patients and their families, regardless of their stage of disease or the need for other therapies, in accordance with their values and preferences. Palliative care is both a philosophy of care and an organized,	L 052	L052 (Resident #95) 1. Resident #95 is discharged. 2. A review of physician orders for residents nearing end-of-life, identified the same or similar Comfort Care orders. The Medical Director will implement corrective actions. 3. The Medical Director will develop a plan to replace the terminology of Comfort Care orders with a breakdown of specific orders to provide individualized Palliative Care for residents at the end of life. The resident-specific orders will reflect the resident's choice, with a plan of care to support the resident's personal preferences for care and treatment. The Medical Staff will determine the process and the Medical Director or designee will educate facility staff. The Medical Director will obtain Medical Staff consensus for peer review audit criteria for use by QI Manager to pre-screen for effectiveness of the changes. 4. The QI Manager will pre-screen the current monthly Mortality Review Report using criteria provided by the Medical Director, who will follow with physician peer review. The Medical Director will report physician peer review findings to the Medical Staff and QAPI Committee monthly. 5. Date of Compliance:	6/6/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0005	A. BUILDING: _____ B. WING _____	04/22/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 8 highly structured system for delivering care.... According to the "Lippincott Manual of Nursing Practice Seventh Edition " Palliative Care P162 " Palliative care is the active total care of patients with advanced illness. The focus is no longer on curative treatment, but on quality of life and integrating the physical, psychological, spiritual, and social aspects of care. Principles of Palliative Care P163: 1. Palliative care is an interdisciplinary team approach, including experts from medicine, nursing, social work, the clergy and nutrition. This team is approach is needed to make necessary assessments and to institute appropriate interventions. 2. The essential components of Palliative care are relief of relief of symptom distress, improved quality of life, opening of communication on a regular basis with patients to provide appropriate care on their terms, and psycho social support for patients and families. 3. The goal is to provide comfort and maintain the highest possible quality of life for a long as possible. 4. The traditional focus of palliative care is not on death but on a compassionate understanding of patient suffering and focuses on providing effective pain and symptom management to seriously ill patients, while improving quality of life. 1. Facility staff failed to administer medications in accordance with physician's orders, via [by] Gastrostomy tube, for Resident #78.	L 052	L052(Resident #78) 1. License Nurse that failed to check placement of the gastrostomy tube for residents 78 and 82 received counseling and education regarding medication administration of medications through a gastrostomy tube and for all medications. 2. No other residents were found to be presently affected. 3. An education session to review the facility Medication Administration Policy (includes administration of medications through a gastrostomy tube) will be conducted for all licensed nurses. All licensed nurses will take and must successfully pass an annual Medication Administration Competency: skill and written exam. All licensed nurses to ensure continued competency in medication administration will receive a Medication Administration Observation conducted at least once monthly by the Clinical Manager or designee on all three shifts. 4. The findings of the Medication Administration Observations will be discussed weekly at the Focus QI Meeting with recommendations offered for nurse counselling and/or education and will be reported quarterly by the QI Manager to the QI Committee. 5. Compliance Date:	6/6/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0005	A. BUILDING: _____ B. WING _____	04/22/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 9 Employee #34 was observed on April 14, 2014 during a medication pass at approximately 12:30 PM. The employee was observed preparing Resident #78 ' s medications for administration via Gastrostomy. After checking for residual, Employee #34 proceeded to administer each medication separately through a 60 ml syringe attached to the Gastrostomy tube and allowed each to infuse by gravity. He/she did not check for correct placement of the Gastrostomy tube prior to the administration of the medications. According to the physician ' s order form dated April 4, 2014 directed: "Flush G-Tube (Gastrostomy Tube) with 300 ml of water every shift. Check residual before feeding ..., Check tube for proper placement prior to each feeding, flush or medication administration every shift. " Facility staff failed to check for proper placement of Gastrostomy tube prior to administration of medications. A face-to-face interview was conducted with Employee # 34 on April 14, 2014 at approximately 3:00 PM. He/she acknowledged he/she did not listen with his/her stethoscope for proper placement of the Gastrostomy tube prior to administering the medication. The observation was made on April 14, 2014. 2. Facility staff failed to develop and implement measures to provide comfort care services for Resident #95 who was identified as receiving " comfort care. " A review of the QIS [Quality Indicator Survey]	L 052	L052 (Resident #153) 1. Too much time had elapsed to complete a late entry into nursing progress note of resident # 153. 2. No other residents were found to be presently affected. 3. The licensed nurse will consistently document for three days the status of all residents admitted to the facility: to include vital signs. The process will be added to the Open Charting Policy. All licensed nurse will receive a Back to Basics education session: to include systems assessment, review of the Open Charting Policy and review of documentation of alterations in resident skin integrity. Using the Open Charting Policy all residents experiencing an acute change in status will be documented on in the EMR until the acute change in status is resolved. The Clinical Manager as part of their monthly chart audit will review when appropriate for the resident(s) if the Open Charting Policy was implemented.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0005	A. BUILDING: _____ B. WING _____	04/22/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 10 entrance conference worksheet submitted upon request to the survey team, Resident #95 was identified as requiring " Comfort Care/End of Life Care. " A review of the clinical record revealed that there were no physician orders, treatment or care plan directing staff in caring for and meeting Residents #95 ' s comfort care needs. " A fact- to- face interview was conducted with Employee# 2 on April 21, 2014 at approximately 3:00 PM, when queried requesting a copy of the facilities palliative care policy, he/she stated "there is no policy related to palliative/comfort care. " A face-to-face interview was conducted with the Employee #4 on April 21 at approximately 3:30 PM, when queried regarding how staff knew what comfort care orders and treatment to implement he/she stated the, Physician Orders for Life Sustaining Treatment (POLST) is used as comfort care orders on the unit. Employee #4 stated he/she was not aware of a specific comfort care policy. When queried regarding POLST form last signed and dated April 4, 2008 he/she stated " I was not aware of that. " A face to face interview was conducted with Employee #20 on April 21, 2014 at approximately 4:00 PM, when queried about a comfort care treatment plan he/she replied " The medical team does not write comfort care orders, they discuss care with families and document in the medical record progress notes which the nurses always can use as a guideline " Employee #20 further stated " I don ' t see a need for writing specific comfort care orders. "	L 052	4. Findings from the monthly chart audit to ascertain implementation of the Open Charting policy will be discussed when appropriate at the Weekly Focus QI meeting and will reported quarterly (as part of monthly Chart Audit Tool findings) by the QI Manager to the QI Committee. Implementation of Open Charting Policy will be added to the Chart Audit Tool used by the Clinical Manager to audit 10% of the medical records on their nursing units each month. 5. Compliance Date: <u>L052 (Resident #182)</u> 1. License Nurse that failed to check placement of the gastrostomy tube for resident # 182 received counseling and education regarding medication administration of medications through a gastrostomy tube and for all medications. 2. No other residents were found to be presently affected.	6/6/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0005	A. BUILDING: _____ B. WING _____	04/22/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 11 A face to face interview was conducted with Employee #1 on April 20, 2014 at approximately 5:00 PM when questioned about the facility ' s Palliative/Comfort care program and policies he/she stated " there is no program or policies. " A face to face interview was conducted with Employee #1 on April 21 at approximately 9:15 AM when queried if there was a policy or guidelines for use of Physician Orders for life sustaining treatment form(POLST) His/her response was "no." There was no evidence that the facility was providing palliative care to Resident #95. A face to face interview was conducted with Employee #2 on April 21, 2014 he/she acknowledged the aforementioned findings. The medical record was reviewed on April 21, 2014. 3. Facility staff failed to develop and implement measures to provide comfort care services for Resident #98. A review of the QIS entrance conference worksheet submitted upon request to the survey team, identified Resident #98 as requiring " Comfort Care/End of Life Care. " A review of the clinical record revealed that there were no orders, treatment or care plan directing staff in caring for and meeting Residents #98's comfort care needs. " A fact to face interview was conducted with Employee# 2 on April 21, 2014 at approximately 3:00 PM, when queried requesting a copy of the	L 052	3. An education session to review the facility Medication Administration Policy (includes administration of medications through a gastrostomy tube) will be conducted for all licensed nurses. All licensed nurses will take and must successfully pass an annual Medication Administration Competency: skill and written exam. All licensed nurses to ensure continued competency in medication administration will receive a Medication Administration Observation conducted at least once monthly by the Clinical Manager or designee on all three shifts. 4. The findings of the Medication Administration Observations will be discussed weekly at the Focus QI Meeting with recommendations offered for nurse counselling and/or education and will be reported quarterly by the QI Manager to the QI Committee. 5. Compliance Date:	6/6/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0005	A. BUILDING: _____ B. WING _____	04/22/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 12 facilities palliative care policy, he/she stated "there is no policy related to palliative/comfort care " . A face-to-face interview was conducted with the Employee #4 on April 21 at approximately 3:30 PM, when queried regarding how staff knew what comfort care orders and treatment to implement he/she stated the, Physician Orders for Life Sustaining Treatment (POLST) is used as comfort care orders on the unit. Employee #4 stated he/she was not aware of a specific comfort care policy. When queried regarding POLST form last signed and dated April 4, 2008 he/she stated " I was not aware of that. " A face to face interview was conducted with Employee #20 on April 21, 2014 at approximately 4:00 PM when queried about a comfort care treatment plan he/she replied " The medical team does not write comfort care orders, they discuss care with families and document in the medical record progress notes which the nurses always can use as a guideline " Employee #20 further stated " I don ' t see a need for writing specific comfort care orders, the residents care is individualized. " A face to face interview was conducted with Employee #1 on April 21, 2014 at approximately 5:00 PM when questioned about the facility ' s Palliative/Comfort care program and policies he/she stated " there is no program or policies. " A face to face interview was conducted with Employee #1 on April 21 at approximately 9:15 AM when queried if there was a policy or guidelines for use of Physician Orders for life sustaining treatment form(POLST) His/her	L 052	L052 (Resident #213) 1. License Nurse that failed to administer nasal spray according to physician orders received counseling and education regarding medication administration of all medications. 2. No other residents were found to be presently affected. 3. An education session to review the facility Medication Administration Policy will be conducted for all licensed nurses. All licensed nurses will take and must successfully pass an annual Medication Administration Competency: skill and written exam. All licensed nurses to ensure continued competency in medication administration will receive a Medication Administration Observation conducted at least once monthly by the Clinical Manager or designee on all three shifts. 4. The findings of the Medication Administration Observations will be discussed weekly at the Focus QI Meeting with recommendations offered for nurse counselling and/or education and will be reported quarterly by the QI Manager to the QI Committee. 5. Compliance Date:	6/6/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0005	A. BUILDING: _____ B. WING _____	04/22/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 13 response was " no. " There was no evidence that facility was providing palliative care to Resident #98. A face to face interview was conducted with Employee #2 on April 21, 2014 he/she acknowledged the aforementioned findings. The medical record was reviewed on April 21, 2014. 4. Facility staff failed to develop and implement measures to provide comfort care services for Resident #106 who was identified as receiving " comfort care. " A review of the QIS entrance conference worksheet submitted upon request to the survey team, identified Resident #106 as requiring " Comfort Care/End of Life Care " . A review of the clinical record revealed that there were no orders, treatment or care plan directing staff in caring for and meeting Residents #106's comfort care needs. " A fact to face interview was conducted with Employee #2 on April 21, 2014 at approximately 3:00 PM, when queried requesting a copy of the facilities palliative care policy, he/she stated "there is no policy related to palliative/comfort care. " A face-to-face interview was conducted with the Employee #4 on April 21 at approximately 3:30 PM, when queried regarding how staff knew what comfort care orders and treatment to implement he/she stated the, Physician Orders for Life Sustaining Treatment (POLST) is used as comfort care orders on the unit. Employee #4	L 052	L052 (Resident #291) 1. Medical record could not be corrected. Licensed nurses failing to obtain oxygen saturation level as per physician order have received counselling. 2. No other residents were found to be presently affected. 3. The Clinical Manager will, on a daily basis, audit the resident MAR and TAR of any resident that has received a new medication and/or treatment order to ensure the order has been implemented. Any resident receiving a new medication and/or treatment order will have the Open Charting Policy implemented. Using the Open Charting Policy all residents experiencing an acute change in status will be documented on in the EMR until the acute change in status is resolved. The Clinical Manager as part of their monthly chart audit will review when appropriate for the resident(s) if the Open Charting Policy was implemented. 4. Findings from the monthly chart audit to ascertain implementation of the Open Charting policy will be discussed when appropriate at the Weekly Focus QI meeting and will reported quarterly (as part of monthly Chart Audit Tool findings) by the QI Manager to the QI Committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0005	A. BUILDING: _____ B. WING _____	04/22/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 14 stated he/she was not aware of a specific comfort care policy. When queried regarding POLST form last signed and dated March 13, 2009 he/she stated " I was not aware of that. " A face to face interview was conducted with Employee #20 on April 21, 2014 at approximately 4:00 PM when queried about a comfort care treatment plan he/she replied " The medical team does not write comfort care orders, they discuss care with families and document in the medical record progress notes which the nurses always can use as a guideline " Employee #20 further stated " I don ' t see a need for writing specific comfort care orders , the residents comfort care is individualized ". A face to face interview was conducted with Employee #1 on April 20, 2014 at approximately 5:00 PM when questioned about the facility ' s Palliative/Comfort care program and policies he/she stated " there is no program or policies. " A face to face interview was conducted with Employee #1 on April 21 at approximately 9:15 AM when queried if there was a policy or guidelines for use of Physician Orders for life sustaining treatment form(POLST) His/her response was " no. " There was no evidence that facility was providing palliative care to Residents #106 A face to face interview was conducted with Employee #2 on April 21, 2014 he/she acknowledged the aforementioned findings. The medical record was reviewed on April 21, 2014.	L 052	Implementation of Open Charting Policy will be added to the Chart Audit Tool used by the Clinical Manager to audit 10% of the medical records on their nursing units each month. 5. Compliance Date:	6/6/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0005	A. BUILDING: _____ B. WING _____	04/22/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 15 5. Facility staff failed to complete an admission assessment for Resident #153 in a timely manner. Additionally, facility staff failed to consistently assess and monitor the status of Resident #153 ' s condition. The resident was assessed as having an unwitnessed fall, complaints of shortness of breath and an alteration in skin integrity. A. According to the facility ' s policy " Charting-Documentation " Policy No: IM-00015.86, Revised 11/13, stipulates: " Nursing- 5. A comprehensive note detailing the patient/resident ' s condition is written on admission is entered into the electronic medical record. " A review of the electronic " Progress Notes By Resident " dated March 4, 2014 at 04:34 PM revealed Resident #153 was re-admitted from [hospital named] .... With [diagnoses] of Atrial Fibrillation, CAD (Coronary Artery Disease), COPD (Chronic Obstructive Pulmonary Disease) and Dementia ... On [oxygen]... on 2 liter via nasal cannula. A further review of the " Cardiovascular and Respiratory " sections of the nurses ' observation form revealed that the blood pressure and pulse rate was recorded as being completed on April 18, 2014. The comments section of the form revealed the following note, " 03/04/2014 PM, [nurse named]: Resident Re-admitted note. " The " Attestation " section of the form was signed by a License Practical Nurse and the date recorded as being completed was April 20, 214 at 4:13 AM.	L 052	L052 (Resident #305) 1. Licensed nurse counselled and received education regarding pain assessment and documenting resident's level of pain prior to administration of pain medication. 2. No other residents were found to be presently affected. 3. All licensed nurses will receive education regarding pain assessment and documentation of the resident's level pain level prior to administration of pain medication. All licensed nurses will receive education about Pain Management as part of their orientation and Pain Management will be an annual mandatory education offering. Pain Management. 4. Assessment and documentation of resident level of pain will be added as an item to the Clinical Manager monthly Chart Audit Tool. During the monthly chart audit completed by the Clinical Manager, at least two of the medical records audited must be a resident receiving Pain Management. The findings of the monthly Chart Audit Tools completed by the Clinical Manager are reported quarterly by the QI Manager to the QI Committee. 5. Compliance Date:	6/6/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0005	A. BUILDING: _____ B. WING _____	04/22/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 16 There was no documented evidence that Resident #153 ' s vital signs were assessed and recorded in a timely manner. There was a time lapse of 45 days from when the admission observation form was started on March 4, 2014 to actual completion date of April 20, 2014. A face-to-face interview was conducted with Employee #3 on April 20, 2014 at approximately 11:00 AM regarding the aforementioned findings. He/she acknowledged that the admission assessment was not completed in a timely manner. The clinical record was reviewed on April 20, 2014. B. Facility staff failed to consistently assess and monitor the status of Resident #153 ' s condition. The resident was assessed as having an unwitnessed fall, complaints of shortness of breath and an alteration in skin integrity. Resident #153 was transferred to another assigned room within the same unit on December 2, 2013 at 03:04 PM. According to a quarterly Minimum Data Set (MDS) with a Assessment Reference Date (ARD) of October 15, 2013 revealed in Section I (Active Diagnoses) diagnoses included, CHF (Congestive Heart Failure), COPD (Chronic Obstructive Pulmonary Disease), and Dementia. Physician ' s Orders: The physician ' s order form dated and signed January 6, 2014; with a start date of January 1, 2014 directed, " [Oxygen] at 2 liters via nasal	L 052		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0005	A. BUILDING: _____ B. WING _____	04/22/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 17 cannula for shortness of breath, Change O2 humidifier bottle and nasal cannula weekly and as needed ... Check O2 [saturation] as needed and monitor # [number] of times [resident] is taking off [his/her] nasal cannula. Skin checks by licensed nurse every week. Vigilon monitor." Interim order dated January 30, 2014 at 4:22 AM directed, " [Physical Therapy/Occupational Therapy] Screen post fall. " Nursing Notes: A review of the clinical record revealed the following nursing notes: " December 9, 2013- 10:21 PM- Comments: Resident complains [of shortness of breath] on assessment, HR [Heart rate- 91-], B/P [Blood Pressure] - O2 sat [saturation] checked 95% with 2L/minute Oxygen via nasal cannula continues. Breathing treatment provided as ordered. December 11, 2013- 10:37 PM- Resident alert and responsive. Medication provided as ordered. No acute distress or [shortness of breath] noted at this time. December 12, 2013- 4:21 AM- Resident transferred from [room assigned] on unit [unit named] to room [room and unit named] at 3PM this afternoon. [He/she] remains alert and on continuous oxygen at 2L/minute. [He/she] remains alert and [quiet]. [He/she] refused to go in bed and was still sitting [in] dining area watching television. [He/she] denied pain and	L 052		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0005	A. BUILDING: _____ B. WING _____	04/22/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 18 discomfort. VS [Vital signs] - B/P- 118/64, Respirations-20, Temperature- 97.3 and O2 [saturation] 96% at 2l/min. December 12, 2013 -4:51 AM- Monthly Summary for November 2013- Resident had fall [times] 1 without injury on November 2, 2013 during the 7AM-3PM shift when staff responded to an alarm and upon entering [room named], observed resident in sitting position leaning against the bed. Neuro check protocol initiated and within resident ' s limits .... Continues to receive oxygen via nasal cannula for shortness of breath. No increase [shortness of breath] noted. December 30, 2014- 4:52 AM- ... Respiratory: Shortness of breath or trouble breathing with exertion, Oxygen delivered via Nasal cannula in l/min=2, [Status post] unwitnessed fall from bed. December 31, 2013 12:02 PM- No acute distress noted, no [shortness of breath] noted ... continue on oxygen on 2 liter via [nasal cannula] with no discomfort noted. January 30, 2014- 4:52 AM- Audible bed sensor alarm. Entered resident ' s room. Observed resident on floor. Resident returned to bed via [a] hoya lift. [Range of motion] to upper and lower extremities without statement of discomfort, [Medical doctor] and family notified. Neuro checks in progress. February 2, 2014 11:40 AM- ...sitting in	L 052		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0005	A. BUILDING: _____ B. WING _____	04/22/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 19 wheelchair with oxygen, no evidence of any respiratory distress noted at around 8 AM. Assigned CNA (Certified Nursing Assistant) reported that patient has a [bruise] to [his/her] left upper arm measuring 8 [cm] by 9.3 cm ... denies pain when touch. [Medical doctor] on call was notified ... Vital signs are Temp-97, respirations-20, Pulse-89, Blood Pressure- 123/68, O2 saturation 97%. Continue to monitor patient. February 9, 2014 12:01 PM- While performing ADL (Activities of Daily Living) care, CNA observed resident with skin discoloration, upon assessment, resident was noted with skin discoloration located at left lateral thigh measured 3 cm x1.5cm, non tender upon palpation, surrounding tissue normal ... Will continue to monitor. February 27, 2014 5:14 AM- Resident observed with shortness of breath with [oxygen] via [nasal cannula]. Pulse oximetry- 61%, heart rate-108, [blood pressure] 96/53, Temperature- 95, Respirations-46 and shallow. [Medical doctor] notified. Order obtained to transfer [to hospital] 911. Family notified of transfer to [hospital named]. " A review of the record lacked documented evidence of consistent respiratory assessment(s) for the resident between December 9, 2013 and the time that the resident was transferred out via 911 to an acute hospital on February 27, 2014. The progress notes documented by the nurse on December 9, 2013 revealed that Resident # 153 complained of [shortness of breath] on assessment; utilizing O2 at 2l/min via nasal	L 052		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0005	A. BUILDING: _____ B. WING _____	04/22/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 20 cannula for shortness of breath. There were inconsistencies in assessing the resident ' s respiratory status and a lack of follow up assessment to indicate that interventions were effective and episodes of shortness of breath were resolved. The clinical record lacked documented evidence that Resident #153 was consistently monitored after an unwitnessed fall on January 30, 2014. The clinical record lacked documented evidence that skin assessments were consistently conducted on Resident #153 after an alteration in skin integrity was identified by the Certified Nursing Assistant on February 9, 2014. Facility staff failed to consistently assess and monitor the status of Resident #153 ' s condition. A face-to-face interview was conducted with Employee #3 on April 18, 2014 at approximately 10:00 AM. He/she acknowledged the aforementioned findings. The clinical record was reviewed on April 18, 2014. 6. Facility staff failed to administer medications in accordance with physician's orders, via [by] Gastrostomy tube, for Residents #182. Employee #34 was observed on April 14, 2014	L 052		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0005	A. BUILDING: _____ B. WING _____	04/22/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 21 during a medication pass at approximately 12:30 PM. The employee was observed preparing Resident #182 ' s medications for administration via Gastrostomy. After checking for residual, Employee #34 proceeded to administer each medication separately through a 60 ml syringe attached to the Gastrostomy tube and allowed each to infuse by gravity. He/she did not check for correct placement of the Gastrostomy tube prior to the administration of the medications. According to physician order form dated April 4, 2014 directed: " Flush G-Tube (Gastrostomy Tube) with 300 ml of water every shift. Check residual before feeding ... Check tube for proper placement prior to each feeding, flush or medication administration every shift. " Facility staff failed to check for proper placement of Resident #182 ' s Gastrostomy tube prior to administration of medications. A face-to-face interview was conducted with Employee #34 on April 14, 2014 at approximately 3:00 PM. He/she acknowledged that he/she did not check for proper placement with her stethoscope prior to administering the medication. The observation was made on April 14, 2014. 7. Facility staff failed to obtain physician's orders for hospice services for Resident #211. A review of the " Physician Order Sheet and Plan of Care " revealed that the resident was admitted to the facility on February 21, 2014 with the following diagnosis: Adenocarcinoma of the Esophagus, Hx [history] [of] Upper	L 052		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0005	A. BUILDING: _____ B. WING _____	04/22/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 22 Gastrointestinal bleed secondary to Adenocarcinoma of [the] esophagus. According to the Interdisciplinary Progress Note dated February 24, 2014, no time indicated, " 81 year old with Esophogeal Adenocarcinoma admitted to [facility name] 2/21/14 [February 21, 2014] DNR/DNI [Do Not Resuscitate/Do Not Intubate] in Hospice. " Review of the " Progress Notes By Resident " revealed that hospice care had been conducted February 22, 2014 through March 12, 2014. Further review of the medical record lacked evidence of physician orders to initiate hospice services for Resident #211. A face-to-face interview was conducted on April 21, 2014 with Employee #1 at approximately 10:00 AM. A query was made regarding the facility ' s process when admitting a resident to hospice service. Employee #1 stated that "if the resident is an " in patient " resident, the medical director would be the admitting physician that is already on staff. If the resident is not a resident of this long term care facility, the hospital will speak with the liaison here at this facility and then admit through the regular process and the admitting nurse would call and confirm the admissions orders. Employee #1 acknowledged that there were no admitting orders for hospice services for the	L 052		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0005	A. BUILDING: _____ B. WING _____	04/22/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 23 Resident #211. A face-to-face interview was conducted on April 21, 2014 with Employee #20 at approximately 10:00 AM. A query was made regarding the lack of physician ' s orders for admitting the resident to hospice services. After review of the medical record, Employee #20 acknowledged the lack of an order for hospice services. However, stated that the resident did receive the services as intended. 8. Facility staff failed to ensure Resident #213 was administered a nasal spray in accordance with the physician ' s orders. A medication observation was conducted on April 15, 2014 at approximately 10:00 AM. During the observation Employee #16 administered two (2) sprays of " Deep Sea 0.65% Spray " in each nostril of the resident. A review of the April 2014 " Physician ' s Order Form " last signed and dated April 7, 2014 directed, Deep Sea 0.65% Spray - 1 spray each nostril every four hours as needed for dryness. " Facility staff failed to ensure that a nasal spray was administered to resident in accordance with the physician ' s orders [one (1) spray per nostril as opposed to 2 sprays]. A face-to-face interview was conducted with Employee #16 on April 15, 2014 at approximately 10:15 AM. He/she acknowledged that the resident was administered two (2) sprays in each nostril at the time of the administration. The observation occurred on April 15, 2014.	L 052		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0005	A. BUILDING: _____ B. WING _____	04/22/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 24 9. Facility staff failed to assess Resident #291 ' s oxygen saturation level as directed by the physician. A review of the Physician ' s order sheet and plan of care signed and dated on February 27, 2014 directed, Oxygen at 2 liters per minute via nasal cannula continuous, check pulse ox [oxygen saturation] every shift. " A review of the Medication and Treatment Administration record revealed that the 11P-7A shift left the slot allotted for check pulse ox every shift scheduled for April 22, 2014 was " blank " indicating that the treatment was not done. The Medication and Treatment Administration record " lacked evidence that resident #291 ' s pulse oximetry was checked on February 22, 2014 11PM - 7AM shift. A face-to-face interview was conducted on April 22, 2014 at approximately 3:05PM with Employee #7. After reviewing the medication and treatment administration record, he /she acknowledge the findings. The record was reviewed April 22, 2014. 10. Facility staff failed to assess Resident #305 ' s pain prior to administration of pain medication. A. According to the facility ' s policy " Pain Management " , Policy No: PE-00008.01, revised date 11/13 stipulates, " II- Pain Assessment-Administration of Pain Medications: a. prior to administration of PRN [as needed] medications	L 052		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0005	A. BUILDING: _____ B. WING _____	04/22/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 25 for pain, the licensed nurse must assess the resident ' s /patient level of pain using a quantitative scale. The quantitative scale is 0-10: 1 being the less severe level of pain and 10 being the most severe level of pain .... " A medication observation was conducted on April 14, 2014 at approximately 10:30 AM. During the observation Employee #16 made an attempt to reposition Resident #305. At this time, the resident grimaced. Employee #15 asked the question, " Are you in pain. " Resident #305 replied, " Yes. " Employee #16 stated, " I will give you something for pain. " The employee returned to the medication cart, obtained two (2) tablets of acetaminophen along with the other scheduled medications from the medication cart. He/she returned to the resident ' s room and administered the pain medication. " The physician ' s order dated April 12, 2014 and signed by the physician on April 13, 2014, directed " Acetaminophen 325mg 2 [two] [tablets] p.o. [by mouth] q [every] 6 h [hours] prn (as needed) for pain. " According to an interim order form dated April 11, 2014 at 4:00 PM directed, " MSO4 (Morphine Sulfate) (20 mg/ml) oral concentrate. Take 0.25ml (5mg) by mouth or under the tongue every 4 [hours] prn [as needed] [for] moderate to severe pain or shortness of breath. " The April 2014 MAR (Medication Administration Record) revealed: " Morphine Sulfate 20mg/ml 0.25ml (5mg by mouth or under the tongue every 4 (four) hours as needed [for] moderate to severe pain or shortness of breath. "	L 052		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0005	A. BUILDING: _____ B. WING _____	04/22/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 26 A review of the back of the MAR revealed that Employee #16 recorded that acetaminophen 325mg - two (2) [tablets] were administered for pain at 10:30 AM and recorded that the acetaminophen was effective at 12:00 PM. There was no evidence that facility staff assessed the resident ' s level of pain prior to the administration of acetaminophen to determine the appropriate medication to administer based on the parameters. A face-to-face interview was conducted with Employee #18 on April 14, 2014 at approximately 10:30 AM. He/she acknowledged the aforementioned findings. The observation and clinical record was conducted on April 14, 2014.	L 052		
L 056	3211.5 Nursing Facilities Nursing personnel, licensed practical nurses, nurse aides, orderlies, and ward clerks shall be assigned duties consistent with their education and experience and based on the characteristics of the patient load. This Statute is not met as evidenced by: Based on record review and staff interview during a review of staffing [direct care per resident day hours], it was determined that facility staff failed to meet minimum nurse staffing requirements in accordance with Title 22 DCMR Section 3211, Nursing Personnel and Required Staffing Levels. The findings include: A review of Nurse Staffing was conducted on April 22, 2014 at approximately 1:30 PM.	L 056		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0005	A. BUILDING: _____ B. WING _____	04/22/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 056	Continued From page 27 According the District of Columbia Municipal Regulations for Nursing Facilities: 3211.5 Beginning January 1, 2012, each facility shall provide a minimum daily average of four and one tenth (4.1) hours of direct nursing care per resident per day, of which at least six tenths (0.6) hours shall be provided by an advanced practice registered nurse or registered nurse, which shall be in addition to any coverage required by subsection 3211.5. Of the five (5) days reviewed, one (1) of the days failed to meet the 0.6 [six tenths] hours of direct nursing care per resident day for Registered Nurse/APRN [Advanced Practice Registered Nurse] as follows: April 20, 2014 - 0.51 hours of direct nursing (RN) care per resident day Of the five (5) days reviewed, two (2) of the days failed to meet minimum daily average of four and one tenth (4.1) hours of direct nursing care per resident per day as follows: April 19, 2014 - 3.3 hours of direct nursing care per resident day April 20, 2014 - 3.66 hours of direct nursing care per resident day The review was made in the presence of Employee #37 who acknowledged the findings.	L 056	L056 4.1 hours of direct nursing care per resident 1. Failure to meet standard was acknowledged by facility. 2. Director of Nursing or designee will meet daily with Staffing Coordinator to ensure staffing needs have been filled and meet daily PPD for staffing requirements. 3. Director of Nursing and Staffing Coordinator will meet weekly with the Human Resources Department to review staff recruitment and retention offerings. 4. Human Resources Department will submit a quarterly report of recruitment and retention efforts: report includes retention percentages of licensed and unlicensed staff, to the QI Manager. QI Manager submits report quarterly to the QI Committee. 5. Compliance Date:	Ongoing
L 083	3216.4 Nursing Facilities Physical restraints shall not be applied unless:	L 083		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0005	A. BUILDING: _____ B. WING _____	04/22/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 083	Continued From page 28 (a)The facility has explored or tried less restrictive alternatives to meet the resident's needs and such trails have bene documented in the resident's medical record as unsuccessful; (b)The restraint has been ordered by a physician for a specified period of time; (c)The resident is released, exercised and toileted at least every two (2) hours,except when a resident's rest would be unnecessary disturbed. (d)The use of the restraint doe not result in a decline in the resident's physical, mental psychological or functional status; and (e)The use of the restraint is assessed and re-evaluated when there is a significant change in the resident's condition. This Statute is not met as evidenced by: Based on observations, record review and staff interview for eight (8) of 51 sampled residents, it was determined that facility staff failed to ensure residents were free from physical restraints as evidenced by: eight (8) residents who were observed seated in mobility aids "merry walkers" and were unable to self release and exit at will. Residents' #26, 43, 95, 102, 106, 118, 183 and 177. The findings include: According to the Code of Federal Regulations 483.13 (a) Restraints- Definition of Terms stipulates; "An enclosed framed wheeled walker, with or without a posterior seat, would not meet the definition of a restraint if the resident could easily open the front gate and exit the device. If the resident cannot open the front gate	L 083	L083 1. Residents # 26, 43, 95, 102, 106, 118, 183, and 177 were reassessed by the IDT to determine the Merry Walker or merry Walker with lap tray restraint is least restrictive to meet resident's current needs. The residents were assessed as clinically appropriate for continued Merry Walker use to support goals for safety and freedom of movement. All required restraint assessments were completed. Physical restraint care plans were updated, including potential for gradual restraint reduction or elimination of restraint if appropriate. Physician orders were obtained to include type of restraint, parameter for use, and medical symptom to support restraint use. Responsible parties were notified of IDT's recommendations for continued use of Merry Walker. 2. A facility-wide review identified no other residents affected by the deficient practice.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0005	A. BUILDING: _____ B. WING _____	04/22/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 083	Continued From page 29 (due to cognitive or physical limitations that prevent him or her from exiting the device or because the device has been altered to prevent the resident from exiting the device), the enclosed framed wheeled walker would meet the definition of a restraint since the device would restrict the resident ' s freedom of movement." The Facility's Policy and Procedure No.TX-00001.11 - Restraints Physical: effective 04/11 and revised 10/11 stipulated the following: " If the IDT (Interdisciplinary Team) determines a physical restraint is needed for a resident an assessment must be completed prior to placement of the resident, quarterly, and with any significant change. Any resident requiring the use of a restraint, as determined by the IDT, must have a restraint reduction assessment completed quarterly and /or with a significant change ... Procedure: Steps for Assessment 1. Consult with the IDT to determine the resident ' s cognitive and physical limitations. 2. Review the resident ' s medical record. 3. Review the definition of restraint: focus on the effect the device will have on the resident, not the type of device. 4. If the device meets the definition of a restraint complete the following as applicable. a. Pre-restraining Assessment (complete as initial assessment only) b. Side Rail Assessment (complete quarterly and/or with significant change) c. Merry walker Ambulation Assessment (complete quarterly and/or with significant change) d. Physical Restraint Elimination (complete quarterly and/or with significant change) 5. If the IDT determines a physical restraint is needed , ensure the following steps:	L 083	3. The Merry Walker Policy and Procedure will be reviewed by the IDT and reeducation conducted to review all physical restraint required assessments, physician orders, documentation, care plans, and notifications for residents using Merry Walkers. Residents with physical restraints will be reassessed quarterly and/or if significant change, to determine clinical indications for continued restraint use. Licensed nurses will be reeducated on management of physical restraints and reeducation repeated quarterly. Clinical Managers or designee will update physical restraint care plans quarterly and/or if significant change, based on Merry Walker Use Assessment and Physical Restraint Elimination Assessment Forms recommendations and notify the responsible party of recommendations. 4. Clinical Managers will monitor physical restraint assessment tools monthly and report findings to the QI Manger for review at Focus QI-IDT meetings. A summary of findings will be reported to the QAPI Committee a minimum of quarterly. 5. Compliance Date	6/6/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0005	A. BUILDING: _____ B. WING _____	04/22/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 083	Continued From page 30 a. Notify the resident and/or responsible party b. Physician must document a medical symptom that supports the use of a restraint c. Obtain a physician order for the type of restraint, the parameter for its use, and medical symptoms that support its use. d. Initiate a care plan that includes a process of gradual restraint reduction and/or elimination as appropriate. e. Assess that the restraint used is the least restrictive, to meet the resident ' s current needs. 6. As part of the IDT care plan the Physical Restraint Elimination Assessment must be completed quarterly and at the time of significant change." 1.Facility staff failed to ensure that Resident #95 was free from physical restraints. Resident #95 was observed seated in a " merry walker " in the dining room area on unit 2A, with a self-release front arm cross bar, covered by a lap tray at approximately 11:30 AM on April 17, 2014. The resident did not respond to a query from the surveyor to remove the lap tray and self-release bar to exit the merry walker. A review of the Physician's Order Form (POS) signed and dated April 1, 2014 directed, "Patient to use merry walker when out of bed for safety. Patient to have lap-tray on merry walker whenever patient is in merry walker." A review of the Quarterly MDS (Minimum Data Set) of Resident #95 dated January 24, 2014 revealed that Section G [Functional Status] coded as total dependent for bed mobility, and extensive assistance for transfer, walking in room, corridor and locomotion on unit. Balance	L 083		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0005	A. BUILDING: _____ B. WING _____	04/22/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 083	Continued From page 31 during transitions, and walking was coded as not steady, only able to stabilize with staff assistance, Section I [Active Diagnoses] lists, Non-Alzheimer ' s and Dementia, and Section P [Restraints] was coded as no restraints being used. A face-to-face interview was conducted with Employee #4 on April 17, 2014 at approximately 11:45AM. He/she was queried regarding Resident # 95 ' s ability to exit the merry walker at will. Employee #4 stated, "No, he/she can ' t release the bar or remove the lap tray, however the merry walker is used to provide dignity and to keep him/her from falling. This was implemented by [the] Rehab (Rehabilitation) Department." A face-to-face interview was conducted with Employee #10 on April 17, 2014 at approximately 12:00 PM. When queried regarding Resident #95 ' s use of the merry walker. He/she stated, " Resident #95 has been using the merry walker for years, as a safety measure to prevent falls." Upon further query regarding the last time the resident was assessed regarding his/her cognitive ability to remove the bar and lift the lap tray, Employee #10 stated, "The Occupational Therapist recommended and implemented the lap tray. Resident #95 can't be taught how to remove [the] bar to self-release the bar or [the] lap tray." When queried if the resident has been assessed or evaluated for least restrictive device the Employee #10 replied, "No, the merry walker is not a restraint." Employee #10 stated, "merry walkers are recommended for residents with falls as a safety measure to prevent injuries."	L 083		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0005	A. BUILDING: _____ B. WING _____	04/22/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 083	Continued From page 32 A face-to-face interview was conducted with Employee #11 on April 17, 2014 at approximately 2:30 PM. When queried regarding Resident # 95 ' s ability to remove the lap tray, and exit the merry walker at will. Employee #11 stated, "I observed Resident #95 lying with his/her head on his /her arms across the safety bar. Employee #11 further stated, "The lap-tray was recommended and implemented to assist with better positioning and comfort." When queried regarding Resident # 95 ' s ability to be taught to remove the safety bar and lap-tray at will, the employee stated, " No " . The clinical record lacked evidence that the medical team identified a symptom for the use of the merry walker, and there was no evidence that the interdisciplinary team followed a systematic process for evaluation, and care planning prior to and/or after the use of the merry walker. There was no evidence that the facility staff completed quarterly merry walker ambulation assessments, documented medical symptoms or obtained parameters that supports its use, initiated care plans to include a process of gradual restraint reduction and/or elimination as appropriate, or assessed that the restraint use is the least restrictive, to meet the resident ' s current needs. A face-to-face interview was conducted with Employee #4 on April 17, 2014 at approximately 3:00 PM. He/she acknowledged the aforementioned findings. The record was reviewed on April 17, 2014. Facility staff failed to ensure that Resident #95 was free from physical restraints.	L 083		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0005	A. BUILDING: _____ B. WING _____	04/22/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 083	Continued From page 33 2. Facility staff failed to ensure that Resident #26 was free from physical restraints. Resident #26 was observed seated in a merry walker in a dining room on unit 2A with a self-release front arm cross bar at approximately 2:30 PM on April 21, 2014. A face-to-face interview was conducted with Employee #4 immediately after the observation on April 21, 2014. A query was made to determine if the resident could self-release his/her front arm cross bar at will. Employee #4 stated, " None of the residents in merry walkers on this unit can self release and exit at will, because of their dementia. The Physician's Order Form (POS) signed and dated April 1, 2014 directed, "Move patient in Merry Walker backwards when she/he is not "Activity" [Actively] walking [Resident ' s gender] " A review of the Quarterly MDS (Minimum Data Set) of Resident #26 dated March 7, 2014 revealed that Section G [Functional Status] coded as extensive assistance for bed mobility and transfer, and limited assistance for walking in room, corridor, and locomotion on and off unit. Section I [Active Diagnoses] lists Non-Alzheimer ' s and Dementia, Section P [Restraints] was coded as restraints being used daily. There was no evidence that the medical team identified a symptom for the use of the merry walker and there was no evidence that the interdisciplinary team followed a systematic process for evaluation and care planning prior to and/or after the use of the merry walker. There was no evidence that the resident was able to	L 083		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0005	A. BUILDING: _____ B. WING _____	04/22/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 083	Continued From page 34 voluntarily release the cross bar latch. There was no evidence that the facility staff completed quarterly merry walker ambulation assessments, documented medical symptoms, obtained parameters that supports its use, initiated care plans to includes a process of gradual restraint reduction and /or elimination as appropriate, or assessed that the restraint use is the least restrictive, to meet the resident ' s current needs. A face-to-face interview was conducted with Employee #4 on April 21, 2014 at approximately 3:00 PM. He/she acknowledged the aforementioned findings. The Medical Record was reviewed on April 21, 2014. Facility staff failed to ensure that Resident #26 was free from physical restraints. 3. Facility staff failed to ensure that Resident #43 was free from physical restraints. Resident #43 was observed seated in a " merry walker " in an open day room area on unit 2A with a self-release front arm cross bar at approximately 2:30 PM on April 21, 2014. A face-to-face interview was conducted with Employee #4 on April 21, 2014 at approximately 2:45 PM. A query was made to determine if the resident could self-release his/her front arm cross bar at will. Employee #4 stated, " No " A review of a physician's order on the Physician Order Form (POS) dated April 1, 2014 directed, "Pt [patient] is to use merry walker for mobility and ambulation within the unit " .	L 083		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0005	A. BUILDING: _____ B. WING _____	04/22/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 083	Continued From page 35 A review of the Quarterly MDS (Minimum Data Set) of Resident #43 dated March 7,2014 revealed that Section G [Functional Status] was coded as supervision needed for bed mobility, transfer, walking in room and corridor and locomotion on unit with limited assistance with locomotion off unit. Section I [Active Diagnoses] lists, Non-Alzheimer ' s and Dementia, and Section P [Restraints] was coded as restraints being used daily. There was no evidence that the medical team identified a symptom for the use of the merry walker and there was no evidence that the interdisciplinary team followed a systematic process for evaluation and care planning prior to and/or after the use of the merry walker. There was no evidence that the facility staff completed quarterly merry walker ambulation assessments, documented medical symptoms or obtained parameters that supports its use, initiated care plans to includes a process of gradual restraint reduction and /or elimination as appropriate, or assessed that the restraint use is the least restrictive, to meet the resident ' s current needs. A face-to-face interview was conducted with Employee #4 on April 21, 2014 at approximately 3:00 PM. He/she acknowledged the aforementioned findings. Facility staff failed to ensure that Resident #43 was free from physical restraints. 4. Facility staff failed to ensure that Resident #102 was free from physical restraints.	L 083		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0005	A. BUILDING: _____ B. WING _____	04/22/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 083	Continued From page 36 Resident # 102 was observed seated in a " merry walker " in the day room area on the unit 2A with a self-release front arm cross bar at approximately 2:30 PM on April 21, 2014. A review of the Physician Order Form (POS) signed and dated April 1, 2014 directed, "Patient is to use Merry Walker for Mobility " A face-to-face interview was conducted with Employee #4 on April 21, 2014 at approximately 2:45 PM. A query was made to determine if the resident could self-release his/her front arm cross bar at will. Employee #4 stated, " No " . There was no evidence that the medical team identified a symptom for the use of the merry walker and there was no evidence that the interdisciplinary team followed a systematic process for evaluation and care planning prior to and/or after the use of the merry walker. A review of the Quarterly MDS (Minimum Data Set) of Resident #102 dated January 24, 2014 revealed that Section G [Functional Status] was coded as extensive assistance for, bed mobility and for transfer, and limited assistance for walking in room, corridor, locomotion on unit and extensive assistance with locomotion off unit. Section I [Active Diagnoses] lists, Non-Alzheimer ' s and Dementia. Section P [Restraints] was coded as no restraints being used. There was no evidence that the facility staff completed quarterly merry walker ambulation assessments, documented medical symptoms or obtained parameters that supports its use, initiated care plans to includes a process of gradual restraint reduction and /or elimination as appropriate, or assessed that the restraint use is	L 083		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0005	A. BUILDING: _____ B. WING _____	04/22/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 083	Continued From page 37 the least restrictive, to meet the resident ' s current needs. A face-to-face interview was conducted with Employee #4 on April 21, 2014 at approximately 3:00 PM. He/she acknowledged the aforementioned findings. Facility staff failed to ensure Resident #102 free from physical restraints. The medical record was reviewed on April 22, 2014. 5. Facility staff failed to ensure that Resident #106 was free from physical restraints. Resident # 106 was observed seated in a " merry walker " in an open day room area on the unit 2A with a self-release front arm cross bar at approximately 2:30 PM on April 21, 2014. A face-to-face interview was conducted with Employee #4 on April 21, 2014 at approximately 2:45 PM. A query was made to determine the Resident #106 could self-release his/her front arm cross bar at will. Employee #4 stated, "No" . A review of the Physician Order Form (POS) signed and dated April 1, 2014 directed, "Patient is to use Merry Walker for ambulation within unit " A review of the Quarterly MDS (Minimum Data Set) of Resident #106 dated February 10,2014 revealed that Section G [Functional Status] was coded as extensive assistance for bed mobility and transfer, and limited assistance for walking in room, corridor, and locomotion on unit. Section I [Active Diagnoses] lists, Non-Alzheimer ' s and Dementia, and Section P [Restraints] was coded as restraints being used daily. There was no evidence that the medical team identified a symptom for the use of the merry	L 083		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0005	A. BUILDING: _____ B. WING _____	04/22/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 083	Continued From page 38 walker and there was no evidence that the interdisciplinary team followed a systematic process for evaluation and care planning prior to and/or after the use of the merry walker. There was no evidence that the facility staff completed quarterly merry walker ambulation assessments, documented medical symptoms or obtained parameters that supports its use, initiated care plans to includes a process of gradual restraint reduction and /or elimination as appropriate, or assessed that the restraint use is the least restrictive, to meet the resident ' s current needs. A face-to-face interview was conducted with Employee #4 on April 21, 2014 at approximately 3:00 PM. He/she acknowledged the aforementioned findings. Facility staff failed to ensure Resident #106 free from physical restraints. The Medical Record was reviewed on April 21, 2014. 6. Facility staff failed to ensure that Resident #118 was free from physical restraints. Resident # 118 was observed seated in a " merry walker " in an open day room area on the unit 2A with a self-release front arm cross bar at approximately 2:30 PM on April 21, 2014. A face- to- face interview was conducted with Employee #4 on April 21, 2014 at approximately 2:45 PM. A query was made to determine if Resident # 118 could self-release his/her front arm cross bar at will. Employee #4 stated, " No " A review of a physician's order on the Physician Order Form (POS) dated April 1, 2014 directed,	L 083		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0005	A. BUILDING: _____ B. WING _____	04/22/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 083	Continued From page 39 "Merry Walker daily for safe ambulation " A review of the Quarterly MDS (Minimum Data Set) of Resident #118 dated March 27, 2014 revealed that Section G [Functional Status] was coded as extensive assistance for bed mobility, transfer, and limited assistance for walking in room, corridor, and locomotion on unit. Section I [Active Diagnoses] lists Non-Alzheimer ' s and Dementia, Section P [Restraints] was coded as restraints being used daily. There was no evidence that the medical team identified a symptom for the use of the merry walker and there was no evidence that the interdisciplinary team followed a systematic process for evaluation and care planning prior to and/or after the use of the merry walker. There was no evidence that the facility staff completed quarterly merry walker ambulation assessments, documented medical symptoms or obtained parameters that supports its use, initiated care plans to includes a process of gradual restraint reduction and /or elimination as appropriate, or assessed that the restraint use is the least restrictive, to meet the resident ' s current needs. A face-to-face interview was conducted with Employee #4 on April 21, 2014 at approximately 3:00 PM. He/she acknowledged the aforementioned findings. Facility staff failed to ensure that Resident #118 was free from physical restraints. The Medical Record was reviewed on April 21, 2014. 7. Facility staff failed to ensure that Resident	L 083		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0005	A. BUILDING: _____ B. WING _____	04/22/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 083	Continued From page 40 #183 was free from physical restraints. Resident #183 was observed seated in a " merry walker " in the day room area on the unit 2A with a self-release front arm cross bar at approximately 2:30 PM on April 21, 2014. A face-to-face interview was conducted with Employee #4 on April 21, 2014 at approximately 2:45 PM. A query was made to determine if Resident # 183 could self-release his/her front arm cross bar at will Employee #4 stated, " No " . A review of the Physician Order Form (POS) signed and dated April 1, 2014 directed, "Patient is to use Merry Walker for mobility. " A review of the Quarterly MDS (Minimum Data Set) of Resident #183 dated January 18, 2014 revealed, Section G [Functional Status] was coded as extensive assistance for bed mobility, limited assistance for transfer, walking in room, corridor and locomotion on unit. Section I [Active Diagnoses] lists Non-Alzheimer ' s and Dementia, and Section P [Restraints] was coded as restraints being used daily. There was no evidence that the medical team identified a symptom for the use of the merry walker and there was no evidence that the interdisciplinary team followed a systematic process for evaluation and care planning prior to and/or after the use of the merry walker. There was no evidence that the facility staff completed quarterly merry walker ambulation assessments, documented medical symptoms or obtained parameters that supports its use,	L 083		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0005	A. BUILDING: _____ B. WING _____	04/22/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 083	Continued From page 41 initiated care plans to includes a process of gradual restraint reduction and /or elimination as appropriate, or assessed that the restraint use is the least restrictive, to meet the resident ' s current needs. A face-to-face interview was conducted with Employee #4 on April 21, 2014 at approximately 3:00 PM. He/she acknowledged the aforementioned findings. Facility staff failed to ensure that Resident #183 was free from physical restraints. The Medical Record was reviewed on April 21, 2014. 8. Facility staff failed to ensure that Resident #177 was free from physical restraints. Resident #177 was observed from April 17, 2014 at approximately 10:30 AM and on April 22, 2014 at approximately 9:45 AM on unit 1A in the common area, sitting in merry walker in with a self-release latch front arm cross bar. A face-to-face interview was conducted with Resident #177 on April 22, 2014 at approximately 9:45 AM. Resident #177 was asked if he/she could remove him/herself from the device [merry walker]. The Resident replied, " I have been trying to get out of this [placing his/her hands on the self-release bar and pulling on it] but I can ' t. " A face-to-face interview was conducted with Employee #3 on April 22, 2014 at approximately 10:55 AM. A query was made to determine if the resident could self-release and Employee #3 stated, "The resident was not able to self- release from merry walker " . A review of Section G, Functional Status of the Quarterly MDS (Minimum Data Set) dated	L 083		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0005	A. BUILDING: _____ B. WING _____	04/22/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 083	Continued From page 42 January 24, 2014 revealed Resident #177 was coded as total dependent for bed mobility and required extensive assistance for transfers. Section P [Restraints] was coded as no restraints being used A review of a physician's interim orders and Physician Order Form (POS) dated April 1, 2014 presented no orders for the use of a merry walker. There was no evidence that the resident could remove or release him/her self from the merry walker at will. There was no evidence that medical team identified a symptom for the use of the merry walker; and there was no evidence that the interdisciplinary team followed a systematic process for evaluation and care planning prior to and/or after the use of the merry walker. A face-to-face interview was conducted with Employee #4 on April 22, 2014 at approximately 3:00 PM. He/she acknowledged the aforementioned findings. The medical record was reviewed on April 22, 2014. Facility staff failed to ensure Resident #177 free from physical restraints.	L 083	L099 (1) 1. The out dated items were immediately discarded. 2. A check of all refrigerated foods identified no other foods past the expiration date. 3. Dietary Services shift supervisors will monitor expiration dates on refrigerated foods on a daily basis, as part of Open-Closing Checklist. 4. Dietary Services Director or designee will monitor Open-Close Checklist findings on a weekly basis to ensure corrective actions are effective and sustained. The Dietary Director will report findings to the QI Committee monthly. 5. Date of Compliance L099 (2) 1. Ovens and Flat Top were cleaned on April 18, 2014. 2. All ovens were inspected and found to be clean. 3. Dietary Services shift supervisors will monitor cleanliness of ovens and flat top grill daily, as part of Open-Close Checklist. The Master Cleaning List will be revised to increase frequency of oven cleanings to weekly. Flat top grill cleaning will be added to the closing cook's daily cleaning assignment. 4. Dietary Services Director or designee will monitor Open-Close Checklist findings weekly to ensure corrective actions are effective and sustained. The Dietary Services Director will report findings to QI Committee monthly. 5. Date of Compliance	5/23/2014 5/23/2014
L 099	3219.1 Nursing Facilities Food and drink shall be clean, wholesome, free from spoilage, safe for human consumption, and served in accordance with the requirements set forth in Title 23, Subtitle B, D. C. Municipal Regulations (DCMR), Chapter 24 through 40. This Statute is not met as evidenced by: Based on observations made on April 17, 2014 at approximately 9:00 AM, it was determined that	L 099		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0005	A. BUILDING: _____ B. WING _____	04/22/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 099	Continued From page 43 the facility failed to store, prepare, distribute and serve food under sanitary conditions as evidenced by expired foods in one (1) of three (3) refrigerators, one (1) of one (1) soiled flat top grill and two (2) of two (2) soiled convection ovens and two (2) of three (3) soiled air curtains fron one (1) of one (1) dishwashing machine. The findings include: 1. A one-third pan of guacamole stored in refrigerator #3 was expired as of April 12, 2014 and a partially filled salad bar container with shredded yellow cheese stored in refrigerator #3 was expired as of April 13, 2014. 2. One (1) of one (1) flat top grill and two (2) of two (2) convection ovens were soiled. 3. Two (2) of three (3) air curtains from the dishwashing machine were soiled. These observations were made in the presence of Employee #8 who acknowledged the findings.	L 099	L099 (3) 1. New dishwashing machine air curtains have been ordered to replace current curtains. 2. The remaining air curtain was inspected and found clean. 3. Dietary Services shift supervisors will monitor air curtain cleanliness on a weekly basis, as part of the Weekly Checklist. Inspection of dish machine air curtains will be added to the Monthly Sanitation Audit. 4. Weekly Checklists and Monthly Sanitation Audits will be reviewed by Dietary Director or designee to ensure corrective actions are effective and sustained. Findings will be reported to the QAPI Committee monthly. 5. Date of Compliance	5/23/2014
L 145	3226.5 Nursing Facilities The medication for self-administration shall be securely stored and accessible only to the appropriate resident and staff. This Statute is not met as evidenced by: F- 176- Self-administration of Medications	L 145	L145 1. Residents #136 and #300 were assessed for ability to self-administer medications by the interdisciplinary team and approved for self-administration. The Self-Medication Administration Assessment Form was completed. A physician's order was obtained for self-administration and approval to keep medications in the residents' rooms. A locked box was provided for medication storage in the residents' rooms. Licensed nurses instructed Residents #136 (eye drops, eye compresses, and shampoo) and #300 (one oral medication and eye drops) on correct administration (dosage, frequency, route, purpose, etc.) and secure storage of the medication.	
L 182	3229.4 Nursing Facilities In conjunction with the resident's admission, stay, and discharge, the functions of	L 182		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0005	A. BUILDING: _____ B. WING _____	04/22/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 182	Continued From page 44 the social services program shall include the following: (a)Direct service, including therapeutic interventions, casework and group work services to residents, families and other persons considered necessary by the social worker; (b)Advocacy on behalf of residents; (c)Discharge planning; (d)Community liaison and services; (e)Consultation with other members of the facility's Interdisciplinary Care Team; (f)Safeguarding the confidentiality of social service records; and (g)Annual in-service training to other staff of the facility on subjects including, but not limited to, resident's rights, psychosocial aspects of aging and confidentiality. This Statute is not met as evidenced by: Based on record review and staff interview for four (4) of 7 sampled residents reviewed for transfer/discharge rights; it was determined that facility staff failed to provide transfer/discharge and appeal rights notices in accordance with state law. D.C. Law 6-108. Residents F1, 23, 37, 59, 237 and 299. The findings included: Pursuant to D.C. Code §44-1001.01.1; Law 6-108 " ...Whenever a resident is to be discharged, transferred or relocated, a facility	L 182	Self-administration of meds was added to the care plan. Residents will be reassessed quarterly for continued ability to self-administer medications. 2. No other residents were found to be presently affected. 3. All resident's self-administering medication will be assessed to ensure compliance with Self-Medication Policy. Licensed nurses will ensure all required documentation is complete and on the medical record: Self Administration of Medication Assessment Form, physician's order, current Self-Administration of Medications care plan, secure storage, and documentation confirming resident's knowledge of correct self-administration and licensed nurses' required monitoring and documentation. Clinical Managers will conduct a quarterly audit of the medical record for all residents self-administering medications. The current Clinical Manager Audit Tool will be revised to include audit criteria for residents self-administering medications. Clinical Managers and designees will be instructed on correct audit tool use. Licensed nurses will be educated to report to Clinical Manager or designee, medications observed at bedside of residents not currently approved for self-administration.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0005	A. BUILDING: _____ B. WING _____	04/22/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 182	Continued From page 45 representative shall give that resident and his or her representative both oral and written notice of the reasons for, procedures for contesting and proposed effective date of the discharge, transfer or relocation ... " During a review of clinical records on April 21, 2014 at approximately 5:00 PM, the following residents were transferred out of the facility and there was a lack of documented evidence that transfer/discharge and/or appeal rights notices were provided to the resident and/or representative. Resident #237- Transferred to hospital on April 2, 2014. Had not returned to facility. Resident #59- Transferred to hospital on March 28, 2014; returned to facility on April 7, 2014 Resident #37- Transferred to hospital on March 4, 2014; returned to facility. Resident #299- Transferred to hospital on April 3, 2014; had not returned. Facility staff failed to provide transfer/discharge notices and appeal rights as required by state law. A face-to-face interview was conducted with Employee#12 on April 21 2014 at approximately 5:00 PM. He/she stated they have been having problems with the submission of the forms. When they are not done electronically, it is done manually. He/she further stated that one of the social worker positions was vacant and the other social workers were covering. The clinical record was reviewed on April 21, 2014.	L 182	4. Clinical Manager Audit Tool results, including monitoring of residents approved by the IDT at Focus QI-IDT meeting weekly. Audit findings will be reported to the QAPI Committee monthly. 5. Compliance Date L182 1. The completed PL6-108 form and appeal rights notice will be delivered to those patients/residents affected by the deficient practice and a copy placed in their chart. 2. All patients/residents who will be transferred/relocated/discharged will receive a PL6-108 notice and an appeal rights notice completed by the unit or covering social worker. They will be identified by review of the daily census, attendance at daily PPS meetings, and/or the nursing 24-hour report. 3. Per protocol, all PL6-108 forms will be completed and submitted electronically. In the event the form cannot be completed and/or transmitted electronically, the form will be hand-written, delivered to the resident and/or responsible party, and copies faxed to DOH and the Ombudsman's office. A copy of the form will be placed in the resident's chart and a copy maintained in a file kept by the unit social worker and/or Director of Social Services.	6/6/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0005	A. BUILDING: _____ B. WING _____	04/22/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 204	3232.2 Nursing Facilities A summary and analysis of each incident shall be completed immediately and reviewed within forty-eight (48) hours of the incident by the Medical Director or the Director of Nursing and shall include the following: (a)The date, time, and description of the incident; (b)The name of the witnesses; (c)The statement of the victim; (d)A statement indicating whether there is a pattern of occurrence; and (e)A description of the corrective action taken. This Statute is not met as evidenced by: Based on resident interview and record review for two (2) of 51 sampled residents, it was determined that facility staff failed to report allegations of verbal abuse and misappropriation of property for one (1) resident and an allegation of mistreatment for one (1) resident. Residents #6 and 28. The findings include: Facility staff failed to report an allegation of staff to resident verbal abuse and possible misappropriation of property [items not specified]. During a resident interview conducted on April 17, 2014 at 2:00 pm with Resident #6, he/she stated " I had two (2) legitimate complaints about two (2) CNA ' s [Certified Nurse ' s	L 204	4. The Director of Social Services will maintain and update a list of all patients/residents receiving PL6-108 forms and appeal rights notices on a monthly basis. The information will be reported to the QI Committee quarterly. Chart audits will be conducted to ensure that PL6-108 forms were completed timely and accurately. 5. Date of compliance: L204 (Resident #6) 1. The concerns of residents #6 and 28 were investigated; employees were counseled, suspended, and re-instated after investigation concluded the residents' concerns were unsubstantiated. 2. A review of all Concerns alleging abuse identified no unreported resident abuse allegations. 3. Concern reporting will remain a weekly Focus QI-IDT agenda item. Clinical Managers will continue to report Concerns received to Focus QI-IDT. Abuse reporting requirements will be reviewed with all staff via the May 2014 mandatory annual Elder Justice Act education module. 4. The Administrator will be added to distribution list of Focus QI-IDT meeting summaries, which will continue to be distributed to all Nursing Department Focus QI members. All meeting	5/27/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0005	A. BUILDING: _____ B. WING _____	04/22/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 204	Continued From page 47 Assistant]. A. The first complaint involved a CNA " that had been accused of stealing by other people. I saw [him/her] go into my cabinet when [he/she] thought I was asleep. That employee was suspended and brought back and I agreed to let [him/her] work with me again. " The resident did not specify the date of alleged occurrence. A review of the facility ' s " Disciplinary Action Form " revealed that Employee #23 was suspended on December 4, 2013 and returned to duty, " allegations were not confirmed. " A face-to-face interview was conducted on April 18, 2014 at 11:00 AM with Employees #1, 2 and 12. A query was made regarding the above incident. Employee #1 stated the incident was investigated and not substantiated. B. Resident #6 alleged that a CNA would yell and be moody and snappy at times. Talking with him/her [the CNA] was not effective. The resident did not specify a date of occurrence. A face-to-face interview was conducted on April 18, 2014 at 11:00 AM with Employees #1, 2 and 12. A query was made regarding if the State Agency was notified regarding Resident #6 ' s allegations. Employee #1 stated that the facility ' s form, " Resident/Family Communication Tool " was completed, however; he/she had no evidence to support notification to the State Agency. Facility staff failed to report an allegation of verbal abuse and misappropriation of property for Resident #6.	L 204	summary recipients will notify the QI Manager if an open resident abuse allegation is not documented in the Concerns section of Focus QI-IDT meeting summary. The QI Manager will report resident abuse allegation Concerns to QAPI Committee monthly. 5. Compliance Date L211 1. The identified allegation of abuse form – Resident/Family Communication Tool was noted to be resolved, signed and dated. 2. All allegations of abuse and/or grievances will be resolved with in the timeframe of our facility policy. This includes the notification, investigation, action to solution, signature and resolution date. 3. All allegations of abuse and/or grievances will be documented and submitted to Administration for logging into the database. The database will include the pertinent information including the resolution date. 4. The database will be monitored for resolution on a monthly basis and reported to Quality Improvement committee quarterly. 5. Date of Compliance:	6/6/2014 6/6/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0005	A. BUILDING: _____ B. WING _____	04/22/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 204	Continued From page 48 2. Facility staff failed to report an allegation of mistreatment expressed by Resident #28. During a resident interview conducted on April 15, 2014 at 2:30 PM the resident responded " no " in reply to a query " does staff treat you with respect and dignity? " He/she stated " I cannot remember the exact date but a CNA put me to bed one time and that ' s when [he/she] acted up ....There was one [gender specified] that was rough. He/she came in here and threw my shoes and clothes everywhere. I don ' t ' know [his/her] name but they call [his/her name mentioned]. [he/she] no longer takes care of me. I reported [him/her] to the supervisor. A review of the facility documents lacked evidence of any allegations of abuse from Resident #28. A face-to-face interview was conducted with Employee #30 on April 18, 2014 at 1:00 PM. The employee acknowledged that Resident #28 alleged the throwing of clothes and shoes by a CNA on the unit. " I spoke to the CNA and [he/she] said that the resident ' s clothes were placed on the chair and shoes placed beside the wheelchair. He/she denied reporting the incident to the State Agency, " I did not write it up because I thought it had been resolved " However, Employee 35 was made aware. A face-to-face interview was conducted with Employee #5 on April 18, 2014 at 1:15 PM. Tin response to a query regarding the alleged mistreatment by Resident #28, he/she stated " I did not write anything up because I thought it had been resolved. "	L 204	L214 (Power Strips & Three Outlet Connector) 1. The power strips on floor of rooms 356-A and 323 were mounted on the wall. The three-outlet electrical connector in room 305 was inspected and approved for use by Maintenance. 2. A facility-wide resident room inspection will be completed to identify power strips on the floor of resident rooms and electrical outlet connectors not inspected and approved for use by Maintenance. 3. The information provided on admission pertaining to resident-owned electrical equipment in resident rooms will be reviewed by Director of Plant Operations and revised, if indicated. Resident and Family Councils will be reminded that all resident-owned electrical equipment must be inspected and approved by Maintenance prior to use. Environmental Rounds Team and Maintenance Rounds will inspect for power strips and outlet connectors. Housekeepers will report power strips on the floor and outlet connectors observed during routine room cleaning, to the Team Leader who will initiate appropriate corrective action. 4. The Director of Plant Operations, or designee, will review Work Order Requests a minimum of weekly to identify reports of resident/family noncompliant electrical equipment. A summary of findings will be reported to the QAPI Committee monthly. 5. Date of Compliance:	5/26/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0005	A. BUILDING: _____ B. WING _____	04/22/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 204	Continued From page 49 Facility staff failed to report an allegation of mistreatment expressed by for Resident #28.	L 204	L214(Extension Cords) 1. Extension cords were removed from room 323. 2. All resident rooms will be inspected and extensions cords removed. 3. Environmental Rounds Team, Maintenance, and Housekeepers will check for extension cords during routine inspection/cleaning of resident rooms. Extension cords present will be immediately removed. All departments working in resident rooms will be instructed to notify Maintenance immediately for removal of any extension cords observed. Resident and Family Councils will be reminded that extension cords are unsafe and use is prohibited. 4. The Director of Plant Operations, or designee, will report to QAPI Committee monthly if extension cords are found in resident rooms. 5. Date of Compliance	5/26/2014
L 211	3233.4 Nursing Facilities The Administrator or designee of each facility shall review each grievance filed within seventy-two (72) hours of its filing and shall respond in writing to the resident or the Resident's Representative within five (5) business days. This Statute is not met as evidenced by: Based on record review and staff interview for one (1) of 46 sampled residents, it was determined that facility staff failed to resolve a grievance for Resident #174 ' s allegation of physical abuse. The findings include: The " Resident/Family Communication Tool Concern " form initiated on February 24, 2014 at 11:30 PM by the facility staff on behalf of Resident #174 revealed: " Resident Name and Room Number: [Resident ' s name and room number]; Detailed Information: February 27, 2014- 10:40 PM- [Registered Nurse] was notified by [evening charge nurse named] that the resident reported that " [he/she] was smacked on [his/her] face by [his/her] CNA (Certified Nursing Assistant) 15 minutes ago. " ... It was observed that resident ' s right side of eye sclera was reddish with minimal watery drainage. No swelling noted to external upper/lower eyelids. No visible skin discoloration nor any swelling noted to [his/her] face, mouth and nose. [He/she] denied any pain ... [Named physician]	L 211	L214 (#2 Oxygen tanks) 1. All identified oxygen tanks have been secured. 2. Rounds were completed in the facility and all oxygen tanks were checked to be secure. 3. Environmental Rounds Team and weekly Maintenance Rounds will inspect oxygen storage rooms and resident rooms to ensure all oxygen tanks are secure. Tanks that are not secure will be secured immediately. All employees	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0005	A. BUILDING: _____ B. WING _____	04/22/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 211	Continued From page 50 was notified of resident ' s right eye redness, [neurological] checks ordered. Medical team to follow up in AM (morning). [Resident ' s responsible party named] was also notified by phone. " The back of the concern form revealed; " Describe action taken to address concern: Copy provided to Clinical Manager [unit named] to follow-up. Signed [signed evening supervisor named]; Concern Resolved- no checks indicated in front of Yes or No; Dated Resolved- Blank; Reviewed by (Administrator ' s signature): blank; Date; Blank. " According to the Facility ' s Policy and Procedure; " Family/Resident Communication Tool " revised October 2010 stipulates; " 9. The Department Director/Manager or designee receiving the concern will contact the writer of the Family/Resident Communication Tool by telephone, within five (5) business days with a response and/or resolution. 10. It is the responsibility of the Department Director/Manager or designee to document on the Family/Resident Communication Tool the date, time and spoken to in regards to the3 concern. 11. The Family/Resident Communication Tool will contain documentation of the response/resolution including the action steps and/or follow-up taken to address the concern and the staff members involved. " There was no evidence that facility staff ensured that a prompt effort was made to resolve the grievance for Resident #174 for two (2) months. Facility staff failed to resolve a grievance for Resident #174 ' s allegation of physical abuse.	L 211	working in resident rooms and on the units near the oxygen storage will be instructed to observe and report unsecure oxygen tanks immediately. 4. The Environmental Rounds Team will report to the QI Committee monthly any repeat occurrences of this unsafe practice. 5. Compliance Date: L214 (Mirror) 1. The mirror was removed from the dresser in room 135. 2. A facility-wide check of resident room mirrors identified no other occurrences of this deficient practice. 3. Environmental Rounds Team and weekly Maintenance Rounds will inspect security of mirrors in resident rooms. All mirrors are to be securely wall mounted. Housekeepers will be instructed to report unsafe mirror placement observed during routine cleaning to the Team Leader, who will correct the unsafe practice. All employees working in resident rooms will be instructed to observe and report unsafe mirror placement immediately. 4. The Director of Plant Operations will report to the QI Committee monthly any repeat occurrences of this unsafe practice. 5. Date of Compliance	6/6/2014 5/26/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0005	A. BUILDING: _____ B. WING _____	04/22/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 211	Continued From page 51 A face-to-face interview was conducted with Employee #2 on April 18, 2014 at approximately 11:21 AM. He/she stated that [he/she] talked to the employee regarding the incident. Further stated, that human resources intervened. However, the communication/concern form lacked evidence that an internal investigation was conducted. When queried if [he/she] and the administrator signed the form to indicate the concern was resolved; he/she stated; " This is not the original ...let me get the original form. " A follow-up interview was conducted with Employees #1 and #2 on April 21, 2014 at approximately 11:30 AM. Both stated the concern form did not come down to the administrator. He/she further stated; " It was found in Employee #25 ' s office. " The record was reviewed on April 21, 2014.	L 211	L306 1. Call bells in rooms 249-B, 237-A, and 116 were immediately assessed, unplugged, and re-plugged in correctly. Call bell cords in rooms 154, 114, and 128 were immediately replaced. The call bells were triggered and the call bell system was fully functional. 2. Maintenance will check all call bells for correct placement in wall and call bell cords for wear-and-tear. 3. The Director of Plant Operations will schedule a train-the-trainer session on correct call bell placement in wall and recognition of damaged call bell cords for department managers and directors working in resident rooms. All staff working in resident rooms will be educated or reeducated. New employees will be educated during new employee orientation on plugging call bell into wall correctly and recognizing damaged call bell cords. Environmental Rounds Team and Maintenance will inspect call bells and call bell cords during ongoing Rounds. 4. The Director of Plant Operations, or designee, will inspect call bell placement and call bell cords during Rounds. Call bell placement and call bell cord damage will be reported to the QAPI Committee monthly. 5. Compliance Date	5/26/2014
L 214	3234.1 Nursing Facilities Each facility shall be designed, constructed, located, equipped, and maintained to provide a functional, healthful, safe, comfortable, and supportive environment for each resident, employee and the visiting public. This Statute is not met as evidenced by: Based on observations made during an environmental tour of the facility on April 18, 2014 at approximately 11:00 AM, it was determined that facility staff failed to maintain the facility free of accident hazards as evidenced by: four (4) of four (4) power strips and two (2) of two (2) extension cords that were observed on the floor in three (3) of 27 resident's rooms, unsercured oxygen tanks in two (2) of five (5) storage rooms and in one (1)	L 214		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0005	A. BUILDING: _____ B. WING _____	04/22/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 214	Continued From page 52 of 27 resident's rooms and one (1) of one (1) mirror that was stored on top of a dresser unsecured in one (1) of 27 resident's rooms. The findings include: 1. Three (3) of three (3) power strips were in use and stored on the floor of room # 356A, one (1) of one (1) power strip was in use and stored on the floor of room #323, two (2) extension cords were in use and on the floor of room #323, and a three-outlet, electrical connector was in use in room #305, three (3) of 27 resident's rooms. 2. Oxygen tanks were observed unsecured on numerous occasions including: One (1) of eight (8) E-cylinder type tank in the Oxygen storage room on Unit 3A (#A345A) in one (1) of five (5) Oxygen storage rooms and two (2) of 14 E-cylinder type tanks in the Oxygen storage room on Unit 1, two (2) of five (5) Oxygen storage rooms. One (1) of one (1) E-cylinder type tank in resident room #129, one (1) of 27 resident's rooms. 3. One (1) of one (1) mirror was observed on top of a dresser, loose and unmounted in room #135, one (1) of 27 resident's rooms. These observations were made in the presence of Employee #9 who acknowledged the findings.	L 214	L410 (Window Curtains & Window Blinds) 1. Damaged window curtains (rooms 351 and 349) and window blinds (room 128) were identified as damaged prior to the annual survey. Funds are budgeted for damaged window treatment replacements (curtains and blinds) in the July 1, 2014-June 30, 2015 fiscal year. 2. All resident room window treatments will be reassessed by the Director of Plant Operations, or designee, to ensure identification of all in need of replacement. Damaged window treatments that are repairable while awaiting replacement (i.e., removal of broken window blind slats, trimming drapes with hanging threads, etc.) will be repaired. 3. Environmental Rounds Team and weekly Maintenance Rounds will continue to identify damaged window treatments. Environmental Rounds Team reports are reviewed by the Administrator and Director of Plant Operations; Maintenance Rounds reports are reviewed by the Director of Plant Operations. Housekeepers will be instructed to report damaged window treatments observed during routine room cleaning to the Housekeeping Team Leader, who will generate the Work Order Request for repair.	
L 306	3245.10 Nursing Facilities A call system that meets the following	L 306		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0005	A. BUILDING: _____ B. WING _____	04/22/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 306	Continued From page 53 requirements shall be provided: (a)Be accessible to each resident, indicating signals from each bed location, toilet room, and bath or shower room and other rooms used by residents; (b)In new facilities or when major renovations are made to existing facilities, be of type in which the call bell can be terminated only in the resident's room; (c)Be of a quality which is, at the time of installation, consistent with current technology; and (d)Be in good working order at all times. This Statute is not met as evidenced by: Based on observations made during an environmental tour of the facility on April 18, 2014 at approximately 11:00 AM, it was determined that facility staff failed to maintain call bells in good working condition as evidenced by call bells that fail to function as intended in three (3) of 27 resident's rooms, frayed call bell cords in two (2) of 27 resident's rooms and a call bell that was secured with transparent tape in one (1) of 27 resident's rooms. The findings include: 1. Call bells in rooms #249B, #237A and #116 did not consistently initiate an alarm when tested, in three (3) of 27 resident's rooms. 2. Call bell cords were torn and frayed in two (2) of 27 resident's rooms (#154 and #114 and the call bell in room #128 was secured	L 306	All Work Order Requests are reviewed a minimum of weekly by the Director of Plant Operations, or designee, to ensure completion of repairs. 4. The Director of Plant Operations or designee will report a summary of damaged window treatment repairs and replacements to QAPI Committee monthly until damaged window treatments are replaced facility-wide at end of the 2014-2015 fiscal year (06/30/15). 5. Date of Compliance: L410 (Wallpaper) 1. Loose wallpaper was either removed or re-glued in the hallways or Common Areas on the 3 resident units. 2. An inspection of all resident units did not identify any other currently torn or hanging wall paper. 3. Wallpaper on all resident units will continue to be inspected during Environmental Rounds and weekly Maintenance Rounds. Repairs will be completed promptly. One resident unit each fiscal year is budgeted for replacement of wallpaper with paint. The Director of Plant Operations or designee will review bi-monthly Environmental Rounds and weekly Maintenance Reports to ensure damaged wall paper repairs are completed in a timely manner.	5/26/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0005	A. BUILDING: _____ B. WING _____	04/22/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 306	Continued From page 54 with transparent tape in one (1) of 27 resident's rooms (#128). These observations were made in the presence of Employee #9 who acknowledged the findings.	L 306	4. The Director of Plant Operations or designee will inspect the wallpaper in hallways and Common Areas of resident units during rounds to validate prompt identification and repair of newly damaged areas. 5. Compliance Date	5/26/2014
L 410	3256.1 Nursing Facilities Each facility shall provide housekeeping and maintenance services necessary to maintain the exterior and the interior of the facility in a safe, sanitary, orderly, comfortable and attractive manner. This Statute is not met as evidenced by: Based on observations made during an environmental tour of the facility on April 18, 2014 at approximately 11:00 AM, it was determined that the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior as evidenced by seven (7) of seven (7) torn window curtains in two (2) of 27 resident's rooms, loose wallpaper in three (3) of five (5) resident's units, broken window blinds slats in two (2) of 27 resident's rooms and marred walls in four (4) of 27 resident's rooms. The findings include: 1. Five (5) of five (5) sets of window curtains in room #351 were torn in several areas and one (1) of one (1) set of window curtains in room #349 was also torn, two (2) of 27 resident's rooms. 2. The wallpaper was hanging loose, unglued from the wall in three (3) of five (5) resident's units.	L 410	L410 (Marred Walls) 1. The marred walls in rooms 254, 154, 135, and 129 were repaired. 2. A facility-wide resident room inspection will be completed to identify and repair any additional marred walls. 3. Environmental Rounds Team and weekly Maintenance Rounds will continue to inspect walls for damage. Housekeepers will be instructed to report damaged walls observed during routine room cleaning to the Housekeeping Team Leader, who will generate a Work Order Request for repair. All Work Order Requests are reviewed a minimum of weekly by the Director of Plant Operations, or designee, to ensure completion of repairs. 4. The Director of Plant Operations, or designee, will report a summary of marred wall repairs to the QI Committee monthly. 5. Date of Compliance	5/26/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0005	A. BUILDING: _____ B. WING _____	04/22/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 410	Continued From page 55 3. One (1) of five (5) window blinds had a broken slat in room #254 and two (2) of two (2) window blinds in room #128 had broken slats; two (2) of 27 resident's rooms surveyed. 4. The walls were marred in four (4) of 27 resident's rooms (#254, #154, #135, #129). These observations were made in the presence of Employee #9 who acknowledged the findings.	L 410		
L 442	3258.13 Nursing Facilities The facility shall maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This Statute is not met as evidenced by: Based on observations made on April 17, 2014 at approximately 9:00 AM, it was determined that the facility failed to maintain all essential mechanical, electrical, and patient care equipment in safe operating condition as evidenced by two (2) of five (5) Reach-in refrigerators and one (1) of two (2) freezers that have been out of order for more than a year, five (5) of five (5) type E fire extinguishers and two (2) of two (2) type K fire extinguishers that have not been inspected monthly. The findings include: 1. Two (2) of five (5) Reach-in refrigerators located in the kitchen have been out of order for about a year. 2. One (1) of two (2) freezers down. 3. Fire extinguishers located in the kitchen are	L 442	L442 (#1,2 Inoperable equipment) 1. The identified inoperable reach in refrigerators and freezer have been scheduled to be fixed or if they are not operable will be removed from the area. 2. All equipment in the kitchen was checked and is operating to the standard for the equipment. 3. The Dietary manager or designee will complete weekly equipment rounds to inspect all equipment for operations. Inoperable equipment will be reported to have maintenance. Any inoperable equipment that cannot be fixed will be removed. 4. The outcome of the audit will be reported to the monthly Quality Improvement Committee. 5. Compliance Date:	6/6/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0005	A. BUILDING: _____ B. WING _____	04/22/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 442	Continued From page 56 not inspected monthly as required. These observations were made in the presence of Employee #8 who acknowledged the findings.	L 442	L442 (Fire Extinguishers) 1. All kitchen fire extinguishers were inspected. 2. All fire extinguishers were checked facility-wide; all had documentation of monthly checks. 3. Failure to correctly inspect kitchen fire extinguishers was addressed with the employee assigned responsibility for the inspections. The Maintenance Rounds kitchen checklist will be revised to list inspection of ABC and K-type fire extinguishers. New maintenance staff will be trained to identify and inspect both extinguisher types. The Director will review the competency of Maintenance staff to inspect kitchen fire extinguishers a minimum of annually. 4. The Director of Plant Operations, or designee, will review kitchen Maintenance Rounds reports a minimum of weekly and verify inspection of ABC and K-type extinguishers. A summary of findings will be reported to the QI Committee monthly. 5. Compliance Date	5/26/2014