PRINTED: 06/09/2011 FORM APPROVED OMB NO. 0938-0391

CENTER	S FOR MEDICARE	& MEDICAID SERVICES	-		OMB NO. 0938-0391	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		IDENTIFICATION NOMBER.	A. BUILDING			
		095038	B. WING		05/09/2011	
NAME OF PR	OVIDER OR SUPPLIER		STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
METHOD	IST HOME		1	01 CONNECTICUT AVENUE, NW		
			W	ASHINGTON, DC 20008		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI  (EACH CORRECTIVE ACTION SHOUL  CROSS-REFERENCED TO THE APPRO  DEFICIENCY)	D BE COMPLETION	
F 000	(recertification surve through May 9, 2017 were based on obse	ndicator Survey [QIS] y) was conducted on May 4 The following deficiencies rvations, staff interviews, and record review. The total	F 000	THIS PLAN OF CORRECTION IS SUBMIT PURPOSES OF REGULATORY COMPLIA AS PART OF THE METHODIST HOME'S ONGOING EFFORTS TO CONTINUOUS MAINTAIN THE HIGH QUALITY OF CAPSERVICES PROVIDED. AS SUCH IT DOE CONSTITUTE AN ADMISSION OF THE ECONCLUSIONS FOR ANY PURPOSE	LY RE AND S NOT	
F 241 SS=D	483.15(a) DIGNITY INDIVIDUALITY  The facility must promanner and in an erenhances each residue recognition of his or	mote care for residents in a nvironment that maintains or dent's dignity and respect in full	F 241 1. 2.	affected residents by bringing the the dining room only as staff we available to provide the feeding assistance required. Other residents who may require feeding assistance will be identifit through discussions at Monthly N	em into ere 5/9/11 ed Jutrition	
	(2) residents, it was failed to promote dig by the observation of as others dined in the and 37.  The findings include During dining observing dining observing 5, 2011 and Market 2015.	vations of the breakfast meal on ay 6, 2011, it was determined	3.	Alert Committee meetings, review Monthly Nursing Assessments and documentation, update of the quimbos, and care plan reviews. Of identified, these residents will be brought into the dining room only are available to provide the feeding assistance required. Nursing and Dining Services policible revised to address how reside who require feeding assistance a identified and served in the dining in order to maintain their dignity.	and CNA carterly cas staff colors col	
	and 37 's dignity by while others dined.  The observation of t 2011 at 8:30 AM revishared a table in the Health Services Car	the breakfast meal on May 5, realed Residents #34 and 37 edining room on the first floor e unit. Facility staff began eals at 8:34 AM. The meals	4.	will be in-serviced on implementathis policy. Policy implementation and complementation are policy.  Committee, beginning with second quarter reports (July, 2011). Data collection will begin 5/15/11.	iance 5/15/11 irterly vement d	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

CEO/APMINISTRATOR

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
	095038		B. WING			05/09/2011		
	ROVIDER OR SUPPLIER		•	49	EET ADDRESS, CITY, STATE, ZIP CODE 901 CONNECTICUT AVENUE, NW VASHINGTON, DC 20008			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST E	ATEMENT OF DEFICIENCIES SE PRECEDED BY FULL REGULATORY OR TIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE- (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APPROPRI	OULD BE COMPLETION		
F 241	subsequently enterer requirements for fee and 37 sat at their to dined in their preser minutes later], facilit Residents #34 and 3 with total assistance.  A second observation was conducted on MResidents #34 and 3 together. Facility states at 8:44 AM. At 9:07 required no feeding Resident #34 was president #34 was president #34 was preceived his/her mean received his/her mean received his/her mean residents #34 are assistance. The residents that had no assistance had beer	esidents that were seated and/or and the dining area and had no iding assistance. Residents #34 able as others were served and ince. At 9:15 AM [greater than 40 by staff presented meals to 37, each of whom was provided for meal consumption.  In of the first floor breakfast meal day 6, 2011 at 8:30 AM.  By were observed seated ff began serving individual meals AM, after the residents that assistance had been served, resented with his/her meal and consumption. Resident #37 al and assistance at 9:18 AM.  In promote dignity during dining and 37, who required feeding dents waited to eat until after to requirements for feeding in served. The findings were interview with Employee #2 on	F	241				
F 279 SS=D	develop, review and comprehensive plan The facility must dev for each resident tha	CARE PLANS ne results of the assessment to revise the resident's	F2	279				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SUF	
		A. BUILDING	<u> </u>			
	¥	095038	B. WING		05/09	9/2011
	ROVIDER OR SUPPLIER		4	REET ADDRESS, CITY, STATE, ZIP CODE 1901 CONNECTICUT AVENUE, NW WASHINGTON, DC 20008		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST E	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY OR TIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE APPR	N SHOULD BE	(X5) COMPLETION DATE
F 279	needs that are ident assessment.  The care plan must be furnished to attain highest practicable psychosocial well-be and any services that under §483.25 but a resident's exercise of the right to refuse the	describe the services that are to nor maintain the resident's obysical, mental, and eing as required under §483.25; at would otherwise be required ire not provided due to the of rights under §483.10, including eatment under §483.10(b)(4).  T is not met as evidenced by:  ecord reviews and staff ) of 30 sampled residents, it was lity staff failed to develop a care approaches for mouth care irraction and denture care for  :  ers dated April 7, 2011 directed, r & (and) lower teeth cc (with) fluoride anti-cavity toothpaste q g) - cavity prevention.  Will provide toothpaste. The feed on April 7, 2011, "Clean e adhesive sparingly."	F 279	<ol> <li>There was no opportun deficient finding identifications will be resident outcome as a result of finding.</li> <li>Orders for residents hat extractions will be revies immediately upon return by the Nursing Supervisticare plan will be develoned hours to include new or New treatment orders with the beaded to the Treat Administration Record of Development of plans for any physician status post surgical profincluding dental extract Supervisors, Charge Nith MDS Coordinator will be this policy update and of the bear included in the into the included in the into the included in the into the included development of plans for any physician status post surgical profincluding dental extract Supervisors, Charge Nith MDS Coordinator will be this policy update and of the included in the into the included in the included in the into the included in t</li></ol>	ed during the s dental visit days prior. The onegative this deficient ving tooth wed in to the facility for. An interimized within 24 ders received. Vill also continue tment (TAR). Esident care do to specifically interim care orders received cedures, ions. All RN urses, and the ein-serviced on on components erim care plan. and compliance ghous the quarterly lity e, beginning orts (July,	5/9/11 5/11/11 5/11/11

CENTER	S FOR MEDICARE	& MEDICAID SERVICES				<u>OMB NO. 093</u>	<u>8-0391</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		095038	B. WIN	G		05/09/201	11
	OVIDER OR SUPPLIER			4901	ADDRESS, CITY, STATE, ZIP CODE CONNECTICUT AVENUE, NW HINGTON, DC 20008		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREF TAG	X	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COM	(X5) PLETION DATE
F 279	extracted.  Review of the care prevealed that the recipitation with goals and appropost extraction and A face-to-face interview Employee #5 at app 2011. After review employee acknowle care plan with goals status post teeth extraction.	plans on the clinical record cord lacked a care plan baches for mouth care status denture care for the resident.  Item was conducted with roximately 12:31PM on May 9, and the record/care plans, the diged that the record lacked a and approaches for mouth care raction and denture care for the dig was reviewed on May 6,	F		Deficiency States observation Made during tour on May 3, 2011 Surveyors Did Not begin Annual S 3:12 PM on May 4, 2011	at 3:30 P.M. urvey until	**
F 371 SS=B	The facility must - (1) Procure food fro considered satisfact authorities; and	OCURE, SERVE - SANITARY  m sources approved or ory by Federal, State or local listribute and serve food under	F	1. TI	Seven out of seven shelves containing observed soiled.  . Corrective Action for residents as deficient practice: the spices were removed from the shelves were cleaned and sanitized.  Methods to identify other residents.	ffected by elves and all	5/4/11
	Based on an obser tour of the main kito it was determined the prepare and serve f	T is not met as evidenced by:  vation that was made during a hen on May 3, 2011 at 3:30 PM, lat the facility staff failed to bood under sanitary conditions as (7) of seven (7) soiled shelves.		cl fc 3 D tc	deficient practice: Il other shelves and counters in the objection in the object of the counters are no furtor unsanitary conditions.	department were her occurrences cient practices do racks or a cabinet m spices does not	5/4/11 7/1/11

FORM APPROVED OMB NO. 0938-0391

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AND PLAN OF	NEW OF CONTROL OF THE PROPERTY.		A. BUILDING		OON ELLED	
		095038	B. WING		05/09/2011	
NAME OF PR	OVIDER OR SUPPLIER		STR	EET ADDRESS, CITY, STATE, ZIP CODE		
METHOD	IST HOME		4	901 CONNECTICUT AVENUE, NW		
WETHOD			N	VASHINGTON, DC 20008		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRE TIVE ACTION SHOU CROSS-REFEF JCED TO THE APPRODEFICIENCY)	LD BE COMPLÉTION	
F 371	Continued From pag		F 371	Performance Monitoring to ensure sustained:	re solutions are	
	The findings include	:		Monthly sanitation audits conducted by and to ensure compliance.	oy management 6/15/11 Ongoing	
		:30 PM seven (7) of seven (7) pices were observed soiled.	4	Deficiency States observation		
		s made in the presence of f7 who acknowledged these our.		Made during tour on May 3, 2011 at Surveyors Did Not begin Annual Sur 3:12 PM on May 4, 2011		
	483.35(i)(3) DISPOS PROPERLY	SE GARBAGE & REFUSE	F 372	2 of 2 trash receptacles were observed garbage (food waste).	containing	
	The facility must dis properly.	pose of garbage and refuse		Corrective Action for residents afford deficient practice:  The sandwich wrapped in plastic wrap from the trash receptacle in the dish receptacle.	was removed oom and	
	This REQUIREMEN	T is not met as evidenced by:		discarded without the plastic wrap int disposal. Bread ends were removed for receptacle in the kitchen and discarde	om the trash	
	main kitchen on May	vation made during a tour of the y 3, 2011 at 3:30 PM, it was		disposal.		
	garbage and refuse	facility failed to dispose of properly as evidenced by two eceptacles that were observed		Methods to identify other reside deficient practice:  All other trash receptacles were inspethe department to ensure there was revident.	cted throughout	
	The findings include	:				
		3:30 PM, two (2) of two (2) trash eserved containing garbage		<ol> <li>Systemic changes to ensure deficency not occur:</li> <li>Provide separate food waste container and have staff discard food waste into disposals in the dish room throughout</li> </ol>	ers at work stations o the garbage	
		s made in the presence of 7 who acknowledged these our.		re-trained on proper disposal of food  4. Performance Monitoring to ensure	waste, 6/15/11	
F 428	483.60(c) DRUG RE	EGIMEN REVIEW, REPORT		sustained: Dietary Management will monitor tra	sh receptacles 5/4/11	

SS=D IRREGULAR, ACT ON

daily.

Ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  095038			(X2) MULTIF		(X3) DATE SURVEY COMPLETED		
		095038	B. WING			05/09/2011	
	ROVIDER OR SUPPLIER		4	901 CONN	NESS, CITY, STATE, ZIP CODE NECTICUT AVENUE, NW OTON, DC 20008	1 00/0	5/2011
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F 428	The pharmacist must attending physician, these reports must be assed on record redetermined that the pharmacy community Medication Regiment The findings include A review of the clinic revealed a community documented by the community and the pharmacy community of the note to the physician patient has been reconstituted in the associated risk (i.e. hypomagnesia, etc.), recommend retime. Recommend coor prn antacids, if clinical these recommend coor prn antacids, if clinical these recommend coor prn antacids, if clinical these reports at the second and the second at the second and the second at the se	reach resident must be reviewed th by a licensed pharmacist.  It report any irregularities to the and the director of nursing, and be acted upon.  T is not met as evidenced by:  View and staff interview, it was physician failed to act upon a cation associated with a review. Resident #51.  Eal record for Resident #51 cation dated April 5, 2011 consultant pharmacist, entitled Physician. "  Sician read as follows: "This reiving the PPI [Proton-Pump ble, for an extended period. Due as of long term therapy of PPI's fractures, pneumonia, c-differevaluate continued use at this posider a taper and/or ranitidine	F 428	de su occ re ou fir to sig Re occ the ph we as 4. Pc wi Qu Im wi 20	here was no opportunity to eficient finding identified du urvey, as the Pharmacy revocurred more than 30 days esident experienced no negutcome as a result of this dending. It is contained to the properties of t	ring the iew prior. The ative efficient expanded hysician on by the training the enext expanded to expanded hysician on by the training expanded to ensibilities dedication expanded to expand the policy. Expandiance expandi	5/9/11 5/11/11 5/20/11

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	095038		B. WIN	G		05/09	9/2011
	ROVIDER OR SUPPLIER			49	EET ADDRESS, CITY, STATE, ZIP CODE 901 CONNECTICUT AVENUE, NW VASHINGTON, DC 20008		
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F 428	of Pantoprazole sod gastro-esophageal r Medication Administ and May 2011 revea administered in accorders.  A concurrent review evidence that the ph communication. The was aware of the codisagreed with the rewere reviewed and a	ge 6 plants, directed the administration ium 40mg by mouth daily for eflux [Gerd]. A review of the ration Records [MARs] for April aled Pantoprazole was ordance with the physician's of the medical record lacked ysician acted on the pharmacy are was no evidence that he/she mmunication or that he/she ecommendations. The findings acknowledged during a w with Employee #2 on May 9,	F	428			
F 514 SS=B	The facility must main resident in accordant standards and practic accurately document systematically organization. The clinical record must be clinic	ust contain sufficient information nt; a record of the resident's an of care and services provided; eadmission screening conducted ogress notes.  T is not met as evidenced by:	F	514			
	Based on record re-	view and staff interview for					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) ML A. BUIL		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
095038		095038	B. WING			05/09/2011	
	ROVIDER OR SUPPLIER	033300		49	EET ADDRESS, CITY, STATE, ZIP CODE 901 CONNECTICUT AVENUE, NW VASHINGTON, DC 20008	05/09	9/2011
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F 514	one (1) of 22 sample that facility staff faile documentation of the exercises in the resi #14.  A review of the nurs clinical record reveal dated April 21, 2011 April 20, 2011,, r. CNA [Certified Nurshim/her to bed, resic ® leg was giving awhis/her weight, ease A review of prior documentation, "Seleg was giving awhis/her weight, ease A review of prior documentation, "Seleg was giving awhis/her weight, ease A review of prior documentation, "Seleg was giving awhis/her weight, ease A review of prior documentation, "Seleg was giving awhis/her weight, ease A review of prior documentation, "Seleg was giving awhis/her weight, ease A review of prior documentation, "Seleg was giving awhis/her weight, ease A review of prior documentation, "Seleg was giving awhis/her weight, ease A review of prior documentation, "Seleg was giving awhis/her weight, ease A review of prior documentation, "Seleg was giving awhis/her weight, ease A review of prior documentation, "Seleg was giving awhis/her weight, ease A review of prior documentation, "Seleg was giving awhis/her weight, ease A review of prior documentation, "Seleg was giving awhis/her weight, ease A review of prior documentation, "Seleg was giving awhis/her weight, ease A review of prior documentation, "Seleg was giving awhis/her weight, ease A review of prior documentation, "Seleg was giving awhis/her weight, ease A review of prior documentation, "Seleg was giving awhis/her weight, ease A review of prior documentation, "Seleg was giving awhis/her weight, ease A review of prior documentation, "Seleg was giving awhis/her weight, ease A review of prior documentation, "Seleg was giving awhis/her weight, ease A review of the resident was referenced and the reside	ed residents it was determined ed to provide accurate e resident 's physical therapy dent 's clinical record. Resident es' notes in the resident 's led the following documentation at 10:00PM; "Late entry for esident fell during PM care, ing Assistant] was putting dent c/o [complained of] his/her ay. CNA unable to support d him/her to the floor. "  cumentation dated January 7, ealed the following staff reported to writer at 7:25AM ing resident from bed with two standing lift staff lowered "  of April 21, 2011, revealed that terred to the Rehabilitation to screening for transfer with list documentation on the care valuation was dated April 25, e resident 's clinical record evidence of the resident 's	F	514	1. There was no opportunity to correct finding identified during the survey. To completed but yet to be filed. Since the rehab was away on vacation, other staffind it. The screen was completed on 4 communication from the nurse. The st was awaiting family's consent to begin The resident experienced no negative of a result of the deficient finding.  2. Screens post fall will be completed with of notification to therapy staff. A copy of log will be placed on each floor nursing screens shall be filed within 48 hours. Endesignee will carry out the functions in director of rehab. Original log is placed and as a measure to have effective corecopy of the log will now be placed on eawith the documentation. IDT communithe follow up on falls will be carried ou during stand up meeting.  Monthly audit will be performed by disposing for appropriate and timely filing and followed up by quarterly audits by flagship rehab.  Policy implementation and compliance through the quarterly Quality assurance improvement, beginning with second q (July 2011). Data collection from June 1	he screen was e director of ff could not /22/11 after atus then therapy. Dutcome as win 48 hours of screen trackit station. The Regional manage the absence of a in the gym munication; ach floor along cation regarding tevery Wedness rector of rehabing of all document the corporate will be monito rec/quality uarter reports	ger/ the  ng sday 6/1/11  ents of 6/1/11

	ATEMENT OF DEFICIENCIES  ID PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:		A. BUILDING	E CONSTRUCTION		COMPLETED	
		095038	B. WING		05/0	9/2011	
	ROVIDER OR SUPPLIER		49	ET ADDRESS, CITY, STATE, ZIF 01 CONNECTICUT AVENUE ASHINGTON, DC 20008	, NW		
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F 514	A face-to-face interved Employee #8 at app 2011. He/she state am filling in. I will call cannot find it in the later stated," I spoke an e-mail from him/lifew times. Initially, He/she has now agr permission from his/son/daughter has be left but he/she has remployee acknowle regarding the attempthe resident's refuse.	herapist and he/she is checking department. "  view was also held with roximately 4:00PM on May 9, ed, "The manager is away and I sheck the information that he/she I him/her to get the information if e department. " Employee #8 et to the manager and I looked at her. The resident was seen a he/she refused to be screened. Here son/daughter. The seen called and a message was not responded. " The deed that the information ofts to screen the resident and all to be screened should have in the resident's record." The	F 514				
				e de la companya de l			