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

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095038	A. BUILDING _____ B. WING _____	06/13/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METHODIST HOME	4901 CONNECTICUT AVENUE, NW WASHINGTON, DC 20008

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An annual recertification survey was conducted on June 12 and 13, 2008. The following deficiencies were based on observations, record review and staff interviews. The sample included 12 residents based on a census of 47 residents on the first day of the survey and one (1) supplemental resident.	F 000	**THIS PLAN OF CORRECTION IS SUBMITTED FOR PURPOSES OF REGULATORY COMPLIANCE AND AS PART OF THE METHODIST HOME'S ONGOING EFFORTS TO CONTINUOUSLY MAINTAIN THE HIGH QUALITY OF CARE AND SERVICES PROVIDED. AS SUCH IT DOES NOT CONSTITUTE AN ADMISSION OF THE FACTS OR CONCLUSIONS CITED IN THE SURVEY REPORT FOR ANY PURPOSE WHATSOEVER.**	
F 253 SS=D	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations during a tour of the main kitchen on June 12, 2008 between 8:50 AM and 10:00 AM, it was determined that facility staff failed to maintain the facility in an orderly manner as evidenced by: damaged floors, a drain cover, an electrical plate cover, stainless steel panels, a cooking hood and peeling paint on a wall. These observations were made in the presence of Employee #1. The findings include: 1. Floors were observed to be damaged in the following areas: A. The main kitchen floor tile and grout was observed to be damaged throughout the kitchen in one (1) of one (1) floor observed. B. The utility closet in the main kitchen was observed to have damaged floor tile in one (1) of one (1) utility closet observed.	F 253	**F 253: 483.15 (h)(2) Housekeeping/Maintenance** **L 410.3256.1 Nursing Facilities (cross-reference)** Floors/tiles in kitchen, utility closet, employee bathroom damaged. 1. Corrective Action for Residents Affected by Deficient Practice: Floor tiles with chipped corners in utility closet and employee bathroom were replaced. Missing grout in quarry tile in main kitchen as identified was replaced. — 6/25/08 2. Method to Identify Other Residents At Risk for Deficient Practice: Entire kitchen tile floor, utility closet and employee bathroom in the main kitchen area was inspected by maintenance staff and repairs completed as required. — 6/27/08 3. Measures or Systemic Changes to Ensure Deficient Practice Does Not Recur: • Re-educate staff on observation of floor surfaces and appropriate notification to supervisor if damage is observed. • Quotes are being collected for possible installation of a poured epoxy floor surface for kitchen, dish room, utility closest and employee bathroom. • On a monthly basis, floor areas will be randomly checked by Director of Dining Services to ensure deficient practice does not recur. — 6/27/08 4. Performance Monitoring to Ensure Solutions Are Sustained: Report findings in Quarterly QA meeting. **Implementation date: July 24, 2008 and quarterly thereafter x 4 quarters.** — 7/24/08	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	CEO/ADMINISTRATOR	26 JUNE 2008

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.

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F 253	Continued From page 1 C. The employees' bathroom in the main kitchen was observed to have damaged floor tile in one (1) of one (1) employees' bathroom observed. 2. The following was observed damaged: A. The drain cover under the steam table was damaged in one (1) of one (1) drain cover observed. B. The stainless steel panel with the sprayer attached was observed to be loose from the wall and the caulking/seal was loose from the panels. C. A plate cover on the electrical outlet next to the steam table was damaged in one (1) of one (1) electrical plate cover observed. D. The cooking hood attached to the stove was not completely attached to the stove in one (1) of one (1) stove observed. E. Paint was observed peeling from the wall in the main kitchen behind the juice and coffee machine. 3. Brooms were stored on the floor in four (4) of four (4) brooms observed in the utility closet in the main kitchen. Employee #1 acknowledged the above findings at the time of the observations.	F 253	**F 253 483.15(h)(2) Housekeeping/Maintenance** **L 410 3258.1 Nursing Facilities (Cross-reference)** 1. Corrective Action for Residents Affected by Deficient Practice: The drain cover under the steam table has been replaced. The stainless steel panel has been attached permanently to the wall. The cracked plate cover on the electrical outlet next to the steam table has been replaced. The cooking hood is completely attached to the stove. The wall behind the juice and coffee machine has been painted and brooms are hanging. 2. Method to Identify Other Residents At Risk for Deficient Practice: Entire kitchen surface area, stainless steel panels, plate covers on electrical outlets, the cooking hood, kitchen walls and drain covers was inspected by maintenance and dining services staff and repairs completed as required. No other brooms were found on the floor. 3. Measures or Systemic Changes to Ensure Deficient Practice Does Not Recur: • Re-educate staff on observation of walls/painted surfaces, electrical outlets, drain covers and stainless steel panels and appropriate notification to supervisor if damage is observed. Maintenance to repair. • Additional broom racks have been ordered for the utility closet. • On a monthly basis, kitchen areas will be randomly checked by Director of Dining Services to ensure deficient practice does not recur. 4. Performance Monitoring to Ensure Solutions Are Sustained: Report findings in Quarterly QA meeting. **Implementation date: July 24, 2008 and quarterly thereafter x 4 quarters.**	6/16/08 6/16/08 6/16/08 7/24/08
F 371 SS=D	483.35(i)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE The facility must store, prepare, distribute, and serve food under sanitary conditions.	F 371		

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F 371	Continued From page 2	F 371		

This REQUIREMENT is not met as evidenced by:

Based on observations during a tour of the main kitchen on June 12, 2008 between 8:50 AM and 10:00 AM, it was determined that dietary services were not adequate to ensure that foods were prepared and stored in a safe and sanitary manner as evidenced by: soiled stainless steel wall panels and a compressor in the walk in refrigerator and hotel pans stored wet.

The findings include:

1. The set of stainless steel wall panels were observed soiled with grease in one (1) of one (1) set of wall panels observed.

2. The compressor in the walk in refrigerator was soiled in one (1) of one (1) compressor observed.

3. The following hotel pans were stored wet and ready for reuse:

A. Six (6) inch deep long hotel pans in three (3) of six (6) hotel pans observed
B. 1/3 inch hotel pans in two (2) of three (3) hotel pans observed
C. Two (2) inch hotel pans in two (2) of eight (8) hotel pans observed

Employee #1 acknowledged the above findings at the time of the observations.

F 371 483.(j)(2) Sanitary Conditions – Food Prep & Service
L 099 3219.1 Nursing Facilities (cross-reference)

1. Corrective Action for Residents Affected by Deficient Practice:
The stainless steel wall panels and the compressor in the walk in refrigerator were cleaned by the Maintenance Department. Identified hotel pans were pulled from storage, rewashed and allowed to air dry. — 6/16/08

2. Method to Identify Other Residents At Risk for Deficient Practice:
Entire kitchen surface area, walls, and fans were checked and cleaned if needed. All hotel pans were checked for appropriate drying. — 6/16/08

3. Measures or Systemic Changes to Ensure Deficient Practice Does Not Recur:
- Re-educate maintenance and Dining services staff on observation of walls/painted surfaces, fans and other equipment for cleanliness and appropriate notification to supervisor if cleaning needs are observed or equipment in need of Maintenance to repair. — 6/16/08
- In-service for utility staff on system for washing, sanitizing, air drying and storage of hotel pans.
- Drying racks for hotel pans re-arranged to facilitate increased air flow for proper drying.
- On a monthly basis, kitchen areas will be randomly checked by Director of Dining Services to ensure deficient practices do not recur.

4. Performance Monitoring to Ensure Solutions Are Sustained: Report findings in Quarterly QA meeting. **Implementation date: July 24, 2008 and quarterly thereafter x 4 quarters.** — 7/24/08

F 425 SS=D	483.60(a),(b) PHARMACY SERVICES	F 425	

The facility must provide routine and emergency drugs and biologicals to its residents, or obtain

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F 425	Continued From page 3 them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation of the medication carts on one (1) of (2) nursing units and staff interview, it was determined that facility staff failed to initial and date ophthalmic solution containers when first opened. The findings include: On June 12, 2008 at approximately 2:00 PM during the inspection of the medication carts on the 1st floor, three (3) of four (4) containers of Xalatan ophthalmic solution were observed opened. The Xalatan ophthalmic solution containers were not dated or initialed by the nurse. A face-to-face interview was conducted at approximately 2:10 PM with Employee #2. He/she acknowledged that the Xalatan ophthalmic solution containers were not dated and initialed when first	F 425	**F 425 483.60(a), (b) Pharmacy Services** - failure to initial and date ophthalmic solution containers when first opened. 1. Corrective Action for Residents Affected by Deficient Practice: Containers of Xalatan ophthalmic solution that were opened without dates were discarded and replaced with new eyedrops for each of the residents affected. 6/12/08 2. Method to Identify Other Residents At Risk for Deficient Practice: Containers of ophthalmic solutions for all residents in the Health Care Center were examined to determine if other residents were at risk for the deficient practice. None were found. 6/13/08 3. Measures or Systemic Changes to Ensure Deficient Practice Does Not Recur: • Re-educate staff on placing dates/initials on all containers when opened. 6/20/08 • Request pharmacy to place special labeling on solution containers to remind nurses to write the date opened on each container. 6/20/08 • On a monthly basis, randomly check open containers of ophthalmic and other solutions to ensure deficient practice does not recur. **Implementation date: 6/20/08 and ongoing.** 6/20/08 4. Performance Monitoring to Ensure Solutions Are Sustained: Report findings in Quarterly QA meeting. **Implementation date: July 24, 2008 and quarterly thereafter x 4 quarters.** 7/24/08	

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F 425	Continued From page 4	F 425		
	opened.			
F 492 SS=D	483.75(b) ADMINISTRATION The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined that facility staff failed to dispose of food waste as required by State law. The findings include: According to 22 DCMR 3219.8, "Food waste shall be disposed in a garbage disposal system or garbage grinder which is conveniently located near each activity and which has adequate capacity to dispose of all readily grindable food waste (garbage) produced." During a tour of the main kitchen on June 12, 2008 between 8:50 AM and 10:00 AM, dietary staff was observed disposing of food and paper waste in a trash receptacle. It was further observed that food, paper and metal waste were disposed of in the same trash receptacles. Employee #1 acknowledged the above findings at the time of the observation and stated that there were three (3) working garbage disposals in the kitchen .	F 492	**F 492 483.75(b) Administration** **L 106 3219.8 Nursing Facilities** **cross-reference** 1. Corrective Action for Residents Affected by Deficient Practice: All food items are being disposed of via the garbage disposals. 2. Method to Identify Other Residents At Risk for Deficient Practice: The Dining Services Director has observed disposal of food items to ensure that it is being done correctly. 3. Measures or Systemic Changes to Ensure Deficient Practice Does Not Recur: • Re-educate and In-service Dining services staff on the use of garbage disposals for disposing of appropriate food waste. On a monthly basis, kitchen areas will be randomly checked by Director of Dining Services to ensure deficient practice does not recur. 4. Performance Monitoring to Ensure Solutions Are Sustained: Report findings in Quarterly QA meeting. **Implementation date: July 24, 2008 and quarterly thereafter x 4 quarters.**	6/12/08 6/12/08 6/13/08 7/24/08