MH OF DC POLACEPELE PAGE 82/82

YOUNG 9/21/06 PRINTED: 09/01/2008

FORM APPROVED

CARD NO. 0038-0391

DEPARTMENT OF HEALTH AND HUMAN SIERVICES

FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICAR	E & MEDICAID SE TVICES			OND INO	0930-035
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPTLIER/CLIA IDENTIFICATION NUMBER;	(X2) MU A BUIL	LTIPLE CONSTRUCTION DING	(X3) DATE S COMPLE	
	095(138	B. WING	3	08/2	3/2006
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	P CODE	
METHODIST HOME			4901 CONNECTICUT AVENUE, WASHINGTON, DC 20008	, NW	
PREFIX : (EACH DEFICIENC	ATEMENT OF DEFICIE CIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INF() RMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CONTROL OF CON	N SHOULD BE CROSS-	(X5) COMPLETION DATE
on August 22 thro deficiencies were and resident inter sample size was	ication survey was conducted ugh 23, 2006. The following based on observations, staff views and record review. The 12 residents based on a census a first day of survey and two (2)	FO	THIS PLAN OF CORRECT FOR PURPOSES OF BEGU COMPLIANCE AND AS PA METHODIST HOME'S ON CONTINUOUSLY IMPROV SERVICES PROVIDED, AL CONSTITUTE AN ADMISS OR CONCLUSIONS CITEL REPORT FOR ANY PURPO	ILATORY ART OF THE GOING EFFORTS TO VE THE CARE AND S SUCH IT DOES NOT SION OF THE FACTS O IN THE SURVEY	
An individual resident the interdisciplinary of the findings inclusive of the indings inclusive	de; ent JK1's record i evealed a dated July 15, 20, 6, " ng tablets. One triblet	F 1'	of Drugs - fallure to asset JK1 for self administration 1. Corrective Action to Affected by Deficier. The assessment of resident capability to self administratives on August 24, 2206. The team approved resident administer his medication assessment.	ses Resident in of drugs in Resident in Practice: it Practice: dent JK1's ster his a completed he interdisciplinary it JK1 to self ions as a result of intify Other for Deficient whewed to ay have administer	08/24/06
According to a ha 2006 60-day orde Resident should be	nd-written order () the August rs signed August 3, 2006, " le allowed to kee: nitro in [his/ on the should be allowed to use it &		been assessed per polici residents were identified. Completed August 25, 20 3. Measures or Syste to Ensure Deficient Not Recur: • Re-educate staff on administration policy	y. No 006, mic Changes Practice Does self-	08/25/06
	for Self-Administration of dated April 25, 2006, indicated		Completion date: Oc		10/06/06
ABORATORY DIRECTOR'S OR PROV	DERVSUPPLIER REP: ESENTATIVE'S SIGN	VATURE	TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (*) dennies 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 corn: dion is provided. For number, 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 regulate to continued program participation.

ADMINISTEASOR

11 SETTEMBER 2006

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	Γ΄.	ULTIP LOING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		095038	B. W₩	IG		08/2	3/2006
METHODIST HOME (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREF TAG	490 W/	EET ADDRESS, CITY, STATE, ZIP CODE 01 CONNECTICUT AVENUE, NW ASHINGTON, DC 20008 PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE D	BE CROSS-	(XS) COMPLETION DATE
	approval to grant the self-administer medications, the inassess the patient ability to carry out the policy." A face-to-face intercharge nurse on Adapproximately 11:00 the resident had nit bedside. The record 2006.	inary care team denied ne resident the opportunity to dication. There was no cord that the resident was re- dministration of medication. cility's policy, "Self ications", number 2.2, Section self administers his/her ter-disciplinary team must s cognitive, physical and visual this responsibility per Center		253	 Revise Twenty-Four Hour Reppolicy to require inclusion of residents being assessed for tability to self-administer meds 24-hour report. Completion da Oct. 6, 2006 Review 24-hour report daily to identify residents undergoing administration assessments. Sept. 1, 2006 Review charts of these resider after 3-day assessment period ensure assessment has been completed. Sept. 1, 2006 Performance Monitoring to Ensure Solutions Are Sustaine Report findings in Quarterfy QA meeting. Completion date: Oct. 6, 2006. 	their on te: self- nts if to	10/06/06 09/01/06 09/01/06
SS=E	The facility must promaintenance services anitary, orderly, and the sanitary and the sanitary maintenance servicensure that the fact and sanitary mannexhaust vents, bas	rovide housekeeping and ces necessary to maintain a nd comfortable interior. NT is not met as evidenced by tions during the survey period, that housekeeping and ces were not adequate to illity was maintained in a safe er as evidenced by: soiled se surfaces on mechanical lifts on top of closets and tables;	•		The light dust in the identificinstances did not negatively resident care and has been addressed as indicated on the following page.	impact	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	IULTIPLE	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		095038	B. WING			08/23/2006		
METHOD	ROVIDER OR SUPPLIER	75,15,17,05,05,10,5,10,5		4901	T ADDRESS, CITY, STATE, ZIP CODE I CONNECTICUT AVENUE, NW SHINGTON, DC 20008			
(X4) ID : PREFIX : TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOUL REFERENCED TO THE APPROPRIATE	D BE CROSS-	(X5) COMPLETION DATE	
	residents' rooms. The findings includ 1. The interior surfaresidents' rooms a with dust in the folk First Floor Rooms room in five (5) of r 11:10 AM and 12:3 Second Floor Room nine (9) observation PM on August 23, 2 2. The base surface bathtubs were soiled the first and second 4:45 PM on August 12:10 PM on August 12:10 PM on August 12:10 PM on August 247, 249, 253 and observations betwee August 22, 2006 ar August 23, 2006. 4. The frontal areas boards were marre rooms. First Floor Rooms 4) of nine (9) observations betwee the first floor Rooms 4) of nine (9) observations 9 observations betwee the first floor Rooms 4) of nine (9) observations 9 observa	tables and foot boards in e: eces of exhaust vents in and common areas were soiled owing areas: 145, 147,153, 169 and bathing nine (9) observations between 0 PM on August 22, 2006. ens 249 and 261 in two (2) of as between 8:37 AM and 12:10 2006. es of mechanical lifts and ed with accumulated dust on d floors between 4:00 PM and 122, 2006 and 11:10 AM and 123, 2006. es of tables and closets were d debris in rooms 145, 146, 256 in six (6) of 18 een 11:10 AM and 12:30 PM on and 8:37 AM and 9:30 AM on es of chairs, tables and foot d and scarred in residents' 146, 147, 151 and 153 in four (vations between 8:37 AM and	F		F 253 1. 1. The light dust identified during was removed on the interior sur of exhaust vents behind the grat all cases. 2. Grates were removed and the in of all exhaust vents were checked dust on interior surface and no owere found to have dust. 3. In-service conducted and docum with all Maintenance Departmen proper cleaning procedures. 4. The Maintenance Supervisor is monitor light dusting checks on rounds. This information will be on the Quarterly QA report and F 253 2. 1. The light dust identified on the Lift and tube during tour was removed in all cases. 2. All lifts and tubs were checked dust on flat surfaces and no other were found to have dust. 3. In-service conducted and docum with all Light Duty Technicians proper cleaning procedures. Housekeeping assignments upd include weekly/monthly dusting tubs. 4. The Housekeeping Supervisor is monitor light dusting checks on rounds. This information will be on the Quarterly QA report and	faces es in terlor ed for others mented int on aware to monthly e entered monitored. mechanical for ers mented on ated to g of lifts and aware to weekly e entered	08/24/06 08/24/06 08/28/06 08/28/06 08/23/06	
	12:10 PM on Augus	st 22, 2006.			, , , , , , , , , , , , , , , , , , , ,		09/06/06	

Statement of Deficiencies And Plan of Correction

Identification # 095038

F	253 3.	
1.	The light dust identified during tour was removed in all cases.	08/22/06
2.	All resident rooms were checked for	00/22/00
	dust on flat surfaces of closets and	
	furnishings and no others were found	
	to have dust.	08/25/06
3.	In-service conducted and documented	
	with all Light Duty Technicians on	
	proper cleaning procedures. Flousekeeping assignments updated to	
	include weekly/monthly dusting where	
	dust was identified in resident rooms.	09/06/06
4.	The Housekeeping Supervisor is aware to	
	monitor light dusting checks on weekly	
	rounds. This information will be entered	
	on the Quarterly QA report and monitored.	09/06/06
F 2	153 4.	
1.	The identified surfaces, of chairs,	
	table legs and foot boards will be	
2	cleaned/repaired, All resident rooms and common areas to	09/29/06
_	be surveyed by staff to determine and	
	and schedule cleaned/repaired if identified.	09/29/06
3.	Condition of furniture will be added to daily	27,27,00
	housekeeping and maintenance rounds.	09/29/06
4.	The Supervisors are aware to repair damage as discovered. This information will be	

entered on the Quarterly QA report

and monitored.

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) M		3	(X3) DATE SURVEY COMPLETED	
		095038	B. WI	NG _		08/2:	3/2006
NAME OF PROVIDER OR SUPPLIER METHODIST HOME				49	EET ADDRESS, CITY, STATE, ZIP CODE 901 CONNECTICUT AVENUE, NW VASHINGTON, DC 20008		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAC	IX :	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETION DATE
F 253	Continued From pa	i	F	253			
 - 		ms 249, 253 and 256 in three (rvations between 8:37 AM and ist 23, 2006.			F284 482 20 (Lyang) 0	;	:
F 281 SS=D	The services provi	MPREHENSIVE CARE PLANS ded or arranged by the facility	F	281	Plans - failure to discard expired medications 1. Corrective Action for Resident Affer Deficient Practice:		!
	•	Sional standards of quality.			The interim med box was replaced on the of the deficient finding. Completed August 2006. 2. Method to Identify Other Residents	# 22,	08/22/06
	it was determined discard expired me				for Deficient Practice: No resident received expired meds from interim box. Completed August 22, 2006 3. Measures or Systemic Changes to Deficient Practice Does Not Recur;	i. Ensure	08/22/06
	medication box, lo the 2nd floor nursi expiration date wri	06, the locked interim cated in the medication room at ng station was inspected. The tten on the interim medication			The night shift nurse will inspect all received in the locked interim box when box is delivered. Any meds we expiration dates that occur prior to of the month will be returned to phase and replacements requested.	meds weekly with the end	
	medications in the the month and the	box were valid until the end of box should be returned to the by August 31, 2008.			Implementation date: August 29, 2 (and ongoing). Nursing policy will be developed to this practice. All nurses will be train	support	08/29/06
	medications were	ation box was opened and randomly inspected. Nine (9) n 100 mg capsules had an			the implementation of this policy. Completion date: October 8, 2006		10/06/06
	expiration date of a Nitrofurantoin caps days after they had	August 2, 2006. The sules were available for use 20 d expired. There was no resident had received this			4. Performance Monitoring to Ensure Solutions Are Sustained: The night nurse will report weekly to DON any expired meds received fro pharmacy. Findings will be docume and presented at the quarterty QA meeting. Implementation date: Seg 5, 2006 (and ongoing).	o the om the ented	9/05/06 & ongoing

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION	(X3) DATE SI COMPLE	
		095038	B. WING		08/2	3/2006
	ROVIDER OR SUPPLIER		4	EET ADDRESS, CITY, STATE, ZIP COI 901 CONNECTICUT AVENUE, NW VASHINGTON, DC 20008		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SHO REFERENCED TO THE APPROPRIA	ULD BE CROSS-	(X5) COMPLETION DATE
F 309 SS=D	Each resident must provide the necess or maintain the high mental, and psychological accordance with the and plan of care. This REQUIREMED Based on record recone (1) of 12 samp determined that the pacemaker check pacemaker check pacemaker check pacemaker check pacemaker accordence on the findings included in the pacemaker of the findings included in the pacemaker of the findings included in the pacemaker of the resident pacemaker on the pacemaker of the resident pacemaker of the r	t receive and the facility must ary care and services to attain nest practicable physical, osocial well-being, in a comprehensive assessment. NT is not met as evidenced by eview and staff interview for led residents, it was a facility staff failed to obtain a per physician's orders for one (int #6.	F 309	F309 483.25 Quality of Care failure to obtain pacemaker che physician order for resident #6. 1. Corrective Action for Resident Practice: The pacemaker check was obtain resident. Completed August 24, 2. Method to Identify Other Refor Deficient Practice: Medical records of the 3 resident Care Center who have pacemaker current per physician ordefound deficient. Completed August 3. Measures or Systemic Chan Deficient Practice Does Note Nurses will continue to revie the end-of-the-month changensure orders have been protranscribed and dates/times checks have been identified off") on the new month's TAI Implementation date: Septem (and ongoing). TARs will be reviewed by the nurse (24-hour checks) to en pacemaker checks have been according to schedule. Any checks that have not been according to schedule.	ent Affected by ned for the 2006. esidents At Risk esiden	08/24/06 08/28/06 09/01/06 & ongoing;
ORM CMS-2	567(02-99) Previous Versions	Obsolete Event ID: MQCS11	Facility I	Sentember 20, 2006 (and annula)	., –	-09/30/06 — t& ongoing ¹⁸

STATEMENT OF DEFICIENCIES (X1) PRO AND PLAN OF CORRECTION IDEN		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 08/23/2006	
		095038					
METHODIST HOME				490	ET ADDRESS, CITY, STATE, ZIP COD DI CONNECTICUT AVENUE, NW ASHINGTON, DC 20008	DE 3C	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SHO REFERENCED TO THE APPROPRIA	OULD BE CROSS-	(X5) COMPLETION DATE
F 314 SS=D	resident, the facility who enters the facility who enters the facility who enters the facility who enters the facility were unavoidable pressure sores reciservices to promote prevent new sores. This REQUIREME: Based on observatione (1) resident, facilities and technique who Resident #10. The findings include A wound treatment observed on August nurse washed handeremoved the slipper and right heels. The approximately one amount of blood provided the provided provide	orehensive assessment of a must ensure that a resident lity without pressure sores ressure sores unless the condition demonstrates that able; and a resident having eives necessary treatment and e healing, prevent infection and from developing. NT is not met as evidenced by ion of a wound treatment for icility staff failed to maintain nile administering the treatment	F	314	F314 483.25c Pressure Sore failure to maintain clean tech while administering the treatm Resident #10. 1. Corrective Action for Re Affected by Deficient Pr. Nurse involved was immediat educated regarding proper te to be used when changing re- dressings. Completed Augus 2006. 2. Method to Identify Residents At Risk for Practice: Licensed nurses received of the facility's dressing of protocol. Completed Aug 2006. The Skin Care Book was reviewed to identify reside requiring dressing change (including skin tears since additional residents have pressure ulcers). Comple August 24, 2006. Nurses were observed pe dressing changes by the Educator to ensure comp with the dressing change protocol. Staff received instruction/correction in in where protocol was violat Completed August 30, 20	esident actice: tely schniques: sidents' st 23, Other Deficient d copies change gust 24, ents es e no eted erforming Nurse sliance instances ted.	08/23/06

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		095038	B. WII	NG_		08	8/23/2006
	ROVIDER OR SUPPLIER		'	4	REET ADDRESS, CITY, STATE, ZIP CODE 4901 CONNECTICUT AVENUE, NW WASHINGTON, DC 20008		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	FIX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOUL REFERENCED TO THE APPROPRIATE	D BE CROSS	
:	gauze pads, unscrepoured the NSS on were not washed at before the nurse cleointment and a drest the National Press Frequently Asked Cand Infection Controvation for the response to a providers should waremove dressings forder to not contaminate the pair of clean (non-streat multiple ulcers done, start with the and move to the lar contaminated appechange gloves between the cleaner wound picked up a box of from a tube, opened a bottle of NSS with	three (3) packages of 4 x 4 ewed the bottle of NSS and to the gauze pads. Hands and gloves were not changed eaned the left heel and applied ssing. The Ulcer Advisory Board, "Questions, Wound Infection of, " web site www.npuap.org/ol>, "evealed the following; all , revealed the following;">http://www.npuap.org/ol>, revealed the following; The past their hands before they from the (dressing) package in a linate the dressings by ackage with soiled hands and/or sponse of question #10, " One terile) gloves can be used to so on the same patient. If this is cleaner appearing wounds ger and /or most aring wounds. When in doubt, ween ulcers. Do not not supplies and wound care ution bottles) with gloves that	F	314	3. Measures or Systemic C to Ensure Deficient F Does Not Recur: Expand current infection or education to emphasize cle dressing change technique Completion date: Septemb 2006. Schedule all nurses to demonstrate competency i dressing change technique specific emphasis on infect control. Completion date: September 22, 2006. Performance Monitoring to Ensure Solutions Are Sus Compile data from competency observations and present at qu QA meeting. Completion date: October 6, 2006.	ean ontrol ean oner 15, over 1	09/15/06

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
			A. BUILDING		001111 22	120		
		095038	B. WI	NG_		08/23	3/2006	
NAME OF P	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE			
METHOD	NST HOME			ı	901 CONNECTICUT AVENUE, NW /ASHINGTON, DC 20008			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE (BE CROSS-	(X5) COMPLETION DATE	
SS=D	Based on the reside assessment, the fare resident who enters indwelling catheter resident's clinical or catheterization was who is incontinent of treatment and servinfections and to refunction as possible. This REQUIREMENT: Based on observation review for one (1) of determined that factorized incontine who was diagnosed. The findings included A review of Resident was coded bladder in Section I days) on the Quarte assessment complete incontine who was diagnosed. The resident was coded bladder in Section I days) on the Quarte assessment complete incontine who was diagnosed. The resident was diaffection on July 12 course of antibiotic notation by the phyfor the urinalysis, the chronic renal insuff. According to the factorized assessment to the factorized assessment to the factorized assessment to the phyfor the urinalysis, the chronic renal insuff.	ent's comprehensive cility must ensure that a since the facility without an is not catheterized unless the condition demonstrates that necessary; and a resident of bladder receives appropriate ices to prevent urinary tract store as much normal bladder es. NT is not met as evidenced by son, interview and record of 12 sampled residents, it was sility staff failed to perform a not assessment for Resident #8 d with a urinary tract infection. Etc. Int #8's record revealed that the las incontinent of bowel and H (Continence in the last 14 erly Minimum Data Set eted July 20, 2006. Integrated with a urinary tract infection and the last 14 erly Minimum Data Set eted July 20, 2006. Integrated with a urinary tract infection on the laboratory report the resident had a history of inciency. Cility's policy entitled, "	F	315	F315 483.25(d) – Urinary Incontination failure to perform complete inconting assessment for Resident #8 who was diagnosed with a UTI. 1. Corrective Action for Residents by Deficient Practice: Resident #8's Minimum Data Sets were viewed for the previous five quarter was assessed as incontinent througentirety of this period. Required assessment be documented retrospective. Completion date: August 25, 2006. 2. Method to Identify Other Reside for Deficient Practice: Minimum Data Sets have been all residents who were assessed month of August and who are so assessments in the month of Secompletion date: August 31, 200. Residents coded as incontinent documented assessment to indicadditional interventions, if any, the implemented. Completion data 31, 2006. 3. Measures or Systemic Change Deficient Practice Does Not Relevise Incontinence Assessment Policicontinence Assessment Policicontin	ent as Affected Were ers. She phout the sessments ely. ents At Risk reviewed for in the cheduled for ptember. M6. have a cate hat should the: August is to Ensure cur: ent Tool to cy. 5, 2006. ation of the cy and ments.	08/25/06 08/31/06 09/15/06 09/22/06	
	Incontinence Asses	cility's policy entitled, " ssment" dated January 23, er #3, "Monitor, record and		:				

PRINTED: 09/01/2006 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI	COMPLE	(X3) DATE SURVEY COMPLETED	
		095038	B WING_		3/2006	
	ROVIDER OR SUPPLIER		4	REET ADDRESS, CITY, STATE, ZIP CODE 901 CONNECTICUT AVENUE, NW VASHINGTON, DC 20008		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEEDED BY FULL 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 315	habits, and contine a. voiding patterns quality of stream e interventions." There was no evid complete assessm including the resid response to interv A face-to-face interventage nurse on A /she acknowledge voiding pattern for	on about the resident's bladder ence or incontinence including: (frequency, volume, time, etc.)e. Response to dence in the record that a ment had been performed, ent's voiding pattern and entions. Enview was conducted with the august 22, 2006 at 9:30 AM. He did that there was no record of a Resident #8 and no evaluation entions. The record was	F 315	Provide guidance and instruction to the interdisciplinary care plan team and MDS Coordinator regarding use of Resident Assessment Protocols to support the assessment of incontinence, and to develop appropriate care plans/management strategies. Completion date: September 22, 2006. Monitor documentation on the Incontinence Assessment Tool monthly to ensure compliance with policy. Document variances and report to DON. Implementation date: September 29, 2006 (and ongoing). 4. Performance Monitoring to Ensure Solutions Are Sustained: Compile data from monitoring activity monthly for presentation to the facility's Quality Assurance (QA) Committee. Implementation	09/22/06 09/2906 & ongoing	
F 329 SS≃D	Each resident's drunnecessary drug drug when used ir duplicate therapy without adequate indications for its adverse conseques should be reduced combinations of the This REQUIREMIES.	ENT is not met as evidenced by	F 329	date: October 6, 2006 (and ongoing). F329 483.25(I)(1) - Unnecessary Drugs - failure to monitor behavior of residents receiving antipsychotic (psychoactive) meds. 1. Corrective Action for Residents Affected by Deficient Practice: Behavior monitoring sheets were instituted for the 4 residents identified during the survey who had this deficient practice. Completion date: September 1, 2006. 2. Method to Identify Other Residents At Ris for Deficient Practice: Residents receiving psychoactive medications were identified using the		
	determined that fa	of 12 sampled residents, it was acility staff failed to monitor the ents receiving antipsychotic		Psychoactive Medication Report generated by the pharmacy. Completion date: September 1, 2006.	09/01/06	

Event ID. MQCS11

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULT	IPLE CONSTRUCTION	(X3) DATE SU COMPLET	
		095038	B. WING _		08/23	3/2006
	ROVIDER OR SUPPLIER		4	REET ADDRESS, CITY, STATE, ZIP CODE 4901 CONNECTICUT AVENUE, NW WASHINGTON, DC 20008		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHOU REFERENCED TO THE APPROPRIAT	LD BE CROSS-	(X5) COMPLETION DATE
F 329	The findings included. 1. Facility staff failed Resident #2 who was medication. A review of Reside physician's order in and most recently to equal 37.5 mg dono evidence in the identified or monitor. A face-to-face intercharge nurse on Atte/she stated, "We antidepressant me The record was review of Resident #3 who was medication. A review of Reside physician's order in recently renewed Adaily for depression the record that facing monitored depress. A face-to-face intercharge nurse on Atte/she stated, "We antidepressant me	dents #2, 3, 4 and 5. e: d to monitor behaviors for as receiving an antidepressant int #2's record revealed a itiated on December 20, 2002 renewed August 3, 2006, " and Zoloft 25 mg 1/2 tab daily aily for depression". There was record that facility staff had red depressive behaviors. view was conducted with the ugust 22, 2006 at 10:55 AM. e don't monitor behaviors for dication" riewed August 22, 2006. d to monitor behaviors for ras receiving an antidepressant int #3's record revealed a intiated on admission and most august 3, 2006, "Zoloft 100 mg in." There was no evidence in lity staff had identified or ive behaviors. Eview was conducted with the ugust 22, 2006 at 10:55 AM. e don't monitor behaviors for	F 329	 In addition to the behavlor mosheets already in place for respectiving antipsychotic meds, were also instituted for reside antidepressants, hypnotics, a drugs. Completion date: Sep 2006. Measures or Systemic Cham Deficient Practice Does Not For Develop policy regarding approf Behavior Monitoring Sheet Completion date: September Educate staff on implemental policy and correct documental included on the Behavlor Monitoring and correct documental included on the Behavlor Monitoring and correct documental included on the Behavlor Monitoring and the Behavlor Monitoring and the Behavlor Monitoring and the Behavlor Monitoring monthly basis for all resident Psychoactive Medication Report paper and the paper of documental policy and compliance with paper oprinteness of documental policy and compliance with paper oprinteness of documental paper oprinteness oprinteness of documental paper oprinteness oprinteness oprinteness oprin	sidents these sheets ints receiving and anxiolytic tember 1, ges to Ensure Recur: ropriate use is. 15, 2006, tion of the ation to be intoring reptember 30, insure Sheets on a s listed on the port generated in date: i). policy and tation. y's Quality Completion	09/01/06 09/15/06 09/30/06 10/1/06 & ongoing

PRINTED: 09/01/2006 FORM APPROVED OMB NO. 0938-0391

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IND PLAN OF CORRECTION SUMBER:		A. BUILI	LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED		
		095038	8. WING	S	08/23/2006		
NAME OF PROVIDER OR SUPPLIER METHODIST HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 4901 CONNECTICUT AVENUE, NW WASHINGTON, DC 20008				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION S REFERENCED TO THE APPROP	SHOULD BE CROSS- COMPLETION		
F 329	Resident #4 who winsomnia. A review of Reside physician's order in most recently rener Trazodone HCL 50 at bedtime for Inso in the record that the monitored the effect A face-to-face intercharge nurse on All He/she stated, "We behaviors." The re 2006. 4. Facility staff faile Resident #5 who winedication. A review of Reside physician's order re "Zoloft 25 mg daily no evidence in the identified or monitor. A face-to-face intercharge nurse on All He/she stated, "We he/she stated, "W	and to monitor behaviors for as receiving a medication for a medication of a medication and the major of the medication. There was no evidence are facility staff had identified or a cts of the medication. There was no evidence are facility staff had identified or a cts of the medication. There was conducted with the argust 22, 2006 at 10:55 AM. And the area of the monitor behaviors for as receiving an antidepressant and the staff had been and the facility staff had been area of the facility staff had been as a conducted with the area of the facility staff had been as	F 33	29			

Event ID MQCS11

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SU COMPLE	
		095038	8. WIN	G		08/2	3/2006
	ROVIDER OR SUPPLIER			4901 (ADDRESS, CITY, STATE, ZIP CODE CONNECTICUT AVENUE, NW HINGTON, DC 20008		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	iÐ PREFI) TAG		PROVIDER'S PLAN OF CORRE EACH CORRECTIVE ACTION SHOUL EFERENCED TO THE APPROPRIATE	D BE CROSS-	(X5) COMPLETION DATE
	The facility must streserve food under serve food food food food food food food foo	NT is not met as evidenced by ions during the survey period, hat dietary services were not a that foods were served and and sanitary manner as d slats on the dish machine, et pans. These observations resence of the Director of	F3	\$A PH 1. 2. 3. 4.	notified about replacing our Director reviewed process ar serviced the utility staff on p sanitation and breakdown of machine. Dining Services Director and Director will monitor complimonthly basis & present to the Administrator for review. We presented on a quarterly basis Quality Assurance Committee subsequent plans of correction and implemented as necessare. Entire amount of hotel and shader rewashed and sanitized staff and supervised by the Director reviewed chemicals at the pot sink as well as the washing procedure. Director had in-service with estaff on proper procedures for Pan washing.	were re- any, was curtain. and in- proper the Dish I Asst. iance on a be fill then be s to the ee, with on developed ry. heet pans by the utility irector. that are used ware entire utility r Pot and I monitor is & will for review. uarterly e Committee ection	8/24/06 8/24/06 8/24/06 8/25/06 and ongoing 8/23/06 8/23/06 8/24/06

PRINTED: 09/01/2006 FORM APPROVED OMB NO. 0938-0391

TOPING	COT OF CHILDION COL	WINEDIONID OF WIDEO			OIND NO. C	7900-0091
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		095038	B. WING		08/23/	2006
NAME OF P	PROVIDER OR SUPPLIER		STR	EET ADDRESS, CITY, STATE, ZIP COD)E	
метнос	DIST HOME			901 CONNECTICUT AVENUE, NW VASHINGTON, DC 20008		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SHO REFERENCED TO THE APPROPRIA	ULD BE CROSS-	(XS) COMPLETION DATE
F 412 SS=D	The nursing facility an outside resource h) of this part, rout under the State plaservices to meet the must, if necessary appointments; and to and from the de	must provide or obtain from e, in accordance with §483.75(ine (to the extent covered an); and emergency dental ne needs of each resident; assist the resident in making by arranging for transportation ntist's office; and must dents with lost or damaged	F 412	F412 483.55(b) Dental Service - failure to provide annual dental for 2 of 12 residents. 1. Corrective Action for Residents Practice: Dental referrals for residents affiliby this deficient practice have be forwarded to the Mobile Dentist; appointments are pending. Condate: September 7, 2006. 2. Method to Identify Other Resident Practice:	dents Affected ected een mpletion desidents At	09/07/06
	Based on observative for two (2) of determined that far annual dental screen. The findings included the facility staff failed screen for Resider A review of Resider	ed to provide an annual dental nt #2.		Medical records for all residents been reviewed to identify if annuscreens have been completed. have been forwarded to the Molfor the 4 residents identified. Codate: September 7, 2006. 3. Measures or Systemic Characteristic Does Not Practice Does Not Residents' annual dental screen scheduled to coincide with the all and Physical examinations. Coloctober 2, 2006 (and ongoing). 4. Performance Monitoring to	ual dental Referrals bile Dentist completion anges to Ensure of Recur: as have now been annual History mpletion date:	10/2/06 8 ongoing
	past 13 months. A face-to-face inte social worker on A approximately 11:0 that the dental screen	erview was conducted with a sugust 22, 2006 at 20 AM. He/she acknowledged een has not been done and lest for the mobile dental unit		Are Sustained. Monitoring will be accomplished the annual dental screen schedifiled in the medical record. Find quarterly in the QA meeting. C October 6, 2006 (and ongoing).	ule with dental co dings will be report completion date:	nsults

are waiting for the dental visit."

was sent on August 1, 2006 and we [the facility]

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUP IDENTIFICATION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL	DITIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED	
. <u>_</u>		095038	B. WING	3	08/2	3/2006
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 4901 CONNECTICUT AVENUE, NW WASHINGTON, DC 20008		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SHOI REFERENCED TO THE APPROPRIA	ULD BE CROSS-	(XS) COMPLETION DATE
F 412	resident had experiloss. The record w 2. Facility staff faile screen for Residen A review of Reside dental screen dated evidence in the reciscreened the resident A face-to-face inter Nursing was conducted a Market of the resident This just fell throug. There was no evideresident had experiloss.	ence in the record that the enced mouth pain or weight as reviewed August 22, 2006. If to provide an annual dental t #8. Int #8's record revealed a d April 21, 2003. There was no ord that the dentist had ent after April 21, 2003. In the dentist had ent after April 21, 2003. In the dentist had ent after April 21, 2003. In the dentist had ent after April 21, 2003. In the dentist had ent after April 21, 2003. In the dentist had ent after April 21, 2003. In the dentist had ent after April 21, 2003. In the dentist had ent after April 21, 2003. In the dentist had ent after April 21, 2003.	F 4	12		
	including procedure acquiring, receiving administering of all the needs of each r	ide pharmaceutical services (es that assure the accurate i, dispensing, and drugs and biologicals) to meet resident.	F 43	F426 483.60(a) Pharmacy Services - failure to administer prescribed medications. Corrective Action for Residents by Deficient Practice: All non-prescribed medications have removed from the medication cart an not available/administered to the residents: Completion date: August 24, 2006.	Affected been d are	08/24/06
	: Based on observati	ons and record review for one ampled resident, it was				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIES (DENTIFICATION NUM		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		095038	B. WING		08/23	/2006
	ROVIDER OR SUPPLIER		49	EET ADDRESS, CITY, STATE, ZIP CO 001 CONNECTICUT AVENUE, NW /ASHINGTON, DC 20008	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SHO REFERENCED TO THE APPROPRI	OULD BE CROSS-	(X5) COMPLETION DATE
F 426	prescribed medical prescribed medications. Resident medications. Resident medications included an inspection of the medications for Refour (4) different placentract pharmacy. The physician's or prescribed 17 rout needed medication present in the medications current mingled in the medication medication medication medication medication medication mingled with current medications.	e facility failed to administer ations and co-mingled non-ations with currently prescribed dent JK1. de: ne medication cart revealed 32 esident JK1, dispensed from harmacies other than facility's ders signed on August 3, 2006 ine medications and four (4) as ns. All 21 medications were	F 426	2. Method to Identify Other Residents Risk for Deficient Practice: MARs of all residents have been comedications currently administered prescribed meds are available/administered prescribed on Systemic Change Deficient Practice Does Not Rie Advise residents and family meaccompany residents to medic that all prescriptions received into the nursing staff. This including from pharmacles other than the contract pharmacy. Completio 2006 (and ongoing). List all drugs prescribed for resident's POS and the MAR. date: October 6, 2006 (and one Expand the consultant pharmamonthly monitoring of Physicial against meds available in the micrompletion date: October 1, 2.4. Performance Monitoring to Enside Sustained. Consultant Pharmacist to report qualifacility's QA meeting. Completion data in the micrompletion data.	mpared against to ensure only ristered to mber 1, 2006. Se to Ensure sour; embers who all appointments must be provided the facility's in date: October 6, didents on the Completion going). cist's role to Include in Order Sheets and cart. 006. Sure Solutions at other the control of the control of the control of the cart.	09/01/07 10/6/06 & ongoing 10/6/06 & ongoing 10/1/06
}						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` ′	ULTIPLE CONSTRUCTION LDING	(X3) DATE SUR COMPLETS	
		095038	B. WI	IG	_08/23/	2006
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP O 4901 CONNECTICUT AVENUE, NO WASHINGTON, DC 20008		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		HOULD BE CROSS-	(X5) COMPLETION DATE
F 441 SS=D	The facility must es infection control prosafe, sanitary, and to prevent the deverging an infection control investigates, control investigates, control investigates, control the facility; decides isolation should be resident; and maint corrective actions of the facility and maint corrective actions of the facility and maint corrective actions of the facility and maintain infection of the findings included the findings included and the findings included it in the findings included in the	stablish and maintain an orgram designed to provide a comfortable environment and dopment and transmission of on. The facility must establish program under which it ols, and prevents infections in what procedures, such as applied to an individual ains a record of incidents and elated to infections. NT is not met as evidenced by ions during a wound treatment, that facility staff failed to control precautions for e: for Resident #10 was at 22, 2006 at 2:40 PM. A se (CNA) was assisting the eatment. The CNA was a "light cover" from the prior to the treatment. After int was completed, the CNA cover" from the roommate's	F	F441 483.65(a) Infection Control failure to maintain infection control Resident #10. 1. Corrective Action for Residen Deficient Practice: CNA involved was immediately e infection control precautions with transmission. Completed August 2. Method to Identify Other Resi Deficient Practice: All staff received copies of the infection control policies. Corr August 24, 2006. Staff were observed by the Ni performing various tasks to er with the policies, and received in instances where policy viola observed. Completed August Measures or Systemic Chang Deficient Practice Does Not R Revise infection control training emphasis on modes of transmisephasis on modes of transmisephamics on modes of transmisephamics on the control of training contaminated material appropriate precautions when resident's clothing and other to residents' belongings, etc. Co- September 22, 2006. 4. Performance Monitoring to Ensu Compile data from competency obsequarisriy QA meeting. Completion of (and ongoing).	ol precautions for at Affected by ducated regarding emphasis on modes of 23, 2006, idents At Risk for a facility's impleted urse Educator while insure compliance d instruction/correction ations were ations were ations were as 10, 2006 instruction for a completion date: and program to expand mission. Completion date: rate competency in ials correctly, maintaining placing or removing pelongings, proper storac impletion date: are Solutions are Sustained invations and present at ate: October 6, 2006	ge of 09/22/06

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
095038		B. WING		08/23/2006	
	ROVIDER OR SUPPLIER		49	EET ADDRESS, CITY, STATE, ZIP CODE 001 CONNECTICUT AVENUE, NW /ASHINGTON, DC 20008	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MEMORITOR DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE D	BE CROSS- COMPLETION
F 514 SS=D	resident in accorda standards and praca accurately docume systematically orga. The clinical record information to ident resident's assessm services provided; preadmission scree and progress notes. This REQUIREME: Based on the revier record, it was deter to complete a disch resident. Resident. The findings includ. According to the fof a resident 5. a. Medical Director provithin 15 days of d. Summary will incluin prognosis (4) A to the resident receip pronounced dead in 28, 2006. There we record by the physical according to the physical prognosis	aintain clinical records on each ince with accepted professional citices that are complete; inted; readily accessible; and inized. must contain sufficient tify the resident; a record of the tents; the plan of care and the results of any ening conducted by the State; s. NT is not met as evidenced by w of one (1) of one (1) closed rmined that the physician failed harge summary for an expired #12 e: acility's policy titled, "Discharge "The physician or the Home's repares a Discharge Summary ischarge b. The Discharge de: (1) Diagnosis and otal recap of the resident's stay wed hospice care and was by the hospice nurse on June as no documentation in the ician to summarize the	F 514	F514 483.75(I)(1) Clinical Record-failure to complete discharge surfor an expired resident. Resident 1. Corrective Action for Reside Affected by Deficient Practice Discharge Summary has be completed by the Medical Director. August 24, 2006. 2. Method to Identify Other Residents At Risk for Deficient Practice: Medical Records Coordinator has completed chart reviews for all discharged residents to identify any closed records that do not have a discharge summary documented. These have been presented to the Medical Director for completion. August 31, 2006. 3. Measures or Systemic Chang to Ensure Deficient Practice Does Not Recur. • Medical Records Coordinato will provide to the Medical Director on a weekly basis any closed record in which the Discharge Summary has not been completed. October 6, 2006 (and ongo! • The Medical Director will complete the required documentation during his weekly visit. October 6, 2006 (and ongo! 4. Performance Monitoring to Solutions Are Sustained: Medical Records Coordinator monitor the process describe above and report compliance quarterly to the facility's QA Committee.	mary #12. mt Sec: em 08/24/06 10/6/06 & ongoing 10/6/06 & ongoing 10/6/06 a ongoing r will di
	August 23, 2006	e record was reviewed on		October 6, 2006.	

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PAGE 02/02

PRINTED: 09/01/2008

FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SI: RVICES

 OMB	NO.	0938-0	1
 (X3) DA	TESL	JRVEY	

CENTERS FOR MEDICARE	& MEDICAID SE TVIC
	(X1) PROVIDER/SUPFLIER/C
AND BLAN OF CORRECTION	IDENTIFICATION NUMBER

O(2) MULTIPLE CONSTRUCTION A BUILDING

COMPLETED

095038

B. WING

08/23/2006

NAME OF PROVIDER OR SUPPLIER

METHODIST HOME

STREET ADDRESS, CITY, STATE, ZIP CODE 4001 CONNECTICUT AVENUE, NW WASHINGTON, DC 20008

(X4) ID PREFIX TAG

SUMMARY STATEMENT OF DEFICIE CIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION PREFIX TAG

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY (%) COMPLETION DATE

F 000 INITIAL COMMENTS

An annual recertification survey was conducted on August 22 through 23, 2006. The following deficiencies were based on observe ions, staff and resident interviews and record neview. The sample size was 12 residents based on a census of 48 residents the first day of survey and two (2) supplemental records.

SS=D

F 176 483,10(n) SELF ADMINISTRATION OF DRUGS

An individual resident may self-adm nister drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this princtice is safe.

This REQUIREMENT is not met an evidenced by

Based on staff interview and record review for one (1) supplemental resident, it was determined that facility staff failed to reassess I esident JK1 for self-administration of medication.

The findings include:

A review of Resident JK1's record revealed a physician's order dated July 15, 20; 6, " Nitroglycerin 0.3 mg tablets. One triblet sublingually every 5 minutes for 3 closes as needed for angina."

According to a hand-written order on the August 2006 60-day orders signed August 3, 2006, Resident should be allowed to kee: nitro in this/ her room. Resident should be allowed to use it & report use later to RN."

The Assessment for Self-Administration of Medication" form dated April 25, 21/06, indicated F 0006

THIS PLAN OF CORRECTION IS SUBMITTED FOR PURPOSES OF RECULATORY COMPLIANCE AND AS PART OF THE METHODIST HOME'S ONGOING EFFORTS TO CONTINUOUSLY IMPROVE THE 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 176 483.10(n) Self Administration of Drugs - failure to assess Resident JK1 for self administration of drugs

 Corrective Action for Resident. Affected by Delicient Practice; The assessment of resident JK1's

capability to self administer his nitrogiyoerin tablets were completed on August 24, 2206. The Interdisciplinary team approved resident JK1 to self administer his medications as a result of

this assessment.

Mathod to Identify Other Residents At Risk for Deficient Practice:

Medical records were reviewed to identify residents who may have.

physician orders to self administer medications and who may not have been assessed per policy. No residents were identified.

Completed August 25, 2008.

- 3. Measures or Systemic Changes to Ensure Deficient Practice Doss Not Regur.
- Re-educate staff on selfadministration policy. Completion date: Oct 6, 2006

TITLE

08/25/08

08/24/06

10/06/06

(X8) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REP. ESENTATIVE'S SIGNATURE

5167

ADMINISTRATOR

11 SETTEMBER 2006

Any deficiency statement ending with an asterisk (") dann as 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 as provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made avail; ble 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) MULTI A. 9UILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
	095038	B. WING _		08/23/2006	
V11/10	ATEMENT OF DEFICIENCIES	ID 4	REET ADDRESS, CITY, STATE, ZIP CODE 901 CONNECTICUT AVENUE, NW VASHINGTON, DC 20008 PROVIDER'S PLAN OF CORRECT	TION (X5)	
1.02.00	MUST BE PRECEEDED BY FULL SCIDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE I		
approval to grant the self-administer me evidence in the recording to the fall Administering Med 4, "If the customer medications, the in assess the patient" ability to carry out to policy." A face-to-face intercharge nurse on A approximately 11:00 the resident had ni	Inary care team denied ne resident the opportunity to dication. There was no cord that the resident was re- idministration of medication. Incility's policy, "Self ications", number 2.2, Section r self administers his/her iter-disciplinary team must s cognitive, physical and visual this responsibility per Center review was conducted with the	F 176	 Revise Twenty-Four Hour Repolicy to require inclusion of residents being assessed for ability to self-administer medical 24-hour report. Completion do Oct. 6, 2006 Review 24-hour report daily to identify residents undergoing administration assessments. Sept. 1, 2006 Review charts of these resides after 3-day assessment periodensure assessment has been completed. Sept. 1, 2006 Performance Monitoring to Ensure Solutions Are Sustain Report findings in Quarterly QA meeting. Completion date: Oct. 6 2006. 	their s on ate: 10/06/06 o self- 09/01/06 o 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	
The facility must positive maintenance serving sanitary, orderly, at a sanitary orderly, at a sanitary orderly, at the facility maintenance serving ensure that the facility maintenance serving exhaust vents, based on the sanitary maintenance serving ensure that the facility maintenance serving ensure that the facility must provide the sanitary maintenance serving ensurements and the sanitary ensurements and the	rovide housekeeping and ces necessary to maintain a and comfortable interior. INT is not met as evidenced by tions during the survey period, that housekeeping and ces were not adequate to cility was maintained in a safe ier as evidenced by: soiled se surfaces on mechanical lifts ton top of closets and tables;	F 253	The light dust in the identifinstances did not negatively resident care and has been addressed as indicated on the following page.	impact	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	095038	B. WIN	IG		08/2	3/2006	
NAME OF PROVIDER OR SUPPLIER			4901 (ADDRESS, CITY, STATE, ZIP COD CONNECTICUT AVENUE, NW HINGTON, DC 20008	E		
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORF EACH CORRECTIVE ACTION SHOU EFERENCED TO THE APPROPRIA	JLD BE CROSS-	(XS) COMPLETION DATE	
F 253 Continued From p	age 2	F	253				
and marred chairs residents' rooms.	1		F	253 1. The light dust identified during was removed on the interior so of exhaust vents behind the grant and the	urfaces		
,	faces of exhaust vents in and common areas were soiled lowing areas:		2.	all cases, Grates were removed and the of all exhaust vents were chec dust on interior surface and ne	interior ked for	08/24/06	
room in five (5) of 11:10 AM and 12:	145, 147,153, 169 and bathing nine (9) observations between 30 PM on August 22, 2006.		3.	with all Maintenance Departm proper cleaning procedures.	nent on is aware to	08/24/06	
nine (9) observati PM on August 23	ons between 8:37 AM and 12:10 2006.			rounds. This information will on the Quarterly QA report are	be entered	08/28/06	
bathtubs were so the first and second 4:45 PM on Augu 12:10 PM on Augu 3. The top surface soiled with dust a 247, 249, 253 and observations betwo	ces of mechanical lifts and led with accumulated dust on and floors between 4:00 PM and st 22, 2006 and 11:10 AM and lust 23, 2006. es of tables and closets were and debris in rooms 145, 146, 1256 in six (6) of 18 ween 11:10 AM and 12:30 PM on and 8:37 AM and 9:30 AM on		1	dust on flat surfaces and no or were found to have dust. In-service conducted and doc	nd for thers	08/23/06 [08/23/06	
	The frontal areas of chairs, tables and foot boards were marred and scarred in residents'		4.	with all Light Duty Technician proper cleaning procedures. Housekeeping assignments up include weekly/monthly dusti tubs. The Housekeeping Supervisor	pdated to ing of lifts and	09/06/06	
	3 146, 147, 151 and 153 in four (ervations between 8:37 AM and ust 22, 2006.			monitor light dusting checks or rounds. This information will on the Quarterly QA report ar	on weekly be entered	09/06/06	

Statement of Deficiencies And Plan of Correction

Identification # 095038

F 253 3.

1.	The light dust identified during tour
	was removed in all cases.

- All resident rooms were checked for dust on flat surfaces of closets and furnishings and no others were found to have dust.
- In-service conducted and documented with all Light Duty Technicians on proper cleaning procedures.
 Housekeeping assignments updated to include weekly/monthly dusting where dust was identified in resident rooms.
- The Housekeeping Supervisor is aware to monitor light dusting checks on weekly rounds. This information will be entered on the Quarterly QA report and monitored.

F 253 4.

- The identified surfaces, of chairs, table legs and foot boards will be cleaned/repaired.
- All resident rooms and common areas to be surveyed by staff to determine and and schedule cleaned/repaired if identified.
- Condition of furniture will be added to daily housekeeping and maintenance rounds.
- The Supervisors are aware to repair damage as discovered. This information will be entered on the Quarterly QA report and monitored.

08/22/06

08/25/06

09/06/06

09/06/06

09/29/06

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09/29/06

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP		(X3) DATE SURVEY COMPLETED	
	095038	8. WING		08/23/2006	
NAME OF PROVIDER OR SUPPL	IER	49	EET ADDRESS, CITY, STATE, ZIP CODE NOT CONNECTICUT AVENUE, NW IASHINGTON, DC 20008		
PREFIX (EACH DEFICE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEEDED BY FULL OR LSC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE O REFERENCED TO THE APPROPRIATE DEFI	CROSS- COMPLETION	
3) of nine (9) of 12:10 PM on A 12:10 PM on A 483.20(k)(3)(i) SS=D The services produced must meet produce the services produced must be serviced medication be serviced must b	Rooms 249, 253 and 256 in three (bservations between 8:37 AM and ugust 23, 2006. COMPREHENSIVE CARE PLANS rovided or arranged by the facility fessional standards of quality. EMENT is not met as evidenced by ervations during the survey period, ned that facility staff failed to dimedications.	F 253	failure to discard expired medications 1. Corrective Action for Resident Affected Deficient Practice: The interim med box was replaced on the did of the deficient finding. Completed August 22, 2008. 2. Method to Identify Other Residents At I for Deficient Practice: No resident received expired meds from the interim box. Completed August 22, 2008. 3. Measures or Systemic Changes to Ens. Deficient Practice Does Not Recur: The night shift nurse will inspect all med received in the locked interim box weel when box is delivered. Any meds with expiration dates that occur prior to the of the month will be returned to pharma and replacements requested. Implementation date: August 29, 2006 (and ongoing). Nursing policy will be developed to sup this practice. All nurses will be trained of the implementation of this policy. Completion date: October 6, 2006 4. Performance Monitoring to Ensure Solutions Are Sustained: The night nurse will report weekly to the DON any expired meds received from the pharmacy. Findings will be documented.	by	
			and presented at the quarterly QA meeting. Implementation date: Septem 5, 2006 (and ongoing).	9/05/06 & ongoing	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M		PLE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		095038	8. WIN	√G_		08/	23/2006
	ROVIDER OR SUPPLIER			49	EET ADDRESS, CITY, STATE, ZIP CODE 301 CONNECTICUT AVENUE, NW /ASHINGTON, DC 20008	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX :	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHOU REFERENCED TO THE APPROPRIAT	LD BE CROSS-	
F 309 SS=D	Each resident must provide the necess or maintain the high mental, and psychological accordance with the and plan of care. This REQUIREME: Based on record record (1) of 12 samp determined that the pacemaker check (1) resident. Reside The findings included A physician's ordedirected, "Pacemak January". A review of the resident there was no evident had been completed had been completed as a complete charge nurse on All she acknowledged was not done in Julia controlled.	t receive and the facility must ary care and services to attain nest practicable physical, osocial well-being, in e comprehensive assessment NT is not met as evidenced by eview and staff interview for led residents, it was a facility staff failed to obtain a per physician's orders for one (nt #6.	F	309	physician order for resident #6. 1. Corrective Action for Resider Deficient Practice: The pacemaker check was obtaineresident. Completed August 24, 22. Method to Identify Other Residents Care Center who have pacereviewed to determine if pacereviewed to deficient. Completed August 3. Measures or Systemic Change ensure orders have been proportional to the checks have been identified (in off) on the new month's TAR. Implementation date: Septemic (and ongoing). TARs will be reviewed by the incurse (24-hour checks) to ensure pacemaker checks have been according to schedule. Any pacemaker checks have been according to schedule. Any pacemaker checks have been according to schedule. Any pacemaker checks that have not been conscheduled will be reported to the next day for follow up. Implement date: September 1, 2006 (and descenting). Results from the nightly reviews a to the facility's Quality Assurance Committee quarterly. Implement	ed for the 006. didents At Risis in the Healt makers were naker checks. None wast 28, 2006. Ges to Ensurate to perfy or pacemaker operfy or pacemaker as he DON the nentation ongoing). Insure completed as he DON the nentation ongoing). Insure	08/24/06 th 08/24/06 08/28/06 09/01/06 a ongoing 09/01/06 a ongoing
FORM CMS-2	567(02-99) Previous Versions	S Obsolete Event ID: MQCS11	Fé	cility I	September 30, 2006 (and ongoing)	L ,	eet & ongoing 18

STATEMENT OF DEFICIENCIES (X1) PROAND PLAN OF CORRECTION (DE		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL	JLTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		095038	B. WING	3	08/:	23/2006	
METHOD	ROVIDER OR SUPPLIER	ATEMENT OF DEFICIENCIES		STREET ADDRESS, CITY, STATE, ZIP C 4901 CONNECTICUT AVENUE, NV WASHINGTON, DC 20008	W		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFD TAG		HOULD BE CROSS-	(X5) COMPLETION DATE	
F 314 SS=D	Based on the compession of the	prehensive assessment of a y must ensure that a resident sility without pressure sores pressure sores unless the condition demonstrates that able; and a resident having peives necessary treatment and e healing, prevent infection and from developing. NT is not met as evidenced by the staff failed to maintain nile administering the treatment	F3	F314 483.25c Pressure So- failure to maintain clean to while administering the treat Resident #10. 1. Corrective Action for Affected by Deficient Nurse involved was immededucated regarding proper to be used when changing dressings. Completed Aug 2006. 2. Method to Ident Residents At Risk for Practice: Licensed nurses received of the facility's dressing protocol. Completed Aug 2006. The Skin Care Book was reviewed to identify res requiring dressing chare (including skin tears sin additional residents has pressure ulcers). Com August 24, 2006. Nurses were observed dressing changes by th Educator to ensure cor with the dressing chane protocol. Staff receive instruction/correction in where protocol was vio Completed August 30,	echnique atment to Resident Practice: diately r techniques residents' gust 23, tify Other or Deficient ved copies g change August 24, as sidents nges nce no ave apleted i performing ne Nurse mpliance ge d in instances olated.	08/23/06 08/24/06 08/24/06	

	10 I ON MILDIOMINE	WIND SERVICES					ONID NO.	0930-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA !DENTIFICATION NUMBER:	A. BUI	LDING	CONS	STRUCTION	(X3) DATE SI COMPLE	
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		TEMENT OF DEFICIENCIES	ID	4901 WAS	CON	RESS, CITY, STATE, ZIP CODE NECTICUT AVENUE, NW GTON, DC 20008 PROVIDER'S PLAN OF CORREC		(X5)
PREFIX TAG		MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAC			CORRECTIVE ACTION SHOULD ENCED TO THE APPROPRIATE D		COMPLETION
F 314	gauze pads, unscrepoured the NSS on were not washed a before the nurse of ointment and a dre. The National Press Frequently Asked (and Infection Controvaundinfection.htm woundinfection.htm woundinfect of clean (non-streat multiple ulcertone, start with the and move to the la contaminated appetitude of the contaminate dress containers (i.e., so have been in contain	three (3) packages of 4 x 4 and to the bottle of NSS and to the gauze pads. Hands and gloves were not changed eaned the left heel and applied ssing. Sure Ulcer Advisory Board, "Questions, Wound Infection to, "web site www.npuap.org/al>, revealed the following: question #309, "Care ash their hands before they from the (dressing) package in minate the dressings by ackage with soiled hands and/asponse of question #10, "One sterile) gloves can be used to so on the same patient. If this is a cleaner appearing wounds arger and /or most paring wounds. When in doubt, ween ulcers. Do not ing supplies and wound care lution bottles) with gloves that		314	4. Conobs	Measures or Systemic Charles In Ensure Deficient Pr. Does Not Recur: Expand current infection con education to emphasize clear dressing change technique. Completion date: September 2006. Schedule all nurses to demonstrate competency in dressing change technique as specific emphasis on infection control. Completion date: September 22, 2006. Performance Monitoring to Ensure Solutions Are Sustanpile data from competency ervations and present at quarmeeting. Completion date: ober 6, 2006.	actice and actice	09/15/06

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDI	TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	
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NAME OF PROVIDER OR SUPPLIER METHODIST HOME		S	REET ADDRESS, CITY, STATE, ZIP CO 4901 CONNECTICUT AVENUE, NW WASHINGTON, DC 20008		<i></i> 2000
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION SHO REFERENCED TO THE APPROPRI	DULD BE CROSS-	(X5) COMPLETION DATE
assessment, the factoresident who enters indwelling catheter resident's clinical content catheterization was who is incontinent of treatment and service infections and to resident as possible. This REQUIREMENT: Based on observation review for one (1) of determined that factore complete incontines who was diagnosed. The findings included A review of Resident was coded bladder in Section Industry on the Quarter assessment complete. The resident was diagnosed bladder in Section Industry on the Quarter assessment complete incontent was diagnosed bladder in Section Industry on the Quarter assessment complete incontent was diagnosed bladder in Section Industry on the Quarter assessment complete incontent was diagnosed bladder in Section Industry on the Quarter assessment complete incontent was diagnosed bladder in Section Industry on the Quarter assessment complete incontent was diagnosed bladder in Section Industry on July 12 course of antibiotic notation by the physical review of the physical revie	ent's comprehensive cility must ensure that a since the facility without an is not catheterized unless the condition demonstrates that necessary; and a resident of bladder receives appropriate ices to prevent urinary tract store as much normal bladder excessions. In the second residents, it was sillity staff failed to perform a not assessment for Resident #8 downth a urinary tract infection. The second revealed that the last incontinent of bowel and H (Continence in the last 14 erly Minimum Data Set eted July 20, 2006. The second revealed with an oral therapy. According to a sician on the laboratory report ne resident had a history of	F 31	F315 483.25(d) — Urinary Incofailure to perform complete incoassessment for Resident #8 wildiagnosed with a UTI. 1. Corrective Action for Resident Practice: Resident #8's Minimum Data Serviewed for the previous five of was assessed as incontinent the entirety of this period. Require cannot be documented retrosp Completion date: August 25, 26. Method to Identify Other Refor Deficient Practice: Minimum Data Sets have be all residents who were assessments in the month of August and who a assessments in the month of Completion date: August 3: Residents coded as inconting documented assessment to additional interventions, if a be implemented. Completion 31, 2006. 3. Measures or Systemic Charleston Practice Does No. Revise Incontinence Assessment Completion date: Septemble Incontinence Assessment retated documentation requirementation requirementation date: Septemble Completion date: Septemble Completi	dents Affected dets were quarters. She quarters. She aroughout the d assessments ectively. 106. desidents At Risk deen reviewed for dessed in the are scheduled for of September. I, 2006. dents August anges to Ensure of Recur: dessed in the policy. desidents August anges to Ensure of Recur: dessed in the policy. desidents August anges to Ensure of Recur: dessed in the policy. desidents August anges to Ensure of Recur: dessed in the policy. desidents August anges to Ensure of Recur: dessed in the policy. desidents August	08/25/06 ₁ 08/31/06 08/31/06

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	habits, and contine a. voiding patterns quality of stream e interventions." There was no evid complete assessm including the resid response to interve A face-to-face interventions /she acknowledge voiding pattern for for specific intervereviewed August 2	on about the resident's bladder ence or incontinence including: (frequency, volume, time, etc.)e. Response to lence in the record that a ment had been performed, ent's voiding pattern and entions. erview was conducted with the august 22, 2006 at 9:30 AM. He d that there was no record of a Resident #8 and no evaluation entions. The record was 22, 2006.		Provide guidance and instruction interdisciplinary care plan teat Coordinator regarding use of Assessment Protocols to supassessment of incontinence, develop appropriate care plans/management strategies. Completion date: September Monitor documentation on the Incontinence Assessment To ensure compliance with policinary variances and report to DON Implementation date: Septem (and ongoing). Performance Monitoring to Electronic Solutions Are Sustained: Compile data from monitoring act for presentation to the facility's Quantum Assurance (QA) Committee.	m and MDS Resident port the and to s. 22, 2006. e ool monthly to y. Document mber 29, 2006 nsure vity monthly uality ementation	09/22/06 09/2906 & ongoing
	Each resident's drunnecessary drug drug when used in duplicate therapy without adequate indications for its u adverse conseque should be reduced combinations of th This REQUIREME : Based on observareview for four (4)	ENT is not met as evidenced by stion, staff interview and record of 12 sampled residents, it was	F3	F329 483.25(I)(1) — Unnecessar - failure to monitor behavior of re- receiving antipsychotic (psychoad 1. Corrective Action for Reside by Deficient Practice: Behavior monitoring sheets were the 4 residents identified during the had this deficient practice. Comp September 1, 2006. 2. Method to Identify Other Re- for Deficient Practice: Residents receiving psychological positions were identified. Psychoactive Medication Re-	y Drugs sidents ctive) meds. ents Affected instituted for ne survey who letion date: sidents At Risk active using the	09/01/06
		acility staff failed to monitor the ints receiving antipsychotic		by the pharmacy. Completic September 1, 2006.	on date;	09/01/06

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI		LE CONSTRUCTION	(X3) DATE SU COMPLET	
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F 329	The findings includ 1. Facility staff faile Resident #2 who we medication. A review of Reside physician's order in and most recently Zoloft 25 mg daily to equal 37.5 mg dono evidence in the identified or monito. A face-to-face intercharge nurse on A He/she stated, "We antidepressant me The record was review of Resident #3 who we medication. A review of Reside physician's order in recently renewed Adaily for depression the record that face monitored depression. A face-to-face intercharge nurse on A He/she stated, "We antidepressant medication."	dents #2, 3, 4 and 5. e: ed to monitor behaviors for ras receiving an antidepressant ent #2' s record revealed a nitiated on December 20, 2002 renewed August 3, 2006, " and Zoloft 25 mg 1/2 tab daily aily for depression". There was record that facility staff had ored depressive behaviors. rview was conducted with the ugust 22, 2006 at 10:55 AM. e don't monitor behaviors for viewed August 22, 2006. ed to monitor behaviors for vas receiving an antidepressant ent #3's record revealed a nitiated on admission and most August 3, 2006, "Zoloft 100 mg n." There was no evidence in ility staff had identified or sive behaviors. rview was conducted with the august 22, 2006 at 10:55 AM. e don't monitor behaviors for	F 33		 In addition to the behavior monisheets already in place for residence receiving antipsychotic meds, it were also instituted for resident antidepressants, hypnotics, and drugs. Completion date: Septe 2006. Measures or Systemic Change Deficient Practice Does Not Report of Behavior Monitoring Sheets. Completion date: September 15. Educate staff on implementation policy and correct documentation included on the Behavior Monit Sheets. Completion date: September 2006. Performance Monitoring to Ensistency. Review Behavior Monitoring SI monthly basis for all residents. Psychoactive Medication Report of the pharmacy. Completion October 1, 2006 (and ongoing). Determine compliance with polappropriateness of documenta. Report quarterly to the facility's Assurance (QA) Committee. Odate: October 6, 2006 (and ongoing). 	dents nese sheets is receiving if anxiolytic imber 1, es to Ensure cur: oprlate use 3, 2006. In of the on to be toring tember 30, sure heets on a listed on the ort generated date: licy and dition. Is Quality Completion	09/01/06 09/15/06 09/30/06 10/1/06 & ongoing
	THE TECONY WAS TO	FIGHER FIRESON EZ, 2000.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED	
		095038	B. WII	NG_		08/23/2006
	ROVIDER OR SUPPLIER IST HOME			49	EET ADDRESS. CITY, STATE, ZIP 61 CONNECTICUT AVENUE, N ASHINGTON, DC 20008	CODE
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	3. Facility staff fair Resident #4 who insomnia. A review of Resid physician's order most recently renormated the effect of the properties of the physician of the physician's order most recently renormated the effect of the physician of the physician's order physician's physician's order physician'	led to monitor behaviors for was receiving a medication for ent #4's record revealed a initiated on July 6, 2006 and ewed on August 3, 2006, "0 mg tablet 1/2 tablet by mouth omnia". There was no evidence the facility staff had identified or ects of the medication. Perview was conducted with the August 22, 2006 at 10:55 AM. We don't monitor those kinds of ecord was reviewed August 22, and the facility staff had be received an antidepressant ent #5's record revealed a renewed August 3, 2006, by for depression and the facility staff had be record that facility staff had be record		329		

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER		49	EET ADDRESS, CITY, STATE, ZIP CODE 901 CONNECTICUT AVENUE, NW (ASHINGTON, DC 20008		
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	This REQUIREM This REQUIREM Based on observation and part and pa	estore, prepare, distribute, and sanitary conditions. ENT is not met as evidenced by ations during the survey period, distributed that dietary services were not are that foods were served and e and sanitary manner as illed stats on the dish machine, neet pans. These observations a presence of the Director of the dish willed with food and mineral coiled and clean side in one (1) of on at approximately 2:00 PM on a x 24 x 4 inches) washed in the coiled and grease and allowed se in seven (7) of nine (9) approximately 3:00 PM on August are stored with grease and ticles on the inner and outer allowed to dry before reuse in (9) observations at 3:15 PM on	F 371	F371 483.35(i)(2) SANITARY CONDITIONS - F PREP & SERVICE 1. The dish machine curtains we cleaned and sanitized. 2. Ecolab, our chemical companion notified about replacing our of the sanitation and breakdown of machine. 3. Director reviewed process an serviced the utility staff on proper sanitation and breakdown of machine. 4. Dining Services Director and Director will monitor complismonthly basis & present to the Administrator for review. We presented on a quarterly basis Quality Assurance Committee subsequent plans of correction and implemented as necessar. 1. Entire amount of hotel and she were rewashed and sanitized staff and supervised by the Director reviewed chemicals at the pot sink as well as the washing procedure. 3. Director had in-service with estaff on proper procedures for Pan washing. 4. Director & Asst. Director will compliance on a monthly basis present to the Administrator fill will then be presented on a question basis to the Quality Assurance with subsequent plans of corrected developed and implemented a	ny, was curtain. ad in- roper the Dish I Asst. ance on a ne fill then be s to the se, with on developed y. neet pans by the utility irector. that are used ware entire utility r Pot and I monitor is & will or review, uarterly e Committee ection	8/24/06 8/24/06 8/24/06 8/25/06 and ongoing 8/23/06 8/23/06 8/24/06

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	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP (4901 CONNECTICUT AVENUE, N WASHINGTON, DC 20008	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION S REFERENCED TO THE APPROP	SHOULD BE CROSS- CO	(X5) DMPLETION DATE
F 412 SS=D	an outside resourch) of this part, rou under the State plaservices to meet to must, if necessary appointments; and to and from the depromptly refer residentures to a denial service for two (2) determined that if annual dental screen for Reside A review of Residental screen had past 13 months. A face-to-face introcial social worker on a approximately 11 that the dental screen to a stated, "The requirements and the service of the service	y must provide or obtain from ce, in accordance with §483.75(tine (to the extent covered an); and emergency dental he needs of each resident; y, assist the resident in making d by arranging for transportation entist's office; and must idents with lost or damaged tist. ENT is not met as evidenced by ation, staff interview and record of 12 sampled residents, it was acility staff failed to provide an een. Residents #2 and 8. de: led to provide an annual dental ent #2. ent #2's record revealed that a id not been conducted within the erview was conducted within the erview was conducted with a August 22, 2006 at 100 AM. He/she acknowledged reen has not been done and est for the mobile dental unit list 1, 2006 and we [the facility]	F 412	F412 483.55(b) Dental Service failure to provide annual defor 2 of 12 residents. 1. Corrective Action for Residents by Deficient Practice: Dental referrals for residents by this deficient practice have forwarded to the Mobile Denappointments are pending. Cate: September 7, 2006. 2. Method to Identify Other Risk for Deficient Practice Medical records for all reside been reviewed to identify if a screens have been complete have been forwarded to the for the 4 residents identified. date: September 7, 2006. 3. Measures or Systemic Deficient Practice Does Residents' annual dental screen scheduled to coincide with the and Physical examinations. October 2, 2006 (and ongoin 4. Performance Monitorin Are Sustained. Monitoring will be accomplished in the medical record. Figuraterly in the QA meeting October 6, 2006 (and ongoin October 6, 2006 (and October 6	esidents Affected esidents Affected esidents Affected esidents Affected esidents Affected esidents At	ults

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F 426	resident had experioss. The record village of the record village of the record village of the record village of the record of the resident of the record village of the record village of the record village of the record of the record village of the record village of the record of the record village of the record villa	ence in the record that the rienced mouth pain or weight was reviewed August 22, 2006. The dot oprovide an annual dental at #8. Int #8's record revealed a red April 21, 2003. There was no cord that the dentist had lent after April 21, 2003. Inview with the Director of fucted on August 23, 2006 at 9: ated, "When we meet for care view dental screens and make thas had a screening yearly. In the cracks." In the record that the rienced mouth pain or weight was reviewed August 23, 2006. ACY SERVICES - In the record that the rienced mouth pain or weight was reviewed August 23, 2006. ACY SERVICES - In the record that the rienced mouth pain or weight was reviewed August 23, 2006. In the resident of the resident of the resident. In the record review for one of the resident of the residence of th	F 412	F426 483.80(a) Pharmacy Services- Principle to administer prescribed medication prescribed medications. 1. Corrective Action for Residents Affee by Deficient Practice: All non-prescribed medications have bee removed from the medication cart and an not available/administered to the resident Completion date: August 24, 2008.	ions and less with less wi	08/24/06
	() supplemental	sampled resident, it was				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI	LTIPLE CONSTRUCTION DING	(X3) DATE SUI COMPLET	
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF 4901 CONNECTICUT AVENUE, WASHINGTON, DC 20008	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES BY MUST BE PRECEEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTION REFERENCED TO THE APPRO	SHOULD BE CROSS-	(X5) COMPLETION DATE
F 426	prescribed medical prescribed medications. Resimedications. Resimedications. Resimedications for Resimedications for Resource of Resimedications for Resource of R	ne facility failed to administer ations and co-mingled non- ations with currently prescribed ident JK1. de: the medication cart revealed 32 esident JK1, dispensed from charmacies other than facility's y. rders signed on August 3, 2006 tine medications and four (4) as ons. All 21 medications were	F 4:	2. Method to Identify Other I Risk for Deficient Practice MARs of all residents have be medications currently administ prescribed meds are available/ residents. Completion date: S 3. Measures or Systemic Charletent Practice Does N • Advise residents and familiacompany residents to make a light prescriptions received to the nursing staff. This is from pharmacles other that contract pharmacy. Compact pharmacy. Compact pharmacy. Compact pharmacy. List all drugs prescribed for resident's POS and the M date: October 6, 2006 (an expand the consultant pharmonthly monitoring of Phyagainst meds available in Completion date: October 4. Performance Monitoring to Are Sustained. Consultant Pharmacist to report facility's QA meeting. Completion	en compared against ered to ensure only administered to ensure only administered to beptember 1, 2006. nanges to Ensure lot Recur: illy members who nedical appointments wed must be provided includes meds provided an the facility's pletion date: October 6, or residents on the AR. Completion ad ongoing), armacist's role to include visician Order Sheets the med cart. 1, 2006. 5 Ensure Solutions	09/01/07 10/6/06 & ongoing 10/6/06 & ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI	LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		095038	B. WING	·	08/23	3/2006
	ROVIDER OR SUPPLIER		;	STREET ADDRESS, CITY, STATE, ZIP CO 4901 CONNECTICUT AVENUE, NW WASHINGTON, DC 20008		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION SHO REFERENCED TO THE APPROPRI	OULD BE CROSS-	(X5) COMPLETION DATE
F 441 SS=D	The facility must exinfection control prisafe, sanitary, and to prevent the development of the development of the facility; decides isolation should be resident; and main corrective actions. This REQUIREMED Based on observant was determined maintain infection Resident #10. The findings included the facility of the findings included the findings included the finding that the f	stablish and maintain an ogram designed to provide a comfortable environment and elopment and transmission of ion. The facility must establish I program under which it ols, and prevents infections in a what procedures, such as applied to an individual stains a record of incidents and related to infections. INT is not met as evidenced by those during a wound treatment, that facility staff failed to control precautions for the control precautions	F 4	- failure to maintain infection control - failure to maintain infection control Resident #10. 1. Corrective Action for Resident / Deficient Practice: CNA involved was immediately edu infection control precautions with en transmission. Completed August 23 2. Method to Identify Other Reside Deficient Practice: - All staff received copies of the f infection control policies. Comp August 24, 2006. - Staff were observed by the Nur performing various tasks to ens with the policies, and received in instances where policy violate observed. Completed August 3 3. Measures or Systemic Change Deficient Practice Does Not Re - Revise infection control training emphasis on modes of transmit September 15, 2006. - Schedule all staff to demonstrate handling contaminated material appropriate precautions when p resident's clothing and other be residents' belongings, etc. Com September 22, 2006. 4. Performance Monitoring to Ensure Compile data from competency observ quarterly QA meeting. Completion dat (and ongoing).	Affected by cated regarding nphasis on modes of 1, 2006. ents At Risk for facility's pleted se Educator while sure compliance instruction/correction ions were 0,2006. s to Ensure cur: I program to expand to competency in the c	09/15/06 ng age of 09/22/06

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		08/23/2006	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
METHOD	DIST HOME			4901 CONNECTICUT AVENUE, N WASHINGTON, DC 20008		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF C (EACH CORRECTIVE ACTION S REFERENCED TO THE APPROP	HOULD BE CROSS- COMPLETION	
F 514 SS=D	resident in accord standards and procurately docum systematically organized in accurately docum systematically organized in accurately docum systematically organized in accurately document in accurate in accura	maintain clinical records on each dance with accepted professional actices that are complete; nented; readily accessible; and ganized. Id must contain sufficient entify the resident; a record of the ements; the plan of care and di; the results of any reening conducted by the State; res. ENT is not met as evidenced by liew of one (1) of one (1) closed termined that the physician failed echarge summary for an expired int #12	F 514	F514 483.75(I)(1) Clinical failure to complete dischafor an expired resident. Re Corrective Action for Affected by Deficient Discharge Summary completed by the Medical Director. August 24 Method to Identify Of Residents At Risk for Deficient Practice: Medical Records Coordinate completed chart reviews for discharged residents to identify any closed records that do have a discharge summary documented. These have be presented to the Medical D for completion. August 31 Measures or Systemic to Ensure Deficient I Does Not Recur. Medical Records Coordinate to the Medical Director on a weekly any closed record in the Discharge Summare not been completed. October 6, 2006 (and The Medical Director complete the required documentation during weekly visit. October 6, 2006 (and Performance Monitor Solutions Are Sustain Medical Records Coordinate and report conquarterly to the facility to the facility of the facili	arge summary esident #12. Resident t Practice: bas been edical 4, 2006. ther tor has r all ntify not een irector 1, 2006. c Changes Practice widinator fedical basis which ary has d ongoing). r will is his d ongoing). ring to Ensure ned; ordinator will described appliance	
		The record was reviewed on		QA Committee. October 6, 2006.	10/6/06	