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

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 _____	08/23/2006

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

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F 000	INITIAL COMMENTS An annual recertification survey was conducted on August 22 through 23, 2006. The following deficiencies were based on observations, staff and resident interviews and record review. The sample size was 12 residents based on a census of 48 residents the first day of survey and two (2) supplemental records.	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 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 SS=D	483.10(n) SELF ADMINISTRATION OF DRUGS An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review for one (1) supplemental resident, it was determined that facility staff failed to reassess Resident JK1 for self-administration of medication. The findings include; A review of Resident JK1's record revealed a physician's order dated July 15, 2006, " Nitroglycerin 0.3 mg tablets. One tablet sublingually every 5 minutes for 3 doses 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 keep nitro in [his/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, 2006, indicated	F 176	**F 176 483.10(n) Self Administration of Drugs** - failure to assess Resident JK1 for self administration of drugs 1. Corrective Action for Resident Affected by Deficient Practice: The assessment of resident JK1's capability to self administer his nitroglycerin tablets were completed on August 24, 2206. The interdisciplinary team approved resident JK1 to self administer his medications as a result of this assessment. 08/24/06 2. Method 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, 2006. 08/25/06 3. Measures or Systemic Changes to Ensure Deficient Practice Does Not Recur: • Re-educate staff on self-administration policy. Completion date: Oct 6, 2006 10/06/06	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

ADMINISTRATOR — 11 SEPTEMBER 2006

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 176	Continued From page 1 that the interdisciplinary care team denied approval to grant the resident the opportunity to self-administer medication. There was no evidence in the record that the resident was re-assessed for self-administration of medication. According to the facility's policy, "Self Administering Medications", number 2.2, Section 4, "If the customer self administers his/her medications, the inter-disciplinary team must assess the patient's cognitive, physical and visual ability to carry out this responsibility per Center policy." A face-to-face interview was conducted with the charge nurse on August 23, 2006 at approximately 11:00 AM. He/she confirmed that the resident had nitroglycerin tablets at the bedside. The record was reviewed on August 23, 2006.	F 176	• Revise Twenty-Four Hour Report policy to require inclusion of residents being assessed for their ability to self-administer meds on 24-hour report. Completion date: Oct. 6, 2006 • Review 24-hour report daily to identify residents undergoing self-administration assessments. Sept. 1, 2006 • Review charts of these residents after 3-day assessment period to ensure assessment has been completed. Sept. 1, 2006 4. Performance Monitoring to Ensure Solutions Are Sustained: Report findings in Quarterly QA meeting. Completion date: Oct. 6, 2006.	10/06/06 09/01/06 09/01/06 10/06/06
F 253 SS=E	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 the survey period, it was determined that housekeeping and maintenance services were not adequate to ensure that the facility was maintained in a safe and sanitary manner as evidenced by: soiled exhaust vents, base surfaces on mechanical lifts and bathtubs; dust on top of closets and tables;	F 253	The light dust in the identified instances did not negatively impact resident care and has been addressed as indicated on the following page.	

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F 253	Continued From page 2 and marred chairs, tables and foot boards in residents' rooms. The findings include: 1. The interior surfaces of exhaust vents in residents' rooms and common areas were soiled with dust in the following areas: First Floor Rooms 145, 147,153, 169 and bathing room in five (5) of nine (9) observations between 11:10 AM and 12:30 PM on August 22, 2006. Second Floor Rooms 249 and 261 in two (2) of nine (9) observations between 8:37 AM and 12:10 PM on August 23, 2006. 2. The base surfaces of mechanical lifts and bathtubs were soiled with accumulated dust on the first and second floors between 4:00 PM and 4:45 PM on August 22, 2006 and 11:10 AM and 12:10 PM on August 23, 2006. 3. The top surfaces of tables and closets were soiled with dust and debris in rooms 145, 146, 247, 249, 253 and 256 in six (6) of 18 observations between 11:10 AM and 12:30 PM on August 22, 2006 and 8:37 AM and 9:30 AM on August 23, 2006. 4. The frontal areas of chairs, tables and foot boards were marred and scarred in residents' rooms. First Floor Rooms 146, 147, 151 and 153 in four (4) of nine (9) observations between 8:37 AM and 12:10 PM on August 22, 2006.	F 253	F 253 1. 1. The light dust identified during tour was removed on the interior surfaces of exhaust vents behind the grates in all cases. 08/24/06 2. Grates were removed and the interior of all exhaust vents were checked for dust on interior surface and no others were found to have dust. 08/24/06 3. In-service conducted and documented with all Maintenance Department on proper cleaning procedures. 08/28/06 4. The Maintenance Supervisor is aware to monitor light dusting checks on monthly rounds. This information will be entered on the Quarterly QA report and monitored. 08/28/06 F 253 2. 1. The light dust identified on the mechanical Lift and tube during tour was removed in all cases. 08/23/06 2. All lifts and tubs were checked for dust on flat surfaces and no others were found to have dust. 08/23/06 3. In-service conducted and documented with all Light Duty Technicians on proper cleaning procedures. Housekeeping assignments updated to include weekly/monthly dusting of lifts and tubs. 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 253 3.

1. The light dust identified during tour was removed in all cases.	08/22/06
2. All resident rooms were checked for 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. Housekeeping 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 253 4.

1. The identified surfaces, of chairs, table legs and foot boards will be cleaned/repaired.	09/29/06
2. All resident rooms and common areas to 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 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.	09/29/06

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F 253	Continued From page 3 Second Floor Rooms 249, 253 and 256 in three (3) of nine (9) observations between 8:37 AM and 12:10 PM on August 23, 2006.	F 253		
F 281 SS=D	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by : Based on observations during the survey period, it was determined that facility staff failed to discard expired medications. The findings include: On August 22, 2006, the locked interim medication box, located in the medication room at the 2nd floor nursing station was inspected. The expiration date written on the interim medication box was "8/06". This indicated that the medications in the box were valid until the end of the month and the box should be returned to the contract pharmacy by August 31, 2006. The interim medication box was opened and medications were randomly inspected. Nine (9) of 10 Nitrofurantoin 100 mg capsules had an expiration date of August 2, 2006. The Nitrofurantoin capsules were available for use 20 days after they had expired. There was no evidence that any resident had received this medication after it had expired.	F 281	**F281 483.20 (k)(3)(i) – Comprehensive Care Plans -** failure to discard expired medications 1. Corrective Action for Resident Affected by Deficient Practice: The interim med box was replaced on the day of the deficient finding. **Completed August 22, 2006.** 2. Method to Identify Other Residents At Risk for Deficient Practice: No resident received expired meds from the interim box. **Completed August 22, 2006.** 3. Measures or Systemic Changes to Ensure Deficient Practice Does Not Recur: • The night shift nurse will inspect all meds received in the locked interim box weekly when box is delivered. Any meds with expiration dates that occur prior to the end of the month will be returned to pharmacy and replacements requested. Implementation date: August 29, 2006 (and ongoing). • Nursing policy will be developed to support this practice. All nurses will be trained on 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 and presented at the quarterly QA meeting. Implementation date: **September 5, 2006 (and ongoing).**	08/22/06 08/22/06 08/29/06 10/06/06 9/05/06 & ongoing

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F 309 SS=D	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by : Based on record review and staff interview for one (1) of 12 sampled residents, it was determined that the facility staff failed to obtain a pacemaker check per physician's orders for one (1) resident. Resident #6. The findings include: A physician's order initiated on June 23, 2006 directed,"Pacemaker check every July-October-January". A review of the resident's record revealed that there was no evidence that a pacemaker check had been completed at the time of this review. A face-to-face interview was conducted with the charge nurse on August 22, 2006 at 4:12 PM. He /she acknowledged that the pacemaker check was not done in July and had not been completed at this time. The record was review on August 22 , 2006.	F 309	**F309 483.25 Quality of Care** - failure to obtain pacemaker check per physician order for resident #6. 1. Corrective Action for Resident Affected by Deficient Practice: The pacemaker check was obtained for the resident. **Completed August 24, 2006.** 2. Method to Identify Other Residents At Risk for Deficient Practice: Medical records of the 3 residents in the Health Care Center who have pacemakers were reviewed to determine if pacemaker checks were current per physician orders. None was found deficient. **Completed August 28, 2006.** 3. Measures or Systemic Changes to Ensure Deficient Practice Does Not Recur: • Nurses will continue to review TARs during the end-of-the-month changeover to ensure orders have been properly transcribed and dates/times for pacemaker checks have been identified (i.e. "blocked off") on the new month's TAR. Implementation date: **September 1, 2006 (and ongoing).** • TARs will be reviewed by the night shift nurse (24-hour checks) to ensure pacemaker checks have been completed according to schedule. Any pacemaker checks that have not been completed as scheduled will be reported to the DON the next day for follow up. Implementation date: **September 1, 2006 (and ongoing).** 4. Performance Monitoring to Ensure Solutions Are Sustained: Results from the nightly reviews are presented to the facility's Quality Assurance (QA) Committee quarterly. Implementation date: **September 30, 2006 (and ongoing).**	08/24/06 08/28/06 09/01/06 & ongoing 09/01/06 & ongoing 09/30/06 & ongoing

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F 314 SS=D	483.25(c) PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by : Based on observation of a wound treatment for one (1) resident, facility staff failed to maintain clean technique while administering the treatment . Resident #10 The findings include: A wound treatment for bilateral necrotic heels was observed on August 22, 2006 at 2:40 PM. The nurse washed hands, donned gloves and removed the slippers and dressings from the left and right heels. The right heel had an approximately one (1) inch areas with a small amount of blood present. The left heel had no drainage. After washing hands, the nurse picked up the box of gloves and donned clean gloves. The nurse cleaned the right heel with 4 x 4 gauze pads previously moistened with normal sterile saline (NSS). He/she then picked up the tube of enzymatic ointment, applied the ointment onto a sterile cotton tipped applicator and applied the ointment to the right heel. Sterile 4 x 4 gauze pads and sterile gauze were applied to the wound	F 314	**F314 483.25c Pressure Sores** - failure to maintain clean technique while administering the treatment to Resident #10. 1. Corrective Action for Resident Affected by Deficient Practice: Nurse involved was immediately educated regarding proper techniques to be used when changing residents' dressings. Completed August 23, 2006.	08/23/06
			2. Method to Identify Other Residents At Risk for Deficient Practice: • Licensed nurses received copies of the facility's dressing change protocol. Completed August 24, 2006.	08/24/06
			• The Skin Care Book was reviewed to identify residents requiring dressing changes (including skin tears since no additional residents have pressure ulcers). Completed August 24, 2006.	08/24/06
			• Nurses were observed performing dressing changes by the Nurse Educator to ensure compliance with the dressing change protocol. Staff received instruction/correction in instances where protocol was violated. Completed August 30, 2006.	08/30/06

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F 314	Continued From page 6 The nurse opened three (3) packages of 4 x 4 gauze pads, unscrewed the bottle of NSS and poured the NSS onto the gauze pads. Hands were not washed and gloves were not changed before the nurse cleaned the left heel and applied ointment and a dressing. The National Pressure Ulcer Advisory Board, " Frequently Asked Questions, Wound Infection and Infection Control, " web site www.npuap.org/ woundinfection.html <http://www.npuap.org/ woundinfection.html>, revealed the following; In the response to question #309, " Care providers should wash their hands before they remove dressings from the (dressing) package in order to not contaminate the dressings by reaching into the package with soiled hands and/ or gloves. " According to the response of question #10, " One pair of clean (non-sterile) gloves can be used to treat multiple ulcers on the same patient. If this is done, start with the cleaner appearing wounds and move to the larger and /or most contaminated appearing wounds. When in doubt, change gloves between ulcers. Do not contaminate dressing supplies and wound care containers (i.e., solution bottles) with gloves that have been in contact with the ulcer. " The nurse administered the wound treatment to the cleaner wound first. Additionally, the nurse picked up a box of gloves, squeezed ointment from a tube, opened packages of gauze pads and a bottle of NSS without washing hands and changing gloves between these actions.	F 314	3. Measures or Systemic Changes to Ensure Deficient Practice Does Not Recur: • Expand current infection control education to emphasize clean dressing change technique. Completion date: September 15, 2006. • Schedule all nurses to demonstrate competency in dressing change technique with specific emphasis on infection control. Completion date: September 22, 2006. 4. Performance Monitoring to Ensure Solutions Are Sustained: Compile data from competency observations and present at quarterly QA meeting. Completion date: October 6, 2006.	09/15/06 0922/06 10/06/06

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F 315 SS=D	483.25(d) URINARY INCONTINENCE Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by : Based on observation, interview and record review for one (1) of 12 sampled residents, it was determined that facility staff failed to perform a complete incontinent assessment for Resident #8 who was diagnosed with a urinary tract infection. The findings include: A review of Resident #8's record revealed that the resident was coded as incontinent of bowel and bladder in Section H (Continence in the last 14 days) on the Quarterly Minimum Data Set assessment completed July 20, 2006. The resident was diagnosed with a urinary tract infection on July 12, 2006 and treated with an oral course of antibiotic therapy. According to a notation by the physician on the laboratory report for the urinalysis, the resident had a history of chronic renal insufficiency. According to the facility's policy entitled, " Incontinence Assessment" dated January 23, 2006, page 1, under #3, "Monitor, record and	F 315	**F315 483.25(d) – Urinary Incontinence** – - - - failure to perform complete incontinent assessment for Resident #8 who was diagnosed with a UTI. 1. Corrective Action for Residents Affected by Deficient Practice: Resident #8's Minimum Data Sets were reviewed for the previous five quarters. She was assessed as incontinent throughout the entirety of this period. Required assessments cannot be documented retrospectively. **Completion date: August 25, 2006.** 2. Method to Identify Other Residents At Risk for Deficient Practice: • Minimum Data Sets have been reviewed for all residents who were assessed in the month of August and who are scheduled for assessments in the month of September. **Completion date: August 31, 2006.** • Residents coded as incontinent have a documented assessment to indicate additional interventions, if any, that should be implemented. **Completion date: August 31, 2006.** 3. Measures or Systemic Changes to Ensure Deficient Practice Does Not Recur: • Revise Incontinence Assessment Tool to include all factors listed in the Incontinence Assessment Policy. **Completion date: September 15, 2006.** • Re-educate staff on implementation of the Incontinence Assessment Policy and related documentation requirements. **Completion date: September 22, 2006.**	08/25/06 08/31/06 08/31/06 09/15/06 09/22/06

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F 315	Continued From page 8 evaluate information about the resident's bladder habits, and continence or incontinence including: a. voiding patterns (frequency, volume, time, quality of stream etc.) ...e. Response to interventions." There was no evidence in the record that a complete assessment had been performed, including the resident's voiding pattern and response to interventions. A face-to-face interview was conducted with the charge nurse on August 22, 2006 at 9:30 AM. He /she acknowledged that there was no record of a voiding pattern for Resident #8 and no evaluation for specific interventions. The record was reviewed August 22, 2006.	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 date: **October 6, 2006 (and ongoing).**	09/22/06 09/2906 & ongoing 10/06/06
F 329 SS=D	483.25(l)(1) UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. This REQUIREMENT is not met as evidenced by Based on observation, staff interview and record review for four (4) of 12 sampled residents, it was determined that facility staff failed to monitor the behavior of residents receiving antipsychotic	F 329	**F329 483.25(l)(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 Risk for Deficient Practice: • Residents receiving psychoactive medications were identified using the Psychoactive Medication Report generated by the pharmacy. **Completion date: September 1, 2006.**	09/01/06 09/01/06

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F 329	Continued From page 9 medications. Residents #2, 3, 4 and 5. The findings include: 1. Facility staff failed to monitor behaviors for Resident #2 who was receiving an antidepressant medication. A review of Resident #2' s record revealed a physician's order initiated on December 20, 2002 and most recently renewed August 3, 2006, " Zoloft 25 mg daily and Zoloft 25 mg 1/2 tab daily to equal 37.5 mg daily for depression". There was no evidence in the record that facility staff had identified or monitored depressive behaviors. A face-to-face interview was conducted with the charge nurse on August 22, 2006 at 10:55 AM. He/she stated, "We don't monitor behaviors for antidepressant medication" The record was reviewed August 22, 2006. 2. Facility staff failed to monitor behaviors for Resident #3 who was receiving an antidepressant medication. A review of Resident #3's record revealed a physician's order initiated on admission and most recently renewed August 3, 2006, "Zoloft 100 mg daily for depression." There was no evidence in the record that facility staff had identified or monitored depressive behaviors. A face-to-face interview was conducted with the charge nurse on August 22, 2006 at 10:55 AM. He/she stated, "We don't monitor behaviors for antidepressant medication." The record was reviewed August 22, 2006.	F 329	• In addition to the behavior monitoring sheets already in place for residents receiving antipsychotic meds, these sheets were also instituted for residents receiving antidepressants, hypnotics, and anxiolytic drugs. **Completion date: September 1, 2006.**	09/01/06
			3. <u>Measures or Systemic Changes to Ensure Deficient Practice Does Not Recur:</u> • Develop policy regarding appropriate use of Behavior Monitoring Sheets. **Completion date: September 15, 2006.**	09/15/06
			• Educate staff on implementation of the policy and correct documentation to be included on the Behavior Monitoring Sheets. **Completion date: September 30, 2006.**	09/30/06
			4. <u>Performance Monitoring to Ensure Solutions Are Sustained.</u> • Review Behavior Monitoring Sheets on a monthly basis for all residents listed on the Psychoactive Medication Report generated by the pharmacy. **Completion date: October 1, 2006 (and ongoing).**	10/1/06 & ongoing
			• Determine compliance with policy and appropriateness of documentation. • Report quarterly to the facility's Quality Assurance (QA) Committee. **Completion date: October 6, 2006 (and ongoing).**	10/6/06 & ongoing

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	095038	A. BUILDING _____ B. WING _____	08/23/2006

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F 329	Continued From page 10 3. Facility staff failed to monitor behaviors for Resident #4 who was receiving a medication for insomnia. A review of Resident #4's record revealed a physician's order initiated on July 6, 2006 and most recently renewed on August 3, 2006, " Trazodone HCL 50 mg tablet 1/2 tablet by mouth at bedtime for Insomnia". There was no evidence in the record that the facility staff had identified or monitored the effects of the medication. A face-to-face interview was conducted with the charge nurse on August 22, 2006 at 10:55 AM. He/she stated, "We don't monitor those kinds of behaviors." The record was reviewed August 22, 2006. 4. Facility staff failed to monitor behaviors for Resident #5 who was receiving an antidepressant medication. A review of Resident #5's record revealed a physician's order renewed August 3, 2006, "Zoloft 25 mg daily for depression" There was no evidence in the record that facility staff had identified or monitored depressive behaviors. A face-to-face interview was conducted with the charge nurse on August 22, 2006 at 10:55 AM. He/she stated, "We don't monitor behaviors for antidepressant medication." The record was reviewed August 22, 2006.	F 329		

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F 371 SS=E	483.35(i)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by : Based on observations during the survey period, it was determined that dietary services were not adequate to ensure that foods were served and prepared in a safe and sanitary manner as evidenced by: soiled slats on the dish machine, hotel pans and sheet pans. These observations were made in the presence of the Director of Dietary Services. The findings include: 1. The outer surfaces of plastic slats on the dish machine were soiled with food and mineral deposits on the soiled and clean side in one (1) of one (1) observation at approximately 2:00 PM on August 22, 2006. 2. Hotel pans (14 x 24 x 4 inches) washed in the pot and pan wash area were not thoroughly cleaned of food residue and grease and allowed to dry before reuse in seven (7) of nine (9) observations at approximately 3:00 PM on August 22, 2006. 3. Sheet pans were stored with grease and residual food particles on the inner and outer surfaces and not allowed to dry before reuse in eight (8) of nine (9) observations at 3:15 PM on August 22, 2006.	F 371	**F371 483.35(i)(2) SANITARY CONDITIONS – FOOD PREP & SERVICE** 1. The dish machine curtains were re-cleaned and sanitized. 8/24/06 2. Ecolab, our chemical company, was notified about replacing our curtain. 8/24/06 3. Director reviewed process and in-serviced the utility staff on proper sanitation and breakdown of the Dish machine. 8/24/06 4. Dining Services Director and Asst. Director will monitor compliance on a monthly basis & present to the Administrator for review. Will then be presented on a quarterly basis to the Quality Assurance Committee, with subsequent plans of correction developed and implemented as necessary. 8/25/06 and ongoing 1. Entire amount of hotel and sheet pans were rewashed and sanitized by the utility staff and supervised by the Director. 2. Director reviewed chemicals that are used at the pot sink as well as the ware washing procedure. 8/23/06 3. Director had in-service with entire utility staff on proper procedures for Pot and Pan washing. 8/23/06 4. Director & Asst. Director will monitor compliance on a monthly basis & will present to the Administrator for review. Will then be presented on a quarterly basis to the Quality Assurance Committee with subsequent plans of correction developed and implemented as necessary. 8/24/06 8/25/06 and ongoing	

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F 412 SS=D	483.55(b) DENTAL SERVICES - NF The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by : Based on observation, staff interview and record review for two (2) of 12 sampled residents, it was determined that facility staff failed to provide an annual dental screen. Residents #2 and 8. The findings include: 1. Facility staff failed to provide an annual dental screen for Resident #2. A review of Resident #2's record revealed that a dental screen had not been conducted within the past 13 months. A face-to-face interview was conducted with a social worker on August 22, 2006 at approximately 11:00 AM. He/she acknowledged that the dental screen has not been done and stated, "The request for the mobile dental unit was sent on August 1, 2006 and we [the facility] are waiting for the dental visit."	F 412	**F412 483.55(b) Dental Services** - failure to provide annual dental screen for 2 of 12 residents. 1. Corrective Action for Residents Affected by Deficient Practice: Dental referrals for residents affected by this deficient practice have been forwarded to the Mobile Dentist; appointments are pending. Completion date: September 7, 2006. 2. Method to Identify Other Residents At Risk for Deficient Practice: Medical records for all residents have been reviewed to identify if annual dental screens have been completed. Referrals have been forwarded to the Mobile Dentist for the 4 residents identified. Completion date: September 7, 2006. 3. Measures or Systemic Changes to Ensure Deficient Practice Does Not Recur: Residents' annual dental screens have now been scheduled to coincide with the annual History and Physical examinations. Completion date: October 2, 2006 (and ongoing). 4. Performance Monitoring to Ensure Solutions Are Sustained. Monitoring will be accomplished by randomly comparing the annual dental screen schedule with dental consults filed in the medical record. Findings will be reported quarterly in the QA meeting. Completion date: October 6, 2006 (and ongoing).	09/07/06 09/07/06 10/2/06 & ongoing 10/6/06 & ongoing

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F 412	Continued From page 13 There was no evidence in the record that the resident had experienced mouth pain or weight loss. The record was reviewed August 22, 2006. 2. Facility staff failed to provide an annual dental screen for Resident #8. A review of Resident #8's record revealed a dental screen dated April 21, 2003. There was no evidence in the record that the dentist had screened the resident after April 21, 2003. A face-to-face interview with the Director of Nursing was conducted on August 23, 2006 at 9: 20 AM. He/she stated, "When we meet for care conference, we review dental screens and make sure each resident has had a screening yearly. This just fell through the cracks." There was no evidence in the record that the resident had experienced mouth pain or weight loss. The record was reviewed August 23, 2006.	F 412		
F 426 SS=D	483.60(a) PHARMACY SERVICES - PROCEDURES 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. This REQUIREMENT is not met as evidenced by : Based on observations and record review for one (1) supplemental sampled resident, it was	F 426	**F426 483.60(a) Pharmacy Services- Procedures** - failure to administer prescribed medications and co-mingling of non-prescribed medications with prescribed medications. 1. Corrective Action for Residents Affected by Deficient Practice: All non-prescribed medications have been removed from the medication cart and are not available/administered to the resident. Completion date: August 24, 2006.	08/24/06

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F 426	Continued From page 14 determined that the facility failed to administer prescribed medications and co-mingled non-prescribed medications with currently prescribed medications. Resident JK1. The findings include: An inspection of the medication cart revealed 32 medications for Resident JK1, dispensed from four (4) different pharmacies other than facility's contract pharmacy. The physician's orders signed on August 3, 2006 prescribed 17 routine medications and four (4) as needed medications. All 21 medications were present in the medication cart. In addition to the prescribed medications, six (6) medications currently not prescribed were co-mingled in the medication cart,Ultram 50 mg, Synthroid 0.1 mg, Altace 5 mg, Fosamax 70 mg, Docusate Na 100 mg and Citracal (Calcium 630 mg and Vitamin D 400 International Units). During observation of medication pass on August 23, 2006 at approximately 8:45 AM, two (2) of the six (6) non-prescribed medications were administered to the resident, Citracal and Docusate Na. A face-to-face interview with the medication nurse was conducted on August 23, 2006 at 11:30 AM. He/she acknowledged that the Citracal and Docusate were not prescribed by the physician and additional medications not prescribed were co-mingled with currently prescribed medications. The record was reviewed on August 23, 2006.	F 426	2. Method to Identify Other Residents At Risk for Deficient Practice: MARs of all residents have been compared against medications currently administered to ensure only prescribed meds are available/administered to residents. Completion date: September 1, 2006. 3. Measures or Systemic Changes to Ensure Deficient Practice Does Not Recur: • Advise residents and family members who accompany residents to medical appointments that all prescriptions received must be provided to the nursing staff. This includes meds provided from pharmacies other than the facility's contract pharmacy. Completion date: October 6, 2006 (and ongoing). • List all drugs prescribed for residents on the resident's POS and the MAR. Completion date: October 6, 2006 (and ongoing). • Expand the consultant pharmacist's role to include monthly monitoring of Physician Order Sheets against meds available in the med cart. Completion date: October 1, 2006. 4. Performance Monitoring to Ensure Solutions Are Sustained. Consultant Pharmacist to report quarterly on findings at facility's QA meeting. Completion date: October 6, 2006.	09/01/07 10/6/06 & ongoing 10/6/06 & ongoing 10/1/06 10/6/06

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F 441 SS=D	483.65(a) INFECTION CONTROL The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections. This REQUIREMENT is not met as evidenced by : Based on observations during a wound treatment, it was determined that facility staff failed to maintain infection control precautions for Resident #10. The findings include: A wound treatment for Resident #10 was observed on August 22, 2006 at 2:40 PM. A Certified Nurse Aide (CNA) was assisting the nurse during the treatment. The CNA was observed removing a "light cover" from the resident, folded it up and placed it in the roommate's closet prior to the treatment. After the wound treatment was completed, the CNA removed the "light cover" from the roommate's closet and placed it on the resident.	F 441	**F441 483.65(a) Infection Control** - failure to maintain infection control precautions for Resident #10. 1. Corrective Action for Resident Affected by Deficient Practice: CNA involved was immediately educated regarding infection control precautions with emphasis on modes of transmission. **Completed August 23, 2006.** 2. Method to Identify Other Residents At Risk for Deficient Practice: • All staff received copies of the facility's infection control policies. **Completed August 24, 2006.** • Staff were observed by the Nurse Educator while performing various tasks to ensure compliance with the policies, and received instruction/correction in instances where policy violations were observed. **Completed August 30,2006.** 3. Measures or Systemic Changes to Ensure Deficient Practice Does Not Recur: • Revise infection control training program to expand emphasis on modes of transmission. **Completion date: September 15, 2006.** • Schedule all staff to demonstrate competency in handling contaminated materials correctly, maintaining appropriate precautions when placing or removing resident's clothing and other belongings, proper storage of residents' belongings, etc. **Completion date: September 22, 2006.** 4. Performance Monitoring to Ensure Solutions Are Sustained: Compile data from competency observations and present at quarterly QA meeting. Completion date: October 6, 2006 (and ongoing).	08/23/06 08/24/06 08/30/06 09/15/06 09/22/06 10./6/06

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F 514 SS=D	483.75(l)(1) CLINICAL RECORDS The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by : Based on the review of one (1) of one (1) closed record, it was determined that the physician failed to complete a discharge summary for an expired resident. Resident #12 The findings include: According to the facility's policy titled, "Discharge of a resident 5. a. "The physician or the Home's Medical Director prepares a Discharge Summary within 15 days of discharge b. The Discharge Summary will include: (1) Diagnosis and prognosis... (4) A total recap of the resident's stay " The resident received hospice care and was pronounced dead by the hospice nurse on June 28, 2006. There was no documentation in the record by the physician to summarize the resident's stay. The record was reviewed on August 23, 2006	F 514	**F514 483.75(l)(1) Clinical Records** -failure to complete discharge summary for an expired resident. Resident #12. 1. Corrective Action for Resident Affected by Deficient Practice: Discharge Summary has been completed by the Medical Director. **August 24, 2006.** — 08/24/06 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.** — 08/31/06 3. Measures or Systemic Changes to Ensure Deficient Practice Does Not Recur: • Medical Records Coordinator 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 ongoing).** — 10/6/06 & ongoing • The Medical Director will complete the required documentation during his weekly visit. **October 6, 2006 (and ongoing).** — 10/6/06 & ongoing 4. Performance Monitoring to Ensure Solutions Are Sustained: Medical Records Coordinator will monitor the process described above and report compliance quarterly to the facility's QA Committee. **October 6, 2006.** — 10/6/06	

POC accepted revised 9/27/06 9/27/06

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

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F 000	INITIAL COMMENTS An annual recertification survey was conducted on August 22 through 23, 2006. The following deficiencies were based on observations, staff and resident interviews and record review. The sample size was 12 residents based on a census of 48 residents the first day of survey and two (2) supplemental records.	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 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 SS=D	483.10(n) SELF ADMINISTRATION OF DRUGS An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review for one (1) supplemental resident, it was determined that facility staff failed to reassess Resident JK1 for self-administration of medication. The findings include; A review of Resident JK1's record revealed a physician's order dated July 15, 2006, " Nitroglycerin 0.3 mg tablets. One tablet sublingually every 5 minutes for 3 doses 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 keep nitro in [his/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, 2006, indicated		**F 176 483.10(n) Self Administration of Drugs - failure to assess Resident JK1 for self administration of drugs** 1. Corrective Action for Resident Affected by Deficient Practice: The assessment of resident JK1's capability to self administer his nitroglycerin tablets were completed on August 24, 2206. The interdisciplinary team approved resident JK1 to self administer his medications as a result of this assessment.	08/24/06
			2. Method 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, 2006.	08/25/06
			3. Measures or Systemic Changes to Ensure Deficient Practice Does Not Recur: • Re-educate staff on self-administration policy. Completion date: Oct 6, 2006	10/06/06

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	ADMINISTRATOR	11 SEPTEMBER 2006

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 176	Continued From page 1 that the interdisciplinary care team denied approval to grant the resident the opportunity to self-administer medication. There was no evidence in the record that the resident was re-assessed for self-administration of medication. According to the facility's policy, "Self Administering Medications", number 2.2, Section 4, "If the customer self administers his/her medications, the inter-disciplinary team must assess the patient's cognitive, physical and visual ability to carry out this responsibility per Center policy." A face-to-face interview was conducted with the charge nurse on August 23, 2006 at approximately 11:00 AM. He/she confirmed that the resident had nitroglycerin tablets at the bedside. The record was reviewed on August 23, 2006.	F 176	• Revise Twenty-Four Hour Report policy to require inclusion of residents being assessed for their ability to self-administer meds on 24-hour report. Completion date: Oct. 6, 2006 • Review 24-hour report daily to identify residents undergoing self-administration assessments. Sept. 1, 2006 • Review charts of these residents after 3-day assessment period to ensure assessment has been completed. Sept. 1, 2006 4. Performance Monitoring to Ensure Solutions Are Sustained: Report findings in Quarterly QA meeting. Completion date: Oct. 6, 2006.	10/06/06 09/01/06 09/01/06 10/06/06
F 253 SS=E	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 the survey period, it was determined that housekeeping and maintenance services were not adequate to ensure that the facility was maintained in a safe and sanitary manner as evidenced by: soiled exhaust vents, base surfaces on mechanical lifts and bathtubs; dust on top of closets and tables;	F 253	The light dust in the identified instances did not negatively impact resident care and has been addressed as indicated on the following page.	

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F 253	Continued From page 2 and marred chairs, tables and foot boards in residents' rooms. The findings include: 1. The interior surfaces of exhaust vents in residents' rooms and common areas were soiled with dust in the following areas: First Floor Rooms 145, 147,153, 169 and bathing room in five (5) of nine (9) observations between 11:10 AM and 12:30 PM on August 22, 2006. Second Floor Rooms 249 and 261 in two (2) of nine (9) observations between 8:37 AM and 12:10 PM on August 23, 2006. 2. The base surfaces of mechanical lifts and bathtubs were soiled with accumulated dust on the first and second floors between 4:00 PM and 4:45 PM on August 22, 2006 and 11:10 AM and 12:10 PM on August 23, 2006. 3. The top surfaces of tables and closets were soiled with dust and debris in rooms 145, 146, 247, 249, 253 and 256 in six (6) of 18 observations between 11:10 AM and 12:30 PM on August 22, 2006 and 8:37 AM and 9:30 AM on August 23, 2006. 4. The frontal areas of chairs, tables and foot boards were marred and scarred in residents' rooms. First Floor Rooms 146, 147, 151 and 153 in four (4) of nine (9) observations between 8:37 AM and 12:10 PM on August 22, 2006.	F 253	F 253 1. 1. The light dust identified during tour was removed on the interior surfaces of exhaust vents behind the grates in all cases. — 08/24/06 2. Grates were removed and the interior of all exhaust vents were checked for dust on interior surface and no others were found to have dust. — 08/24/06 3. In-service conducted and documented with all Maintenance Department on proper cleaning procedures. — 08/28/06 4. The Maintenance Supervisor is aware to monitor light dusting checks on monthly rounds. This information will be entered on the Quarterly QA report and monitored. — 08/28/06 F 253 2. 1. The light dust identified on the mechanical Lift and tube during tour was removed in all cases. — 08/23/06 2. All lifts and tubs were checked for dust on flat surfaces and no others were found to have dust. — 08/23/06 3. In-service conducted and documented with all Light Duty Technicians on proper cleaning procedures. Housekeeping assignments updated to include weekly/monthly dusting of lifts and tubs. — 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 253 3.

1.	The light dust identified during tour was removed in all cases.	08/22/06
2.	All resident rooms were checked for 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. Housekeeping 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 253 4.

1.	The identified surfaces, of chairs, table legs and foot boards will be cleaned/repaired.	09/29/06
2.	All resident rooms and common areas to 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 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.	09/29/06

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	095038	A. BUILDING _____ B. WING _____	08/23/2006

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F 253	Continued From page 3 Second Floor Rooms 249, 253 and 256 In three (3) of nine (9) observations between 8:37 AM and 12:10 PM on August 23, 2006.	F 253		
F 281 SS=D	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by : Based on observations during the survey period, it was determined that facility staff failed to discard expired medications. The findings include: On August 22, 2006, the locked interim medication box, located in the medication room at the 2nd floor nursing station was inspected. The expiration date written on the interim medication box was "8/06". This indicated that the medications in the box were valid until the end of the month and the box should be returned to the contract pharmacy by August 31, 2006. The interim medication box was opened and medications were randomly inspected. Nine (9) of 10 Nitrofurantoin 100 mg capsules had an expiration date of August 2, 2006. The Nitrofurantoin capsules were available for use 20 days after they had expired. There was no evidence that any resident had received this medication after it had expired.	F 281	**F281 483.20 (k)(3)(i) – Comprehensive Care Plans -** failure to discard expired medications 1. Corrective Action for Resident Affected by Deficient Practice: The interim med box was replaced on the day of the deficient finding. **Completed August 22, 2006.** 2. Method to Identify Other Residents At Risk for Deficient Practice: No resident received expired meds from the interim box. **Completed August 22, 2006.** 3. Measures or Systemic Changes to Ensure Deficient Practice Does Not Recur: • The night shift nurse will inspect all meds received in the locked interim box weekly when box is delivered. Any meds with expiration dates that occur prior to the end of the month will be returned to pharmacy and replacements requested. Implementation date: August 29, 2006 (and ongoing). • Nursing policy will be developed to support this practice. All nurses will be trained on 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 and presented at the quarterly QA meeting. Implementation date: **September 5, 2006 (and ongoing).**	08/22/06 08/22/06 08/29/06 10/06/06 9/05/06 & ongoing

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F 309 SS=D	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by : Based on record review and staff interview for one (1) of 12 sampled residents, it was determined that the facility staff failed to obtain a pacemaker check per physician's orders for one (1) resident. Resident #6. The findings include: A physician's order initiated on June 23, 2006 directed,"Pacemaker check every July-October-January". A review of the resident's record revealed that there was no evidence that a pacemaker check had been completed at the time of this review. A face-to-face interview was conducted with the charge nurse on August 22, 2006 at 4:12 PM. He /she acknowledged that the pacemaker check was not done in July and had not been completed at this time. The record was review on August 22 , 2006.	F 309	**F309 483.25 Quality of Care** - failure to obtain pacemaker check per physician order for resident #6. 1. Corrective Action for Resident Affected by Deficient Practice: The pacemaker check was obtained for the resident. **Completed August 24, 2006.** 2. Method to Identify Other Residents At Risk for Deficient Practice: Medical records of the 3 residents in the Health Care Center who have pacemakers were reviewed to determine if pacemaker checks were current per physician orders. None was found deficient. **Completed August 28, 2006.** 3. Measures or Systemic Changes to Ensure Deficient Practice Does Not Recur: • Nurses will continue to review TARs during the end-of-the-month changeover to ensure orders have been properly transcribed and dates/times for pacemaker checks have been identified (i.e. "blocked off") on the new month's TAR. Implementation date: **September 1, 2006 (and ongoing).** • TARs will be reviewed by the night shift nurse (24-hour checks) to ensure pacemaker checks have been completed according to schedule. Any pacemaker checks that have not been completed as scheduled will be reported to the DON the next day for follow up. Implementation date: **September 1, 2006 (and ongoing).** 4. Performance Monitoring to Ensure Solutions Are Sustained: Results from the nightly reviews are presented to the facility's Quality Assurance (QA) Committee quarterly. Implementation date: **September 30, 2006 (and ongoing).**	08/24/06 08/28/06 09/01/06 & ongoing 09/01/06 & ongoing 09/30/06 & ongoing

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F 314 SS=D	483.25(c) PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by : Based on observation of a wound treatment for one (1) resident, facility staff failed to maintain clean technique while administering the treatment . Resident #10 The findings include: A wound treatment for bilateral necrotic heels was observed on August 22, 2006 at 2:40 PM. The nurse washed hands, donned gloves and removed the slippers and dressings from the left and right heels. The right heel had an approximately one (1) inch areas with a small amount of blood present. The left heel had no drainage. After washing hands, the nurse picked up the box of gloves and donned clean gloves. The nurse cleaned the right heel with 4 x 4 gauze pads previously moistened with normal sterile saline (NSS). He/she then picked up the tube of enzymatic ointment, applied the ointment onto a sterile cotton tipped applicator and applied the ointment to the right heel. Sterile 4 x 4 gauze pads and sterile gauze were applied to the wound .	F 314	**F314 483.25c Pressure Sores** - failure to maintain clean technique while administering the treatment to Resident #10. 1. Corrective Action for Resident Affected by Deficient Practice: Nurse involved was immediately educated regarding proper techniques to be used when changing residents' dressings. Completed August 23, 2006. 2. Method to Identify Other Residents At Risk for Deficient Practice: • Licensed nurses received copies of the facility's dressing change protocol. Completed August 24, 2006. • The Skin Care Book was reviewed to identify residents requiring dressing changes (including skin tears since no additional residents have pressure ulcers). Completed August 24, 2006. • Nurses were observed performing dressing changes by the Nurse Educator to ensure compliance with the dressing change protocol. Staff received instruction/correction in instances where protocol was violated. Completed August 30, 2006.	08/23/06 08/24/06 08/24/06 08/30/06

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F 314	Continued From page 6 The nurse opened three (3) packages of 4 x 4 gauze pads, unscrewed the bottle of NSS and poured the NSS onto the gauze pads. Hands were not washed and gloves were not changed before the nurse cleaned the left heel and applied ointment and a dressing. The National Pressure Ulcer Advisory Board, " Frequently Asked Questions, Wound Infection and Infection Control, " web site www.npuap.org/ woundinfection.html <http://www.npuap.org/ woundinfection.html>, revealed the following: In the response to question #309, " Care providers should wash their hands before they remove dressings from the (dressing) package in order to not contaminate the dressings by reaching into the package with soiled hands and/ or gloves. " According to the response of question #10, " One pair of clean (non-sterile) gloves can be used to treat multiple ulcers on the same patient. If this is done, start with the cleaner appearing wounds and move to the larger and /or most contaminated appearing wounds. When in doubt, change gloves between ulcers. Do not contaminate dressing supplies and wound care containers (i.e., solution bottles) with gloves that have been in contact with the ulcer. " The nurse administered the wound treatment to the cleaner wound first. Additionally, the nurse picked up a box of gloves, squeezed ointment from a tube, opened packages of gauze pads and a bottle of NSS without washing hands and changing gloves between these actions.	F 314	3. Measures or Systemic Changes to Ensure Deficient Practice Does Not Recur: • Expand current infection control education to emphasize clean dressing change technique. Completion date: September 15, 2006. • Schedule all nurses to demonstrate competency in dressing change technique with specific emphasis on infection control. Completion date: September 22, 2006. 4. Performance Monitoring to Ensure Solutions Are Sustained: Compile data from competency observations and present at quarterly QA meeting. Completion date: October 6, 2006.	09/15/06 0922/06 10/06/06

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F 315 SS=D	483.25(d) URINARY INCONTINENCE Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by : Based on observation, interview and record review for one (1) of 12 sampled residents, it was determined that facility staff failed to perform a complete incontinent assessment for Resident #8 who was diagnosed with a urinary tract infection. The findings include: A review of Resident #8's record revealed that the resident was coded as incontinent of bowel and bladder in Section H (Continence in the last 14 days) on the Quarterly Minimum Data Set assessment completed July 20, 2006. The resident was diagnosed with a urinary tract infection on July 12, 2006 and treated with an oral course of antibiotic therapy. According to a notation by the physician on the laboratory report for the urinalysis, the resident had a history of chronic renal insufficiency. According to the facility's policy entitled, " Incontinence Assessment" dated January 23, 2006, page 1, under #3, "Monitor, record and	F 315	**F315 483.25(d) – Urinary Incontinence** – - - - failure to perform complete incontinent assessment for Resident #8 who was diagnosed with a UTI. 1. Corrective Action for Residents Affected by Deficient Practice: Resident #8's Minimum Data Sets were reviewed for the previous five quarters. She was assessed as incontinent throughout the entirety of this period. Required assessments cannot be documented retrospectively. **Completion date: August 25, 2006.** 2. Method to Identify Other Residents At Risk for Deficient Practice: • Minimum Data Sets have been reviewed for all residents who were assessed in the month of August and who are scheduled for assessments in the month of September. **Completion date: August 31, 2006.** • Residents coded as incontinent have a documented assessment to indicate additional interventions, if any, that should be implemented. **Completion date: August 31, 2006.** 3. Measures or Systemic Changes to Ensure Deficient Practice Does Not Recur: • Revise Incontinence Assessment Tool to Include all factors listed in the Incontinence Assessment Policy. **Completion date: September 15, 2006.** • Re-educate staff on implementation of the Incontinence Assessment Policy and related documentation requirements. **Completion date: September 22, 2006.**	08/25/06 08/31/06 08/31/06 09/15/06 09/22/06

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F 315	Continued From page 8 evaluate information about the resident's bladder habits, and continence or incontinence including: a. voiding patterns (frequency, volume, time, quality of stream etc.) ...e. Response to interventions." There was no evidence in the record that a complete assessment had been performed, including the resident's voiding pattern and response to interventions. A face-to-face interview was conducted with the charge nurse on August 22, 2006 at 9:30 AM. He /she acknowledged that there was no record of a voiding pattern for Resident #8 and no evaluation for specific interventions. The record was reviewed August 22, 2006.	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 date: **October 6, 2006 (and ongoing).**	09/22/06 09/2906 & ongoing 10/06/06
F 329 SS=D	483.25(l)(1) UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. This REQUIREMENT is not met as evidenced by : Based on observation, staff interview and record review for four (4) of 12 sampled residents, it was determined that facility staff failed to monitor the behavior of residents receiving antipsychotic	F 329	**F329 483.25(l)(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 Risk for Deficient Practice: • Residents receiving psychoactive medications were identified using the Psychoactive Medication Report generated by the pharmacy. **Completion date: September 1, 2006.**	09/01/06 09/01/06

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F 329	Continued From page 9 medications. Residents #2, 3, 4 and 5. The findings include: 1. Facility staff failed to monitor behaviors for Resident #2 who was receiving an antidepressant medication. A review of Resident #2' s record revealed a physician's order initiated on December 20, 2002 and most recently renewed August 3, 2006, " Zoloft 25 mg daily and Zoloft 25 mg 1/2 tab daily to equal 37.5 mg daily for depression". There was no evidence in the record that facility staff had identified or monitored depressive behaviors. A face-to-face interview was conducted with the charge nurse on August 22, 2006 at 10:55 AM. He/she stated, "We don't monitor behaviors for antidepressant medication" The record was reviewed August 22, 2006. 2. Facility staff failed to monitor behaviors for Resident #3 who was receiving an antidepressant medication. A review of Resident #3's record revealed a physician's order initiated on admission and most recently renewed August 3, 2006, "Zoloft 100 mg daily for depression." There was no evidence in the record that facility staff had identified or monitored depressive behaviors. A face-to-face interview was conducted with the charge nurse on August 22, 2006 at 10:55 AM. He/she stated, "We don't monitor behaviors for antidepressant medication." The record was reviewed August 22, 2006.	F 329	• In addition to the behavior monitoring sheets already in place for residents receiving antipsychotic meds, these sheets were also instituted for residents receiving antidepressants, hypnotics, and anxiolytic drugs. **Completion date: September 1, 2006.**	09/01/06
			3. Measures or Systemic Changes to Ensure Deficient Practice Does Not Recur: • Develop policy regarding appropriate use of Behavior Monitoring Sheets. **Completion date: September 15, 2006.**	09/15/06
			• Educate staff on implementation of the policy and correct documentation to be included on the Behavior Monitoring Sheets. **Completion date: September 30, 2006.**	09/30/06
			4. Performance Monitoring to Ensure Solutions Are Sustained. • Review Behavior Monitoring Sheets on a monthly basis for all residents listed on the Psychoactive Medication Report generated by the pharmacy. **Completion date: October 1, 2006 (and ongoing).**	10/1/06 & ongoing
			• Determine compliance with policy and appropriateness of documentation. • Report quarterly to the facility's Quality Assurance (QA) Committee. **Completion date: October 6, 2006 (and ongoing).**	10/6/06 & ongoing

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F 329	Continued From page 10	F 329		

3. Facility staff failed to monitor behaviors for Resident #4 who was receiving a medication for insomnia.

A review of Resident #4's record revealed a physician's order initiated on July 6, 2006 and most recently renewed on August 3, 2006, " Trazodone HCL 50 mg tablet 1/2 tablet by mouth at bedtime for Insomnia". There was no evidence in the record that the facility staff had identified or monitored the effects of the medication.

A face-to-face interview was conducted with the charge nurse on August 22, 2006 at 10:55 AM. He/she stated, "We don't monitor those kinds of behaviors." The record was reviewed August 22, 2006.

4. Facility staff failed to monitor behaviors for Resident #5 who was receiving an antidepressant medication.

A review of Resident #5's record revealed a physician's order renewed August 3, 2006, "Zoloft 25 mg daily for depression" There was no evidence in the record that facility staff had identified or monitored depressive behaviors.

A face-to-face interview was conducted with the charge nurse on August 22, 2006 at 10:55 AM. He/she stated, "We don't monitor behaviors for antidepressant medication." The record was reviewed August 22, 2006.

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F 371 SS=E	483.35(i)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by : Based on observations during the survey period, it was determined that dietary services were not adequate to ensure that foods were served and prepared in a safe and sanitary manner as evidenced by: soiled slats on the dish machine, hotel pans and sheet pans. These observations were made in the presence of the Director of Dietary Services. The findings include: 1. The outer surfaces of plastic slats on the dish machine were soiled with food and mineral deposits on the soiled and clean side in one (1) of one (1) observation at approximately 2:00 PM on August 22, 2006. 2. Hotel pans (14 x 24 x 4 inches) washed in the pot and pan wash area were not thoroughly cleaned of food residue and grease and allowed to dry before reuse in seven (7) of nine (9) observations at approximately 3:00 PM on August 22, 2006. 3. Sheet pans were stored with grease and residual food particles on the inner and outer surfaces and not allowed to dry before reuse in eight (8) of nine (9) observations at 3:15 PM on August 22, 2006.	F 371	**F371 483.35(i)(2)** **SANITARY CONDITIONS – FOOD PREP & SERVICE** 1. The dish machine curtains were re-cleaned and sanitized. 8/24/06 2. Ecolab, our chemical company, was notified about replacing our curtain. 8/24/06 3. Director reviewed process and in-serviced the utility staff on proper sanitation and breakdown of the Dish machine. 8/24/06 4. Dining Services Director and Asst. Director will monitor compliance on a monthly basis & present to the Administrator for review. Will then be presented on a quarterly basis to the Quality Assurance Committee, with subsequent plans of correction developed and implemented as necessary. 8/25/06 and ongoing 1. Entire amount of hotel and sheet pans were rewashed and sanitized by the utility staff and supervised by the Director. 2. Director reviewed chemicals that are used at the pot sink as well as the ware washing procedure. 8/23/06 3. Director had in-service with entire utility staff on proper procedures for Pot and Pan washing. 8/23/06 4. Director & Asst. Director will monitor compliance on a monthly basis & will present to the Administrator for review. Will then be presented on a quarterly basis to the Quality Assurance Committee with subsequent plans of correction developed and implemented as necessary. 8/24/06 and ongoing	

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F 412 SS=D	483.55(b) DENTAL SERVICES - NF The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by : Based on observation, staff interview and record review for two (2) of 12 sampled residents, it was determined that facility staff failed to provide an annual dental screen. Residents #2 and 8. The findings include: 1. Facility staff failed to provide an annual dental screen for Resident #2. A review of Resident #2's record revealed that a dental screen had not been conducted within the past 13 months. A face-to-face interview was conducted with a social worker on August 22, 2006 at approximately 11:00 AM. He/she acknowledged that the dental screen has not been done and stated, "The request for the mobile dental unit was sent on August 1, 2006 and we [the facility] are waiting for the dental visit."	F 412	**F412 483.55(b) Dental Services** - failure to provide annual dental screen for 2 of 12 residents. 1. Corrective Action for Residents Affected by Deficient Practice: Dental referrals for residents affected by this deficient practice have been forwarded to the Mobile Dentist; appointments are pending. Completion date: September 7, 2006. 2. Method to Identify Other Residents At Risk for Deficient Practice: Medical records for all residents have been reviewed to identify if annual dental screens have been completed. Referrals have been forwarded to the Mobile Dentist for the 4 residents identified. Completion date: September 7, 2006. 3. Measures or Systemic Changes to Ensure Deficient Practice Does Not Recur: Residents' annual dental screens have now been scheduled to coincide with the annual History and Physical examinations. Completion date: October 2, 2006 (and ongoing). 4. Performance Monitoring to Ensure Solutions Are Sustained. Monitoring will be accomplished by randomly comparing the annual dental screen schedule with dental consults filed in the medical record. Findings will be reported quarterly in the QA meeting. Completion date: October 6, 2006 (and ongoing).	09/07/06 09/07/06 10/2/06 & ongoing 10/6/06 & ongoing

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	095038	A. BUILDING _____ B. WING _____	08/23/2006

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

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F 412	Continued From page 13 There was no evidence in the record that the resident had experienced mouth pain or weight loss. The record was reviewed August 22, 2006. 2. Facility staff failed to provide an annual dental screen for Resident #8. A review of Resident #8's record revealed a dental screen dated April 21, 2003. There was no evidence in the record that the dentist had screened the resident after April 21, 2003. A face-to-face interview with the Director of Nursing was conducted on August 23, 2006 at 9: 20 AM. He/she stated, "When we meet for care conference, we review dental screens and make sure each resident has had a screening yearly. This just fell through the cracks." There was no evidence in the record that the resident had experienced mouth pain or weight loss. The record was reviewed August 23, 2006.	F 412		
F 426 SS=D	483.60(a) PHARMACY SERVICES - PROCEDURES 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. This REQUIREMENT is not met as evidenced by Based on observations and record review for one (1) supplemental sampled resident, it was	F 426	**F426 483.60(a) Pharmacy Services- Procedures - failure to administer prescribed medications and co-mingling of non-prescribed medications with prescribed medications.** 1. Corrective Action for Residents Affected by Deficient Practice: All non-prescribed medications have been removed from the medication cart and are not available/administered to the resident. Completion date: August 24, 2006.	08/24/06

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F 426	Continued From page 14 determined that the facility failed to administer prescribed medications and co-mingled non-prescribed medications with currently prescribed medications. Resident JK1. The findings include: An inspection of the medication cart revealed 32 medications for Resident JK1, dispensed from four (4) different pharmacies other than facility's contract pharmacy. The physician's orders signed on August 3, 2006 prescribed 17 routine medications and four (4) as needed medications. All 21 medications were present in the medication cart. In addition to the prescribed medications, six (6) medications currently not prescribed were co-mingled in the medication cart,Ultram 50 mg, Synthroid 0.1 mg, Altace 5 mg, Fosamax 70 mg, Docusate Na 100 mg and Citracal (Calcium 630 mg and Vitamin D 400 International Units). During observation of medication pass on August 23, 2006 at approximately 8:45 AM, two (2) of the six (6) non-prescribed medications were administered to the resident, Citracal and Docusate Na. A face-to-face interview with the medication nurse was conducted on August 23, 2006 at 11:30 AM. He/she acknowledged that the Citracal and Docusate were not prescribed by the physician and additional medications not prescribed were co-mingled with currently prescribed medications. The record was reviewed on August 23, 2006.	F 426	2. Method to Identify Other Residents At Risk for Deficient Practice: MARs of all residents have been compared against medications currently administered to ensure only prescribed meds are available/administered to residents. Completion date: September 1, 2006. 3. Measures or Systemic Changes to Ensure Deficient Practice Does Not Recur: • Advise residents and family members who accompany residents to medical appointments that all prescriptions received must be provided to the nursing staff. This includes meds provided from pharmacies other than the facility's contract pharmacy. Completion date: October 6, 2006 (and ongoing). • List all drugs prescribed for residents on the resident's POS and the MAR. Completion date: October 6, 2006 (and ongoing). • Expand the consultant pharmacist's role to include monthly monitoring of Physician Order Sheets against meds available in the med cart. Completion date: October 1, 2006. 4. Performance Monitoring to Ensure Solutions Are Sustained. Consultant Pharmacist to report quarterly on findings at facility's QA meeting. Completion date: October 6, 2006.	09/01/07 10/6/06 & ongoing 10/6/06 & ongoing 10/1/06 10/6/06

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F 441 SS=D	483.65(a) INFECTION CONTROL The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections. This REQUIREMENT is not met as evidenced by : Based on observations during a wound treatment, it was determined that facility staff failed to maintain infection control precautions for Resident #10. The findings include: A wound treatment for Resident #10 was observed on August 22, 2006 at 2:40 PM. A Certified Nurse Aide (CNA) was assisting the nurse during the treatment. The CNA was observed removing a "light cover" from the resident, folded it up and placed it in the roommate's closet prior to the treatment. After the wound treatment was completed, the CNA removed the "light cover" from the roommate's closet and placed it on the resident.	F 441	**F441 483.65(a) Infection Control** - failure to maintain infection control precautions for Resident #10. 1. Corrective Action for Resident Affected by Deficient Practice: CNA involved was immediately educated regarding infection control precautions with emphasis on modes of transmission. **Completed August 23, 2006.** 2. Method to Identify Other Residents At Risk for Deficient Practice: • All staff received copies of the facility's infection control policies. **Completed August 24, 2006.** • Staff were observed by the Nurse Educator while performing various tasks to ensure compliance with the policies, and received instruction/correction in instances where policy violations were observed. **Completed August 30,2006.** 3. Measures or Systemic Changes to Ensure Deficient Practice Does Not Recur: • Revise infection control training program to expand emphasis on modes of transmission. **Completion date: September 15, 2006.** • Schedule all staff to demonstrate competency in handling contaminated materials correctly, maintaining appropriate precautions when placing or removing resident's clothing and other belongings, proper storage of residents' belongings, etc. **Completion date: September 22, 2006.** 4. Performance Monitoring to Ensure Solutions Are Sustained: Compile data from competency observations and present at quarterly QA meeting. Completion date: October 6, 2006 (and ongoing).	08/23/06 08/24/06 08/30/06 09/15/06 09/22/06 10./6/06

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F 514 SS=D	483.75(l)(1) CLINICAL RECORDS The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by : Based on the review of one (1) of one (1) closed record, it was determined that the physician failed to complete a discharge summary for an expired resident. Resident #12 The findings include: According to the facility's policy titled, "Discharge of a resident 5. a. "The physician or the Home's Medical Director prepares a Discharge Summary within 15 days of discharge b. The Discharge Summary will include: (1) Diagnosis and prognosis... (4) A total recap of the resident's stay " The resident received hospice care and was pronounced dead by the hospice nurse on June 28, 2006. There was no documentation in the record by the physician to summarize the resident's stay. The record was reviewed on August 23, 2006	F 514	**F514 483.75(l)(1) Clinical Records** -failure to complete discharge summary for an expired resident. Resident #12. 1. Corrective Action for Resident Affected by Deficient Practice: Discharge Summary has been completed by the Medical Director. **August 24, 2006.**	08/24/06
			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.**	08/31/06
			3. Measures or Systemic Changes to Ensure Deficient Practice Does Not Recur: • Medical Records Coordinator 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 ongoing).**	10/6/06 & ongoing
			• The Medical Director will complete the required documentation during his weekly visit. **October 6, 2006 (and ongoing).**	10/6/06 & ongoing
			4. Performance Monitoring to Ensure Solutions Are Sustained: Medical Records Coordinator will monitor the process described above and report compliance quarterly to the facility's QA Committee. **October 6, 2006.**	10/6/06