Health Regulation Administration (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING B. WING 08/23/2006 095038 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 4901 CONNECTICUT AVENUE, NW METHODIST HOME WASHINGTON, DC 20008 PROVIDER'S PLAN OF CORRECTION (X5)SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE CROSS-COMPLETE (EACH DEFICIENCY MUST BE PRECEEDED BY FULL **PREFIX** PREFIX REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG L 000 THIS PLAN OF CORRECTION IS SUBMITTED L 000 Initial Comments FOR PURPOSES OF REGULATORY COMPLIANCE AND AS PART OF THE An annual licensure survey was conducted on METHODIST HOME'S ONGOING EFFORTS TO August 22 through 23, 2006. The following CONTINUOUSLY IMPROVE THE CARE AND deficiencies were based on observations, staff SERVICES PROVIDED. AS SUCH IT DOES NOT CONSTITUTE AN ADMISSION OF THE FACTS and resident interviews and record review. The OR CONCLUSIONS CITED IN THE SURVEY sample size was 12 residents based on a census REPORT FOR ANY PURPOSE WHATSOEVER. of 48 residents the first day of survey and two (2) supplemental records. L 052 L 052 3211.1 Nursing Facilities Sufficient nursing time shall be given to each resident to ensure that the resident receives the following: (a)Treatment, medications, diet and nutritional supplements and fluids as prescribed, and rehabilitative nursing care as needed; (b)Proper care to minimize pressure ulcers and contractures and to promote the healing of ulcers: (c)Assistants in daily personal grooming so that the resident is comfortable, clean, and neat as evidenced by freedom from body odor, cleaned and trimmed nails, and clean, neat and wellgroomed hair; (d) Protection from accident, injury, and infection; (e)Encouragement, assistance, and training in self-care and group activities; (f)Encouragement and assistance to: (1)Get out of the bed and dress or be dressed in his or her own clothing; and shoes or slippers, which shall be clean and in good repair; (2)Use the dining room if he or she is able; and Health Regulation Administration (X6) DATE TITLE

STLI

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

ADMINISTRATOR

11 SEPTEMBER 2006

Health Regulation Administration (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING B. WING 08/23/2006 095038 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 4901 CONNECTICUT AVENUE, NW METHODIST HOME WASHINGTON, DC 20008 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE CROSS-COMPLETE (EACH DEFICIENCY MUST BE PRECEEDED BY FULL **PREFIX PREFIX** DATE REFERENCED TO THE APPROPRIATE DEFICIENCY) REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG L 052 L 052 Continued From page 1 (3)Participate in meaningful social and recreational activities; with eating; (g)Prompt, unhurried assistance if he or she requires or request help with eating; (h)Prescribed adaptive self-help devices to assist him or her in eating independently; (i)Assistance, if needed, with daily hygiene, including oral acre; and j)Prompt response to an activated call bell or call for help. This Statute is not met as evidenced by: Based on observations, record review and staff interview for six (6) of 12 sampled residents and L 052 3211.1 Nursing Facilities one (1) supplemental sampled resident, it was determined that sufficient nursing time was not provided to residents as evidenced by facility staff F329 483.25(I)(1) - Unnecessary Drugs who failed to: monitor the behaviors of four (4) - failure to monitor behavior of residents residents receiving antipsychotic medications; receiving antipsychotic (psychoactive) meds. obtain a pacemaker check for one (1) resident; 1. Corrective Action for Residents Affected maintain infection control precautions one (1) by Deficient Practice: resident during a wound treatment and administer Behavior monitoring sheets were instituted for prescribed medications and co-mingled nonthe 4 residents identified during the survey who prescribed medications with currently prescribed had this deficient practice. Completion date: 09/01/06 medications Residents # 2, 3, 4, 5, 6, 10 and JK1 September 1, 2006. 2. Method to Identify Other Residents At Risk for Deficient Practice: The findings include: Residents receiving psychoactive 1. Facility staff failed to monitor behaviors for medications were identified using the Resident #2 who was receiving an antidepressant Psychoactive Medication Report generated 09/01/06 medication. by the pharmacy. Completion date: September 1, 2006. A review of Resident #2's record revealed a

Health Regulation Administration (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING 08/23/2006 095038 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 4901 CONNECTICUT AVENUE, NW METHODIST HOME WASHINGTON, DC 20008 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE CROSS-(EACH DEFICIENCY MUST BE PRECEEDED BY FULL **PREFIX** PREFIX DATE REFERENCED TO THE APPROPRIATE DEFICIENCY) REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG L 052 L 052 Continued From page 2 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. In addition to the behavior monitoring A face-to-face interview was conducted with the sheets already in place for residents charge nurse on August 22, 2006 at 10:55 AM. He/she stated, "We don't monitor behaviors for receiving antipsychotic meds, these sheets antidepressant medication" were also instituted for residents receiving The record was reviewed August 22, 2006. antidepressants, hypnotics, and anxiolytic drugs. Completion date: September 1, 2. Facility staff failed to monitor behaviors for 2006. 09/01/06 Resident #3 who was receiving an antidepressant Measures or Systemic Changes to Ensure medication. Deficient Practice Does Not Recur: Develop policy regarding appropriate use A review of Resident #3's record revealed a of Behavior Monitoring Sheets. physician's order initiated on admission and most Completion date: September 15, 2006. recently renewed August 3, 2006, "Zoloft 100 mg 09/15/06 Educate staff on implementation of the daily for depression." There was no evidence in the record that facility staff had identified or policy and correct documentation to be monitored depressive behaviors. included on the Behavior Monitoring Sheets. Completion date: September 30, 09/30/06 A face-to-face interview was conducted with the 2006. charge nurse on August 22, 2006 at 10:55 AM. 4. Performance Monitoring to Ensure He/she stated, "We don't monitor behaviors for Solutions Are Sustained. antidepressant medication." Review Behavior Monitoring Sheets on a The record was reviewed August 22, 2006. monthly basis for all residents listed on the Psychoactive Medication Report generated Facility staff failed to monitor behaviors for 10/1/06 & by the pharmacy. Completion date: Resident #4 who was receiving a medication for ongoing October 1, 2006 (and ongoing). insomnia. Determine compliance with policy and A review of Resident #4's record revealed a appropriateness of documentation. physician's order initiated on July 6, 2006 and · Report quarterly to the facility's Quality most recently renewed on August 3, 2006, " Assurance (QA) Committee. Completion Trazodone HCL 50 mg tablet 1/2 tablet by mouth 10/6/06 & date: October 6, 2006 (and ongoing). at bedtime for Insomnia". There was no evidence ongoing in the record that the facility staff had identified or

Health Regulation Administration (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING 08/23/2006 095038 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 4901 CONNECTICUT AVENUE, NW METHODIST HOME WASHINGTON, DC 20008 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE CROSS-(EACH DEFICIENCY MUST BE PRECEEDED BY FULL **PREFIX** PREFIX DATE REFERENCED TO THE APPROPRIATE DEFICIENCY) REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG F309 483.25 Quality of Care L 052 L 052 Continued From page 3 failure to obtain pacemaker check per monitored the effects of the medication. physician order for resident #6. Corrective Action for Resident Affected by A face-to-face interview was conducted with the Deficient Practice: charge nurse on August 22, 2006 at 10:55 AM. The pacemaker check was obtained for the He/she stated, "We don't monitor those kinds of resident. Completed August 24, 2006. behaviors." The record was reviewed August 22, 08/24/06 Method to Identify Other Residents At Risk 2006. for Deficient Practice: 4. Facility staff failed to monitor behaviors for Medical records of the 3 residents in the Health Resident #5 who was receiving an antidepressant Care Center who have pacemakers were medication. reviewed to determine if pacemaker checks were current per physician orders. None was A review of Resident #5's record revealed a 08/28/06 found deficient. Completed August 28, 2006. physician's order renewed August 3, 2006, 3. Measures or Systemic Changes to Ensure "Zoloft 25 mg daily for depression" There was no evidence in the record that facility staff had Deficient Practice Does Not Recur: Nurses will continue to review TARs during identified or monitored depressive behaviors. the end-of-the-month changeover to A face-to-face interview was conducted with the ensure orders have been properly charge nurse on August 22, 2006 at 10:55 AM. transcribed and dates/times for pacemaker He/she stated, "We don't monitor behaviors for checks have been identified (i.e. "blocked antidepressant medication." The record was off") on the new month's TAR. reviewed August 22, 2006. 09/01/06 Implementation date: September 1, 2006 & ongoing (and ongoing). 5. Facility staff failed to perform a pacemaker TARs will be reviewed by the night shift check for Resident #6. nurse (24-hour checks) to ensure pacemaker checks have been completed A physician's order initiated on June 23, 2006 directed,"Pacemaker check every July-Octoberaccording to schedule. Any pacemaker checks that have not been completed as January". scheduled will be reported to the DON the A review of the resident's record revealed that next day for follow up. Implementation 09/01/06 there was no evidence that a pacemaker check & ongoing date: September 1, 2006 (and ongoing). had been completed at the time of this review. 4. Performance Monitoring to Ensure Solutions Are Sustained: A face-to-face interview was conducted with the Results from the nightly reviews are presented charge nurse on August 22, 2006 at 4:12 PM. He /she acknowledged that the pacemaker check to the facility's Quality Assurance (QA) was not done in July and had not been completed Committee quarterly. Implementation date: -09/30/06 at this time. The record was review on August 22 September 30, 2006 (and ongoing). eet & ongoing.

PRINTED: 09/01/2006 FORM APPROVED **Health Regulation Administration** STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED. A. BUILDING B. WING 095038 08/23/2006 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **4901 CONNECTICUT AVENUE, NW** METHODIST HOME WASHINGTON, DC 20008 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-PREFIX **PREFIX** COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE L 052 | Continued From page 4 L 052 , 2006. F314 483.25c Pressure Sores - failure to maintain clean technique 6. Based on observations during a wound while administering the treatment to treatment, it was determined that facility staff Resident #10. failed to maintain infection control precautions for 1. Corrective Action for Resident Resident #10. Affected by Deficient Practice: Nurse involved was immediately A. A wound treatment for Resident #10 was educated regarding proper techniques observed on August 22, 2006 at 2:40 PM. A to be used when changing residents' Certified Nurse Aide (CNA) was assisting the nurse during the treatment. The CNA was dressings. Completed August 23, 08/23/06 observed removing a "light cover" from the 2006. resident, folded it up and placed it in the Method to Identify roommate's closet prior to the treatment. After Residents At Risk for Deficient the wound treatment was completed, the CNA Practice: removed the "light cover" from the roommate's Licensed nurses received copies closet and placed it on the resident. of the facility's dressing change protocol. Completed August 24, B. A wound treatment for bilateral necrotic heels 08/24/06 was observed on August 22, 2006 at 2:40 PM. 2006. The nurse washed hands, donned gloves and The Skin Care Book was removed the slippers and dressings from the left reviewed to identify residents and right heels. The right heel had an requiring dressing changes approximately one (1) inch areas with a small (including skin tears since no amount of blood present. The left heel had no additional residents have drainage. After washing hands, the nurse picked pressure ulcers). Completed up the box of gloves and donned clean gloves. August 24, 2006. The nurse cleaned the right heel with 4 x 4 gauze 08/24/06 pads previously moistened with normal sterile Nurses were observed performing saline (NSS). He/she then picked up the tube of dressing changes by the Nurse enzymatic ointment, applied the ointment onto a Educator to ensure compliance sterile cotton tipped applicator and applied the with the dressing change ointment to the right heel. Sterile 4 x 4 gauze protocol. Staff received pads and sterile gauze were applied to the wound instruction/correction in instances where protocol was violated.

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 08/30/06

Completed August 30, 2006.

Statement of Deficiencies And Plan of Correction ID # 095038

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.

09/15/06

 Schedule all nurses to demonstrate competency in dressing change technique with specific emphasis on infection control. Completion date: September 22, 2006

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. 0922/06

10/06/06

Health Regulation Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 095038 08/23/2006 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4901 CONNECTICUT AVENUE, NW **METHODIST HOME** WASHINGTON, DC 20008 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REGULATORY OR LSC IDENTIFYING INFORMATION) REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG DATE **TAG** L 052 Continued From page 5 L 052 before the nurse cleaned the left heel and applied ointment and a dressing. F 176 483.10(n) Self Administration The National Pressure Ulcer Advisory Board, " of Drugs - failure to assess Resident Frequently Asked Questions, Wound Infection JK1 for self administration of drugs and Infection Control, " web site www.npuap.org/ Corrective Action for Resident woundinfection.html <a href="http://www.npuap.org/">http://www.npuap.org/</a> Affected by Deficient Practice: woundinfection.html>, revealed the following: The assessment of resident JK1's capability to self administer his In the response to question #309, "Care nitroglycerin tablets were completed providers should wash their hands before they on August 24, 2006. 08/24/06 remove dressings from the (dressing) package in 2. Method to Identify order to not contaminate the dressings by Residents At Risk for Deficient reaching into the package with soiled hands and/ or gloves. " Practice: Medical records were reviewed to According to the response of question #10, " identify residents who may have One pair of clean (non-sterile) gloves can be physician orders to self administer used to treat multiple ulcers on the same patient. medications and who may not have If this is done, start with the cleaner appearing been assessed per policy. No wounds and move to the larger and /or most residents were identified. contaminated appearing wounds. When in doubt, 08/25/06 Completed August 25, 2006. change gloves between ulcers. Do not 3. Measures or Systemic Changes contaminate dressing supplies and wound care to Ensure Deficient Practice Does containers (i.e., solution bottles) with gloves that have been in contact with the ulcer. ' Not Recur: Re-educate staff on self-The nurse administered the wound treatment to administration policy. the cleaner wound first. Additionally, the nurse Completion date: Oct 6, 2006 10/06/06 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. 7. Facility staff failed to administer prescribed medications and co-mingled non-prescribed medications with currently prescribed medications for Resident JK1. An inspection of the medication cart revealed 32

Health Re	egulation Administra	ation						
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 095038		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 08/23/2006		
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY,	STATE, ZIP CODE			
4901 CON			INECTICUT AVENUE, NW ITON, DC 20008					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE O REFERENCED TO THE APPROPRIATE DEFI	OULD BE CROSS- COMPLETE		
L 052	DECLIFATION OF LCC IDENTIFYING INFORMATION		L 052	<ul> <li>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</li> <li>Review 24-hour report daily to identify residents undergoing self-administration assessments. Sept. 1, 2006</li> <li>Review charts of these residents after 3-day assessment period to ensure assessment has been completed. Sept. 1, 2006</li> <li>Performance Monitoring to Ensure Solutions Are Sustained: Report findings in Quarterly QA meeting. Completion date: Oct. 6, 2006.</li> </ul>		10/06/06 09/01/06 09/01/06		
L 099	on August 23, 20 9 3219.1 Nursing F							
	from spoilage, sa served in accorda forth in Title 23, S Regulations (DCI This Statute is no	hall be clean, wholesofe for human consumance with the requirer Subtitle B, D. C. MuniomR), Chapter 24 throot met as evidenced ations during the sun	nption, and ments set cipal ugh 40. by:					

Health Regulation Administration (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED **IDENTIFICATION NUMBER:** A. BUILDING B. WING 095038 08/23/2006 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **4901 CONNECTICUT AVENUE, NW** METHODIST HOME WASHINGTON, DC 20008 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5)ID (X4) ID COMPLETE (EACH DEFICIENCY MUST BE PRECEEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-PRFFIX PREFIX REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG L 099 L 099 Continued From page 7 3219.1 Nursing Facilities it was determined that dietary services were not F371 483.35(i)(2) adequate to ensure that foods were served and SANITARY CONDITIONS - FOOD prepared in a safe and sanitary manner as PREP & SERVICE evidenced by: soiled slats on the dish machine, hotel pans and sheet pans. These observations The dish machine curtains were recleaned and sanitized. were made in the presence of the Director of 8/24/06 Ecolab, our chemical company, was Dietary Services. notified about replacing our curtain. 8/24/06 Director reviewed process and in-The findings include: serviced the utility staff on proper sanitation and breakdown of the Dish 1. The outer surfaces of plastic slats on the dish 8/24/06 machine. machine were soiled with food and mineral 4. Dining Services Director and Asst. deposits on the soiled and clean side in one (1) of Director will monitor compliance on a one (1) observation at approximately 2:00 PM on monthly basis & present to the August 22, 2006. Administrator for review. Will then be presented on a quarterly basis to the 2. Hotel pans (14 x 24 x 4 inches) washed in the Quality Assurance Committee, with pot and pan wash area were not thoroughly subsequent plans of correction developed 8/25/06 and cleaned of food residue and grease and allowed ongoing and implemented as necessary. to dry before reuse in seven (7) of nine (9) observations at approximately 3:00 PM on August 1. Entire amount of hotel and sheet pans 22, 2006. were rewashed and sanitized by the utility staff and supervised by the Director. 3. Sheet pans were stored with grease and 8/23/06 2. Director reviewed chemicals that are used residual food particles on the inner and outer at the pot sink as well as the ware surfaces and not allowed to dry before reuse in washing procedure. eight (8) of nine (9) observations at 3:15 PM on 8/23/06 Director had in-service with entire utility August 22, 2006. staff on proper procedures for Pot and Pan washing. 8/24/06 L 410 L 410 3256.1 Nursing Facilities 4. Director & Asst. Director will monitor compliance on a monthly basis & will Each facility shall provide housekeeping and present to the Administrator for review. maintenance services necessary to maintain the Will then be presented on a quarterly exterior and the interior of the facility in a safe, basis to the Quality Assurance Committee sanitary, orderly, comfortable and attractive with subsequent plans of correction 8/25/06 and manner. developed and implemented as necessary. ongoing This Statute 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

Health Regulation Administration (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING B. WING 095038 08/23/2006 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **4901 CONNECTICUT AVENUE, NW** METHODIST HOME WASHINGTON, DC 20008 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5)(X4) ID (EACH CORRECTIVE ACTION SHOULD BE CROSS-COMPLETE (EACH DEFICIENCY MUST BE PRECEEDED BY FULL **PREFIX** PREFIX REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG L 410 L 410 Continued From page 8 ensure that the facility was maintained in a safe and sanitary manner as evidenced by: soiled F 253 1. exhaust vents, base surfaces on mechanical lifts The light dust identified during tour and bathtubs; dust on top of closets and tables; was removed on the interior surfaces and marred chairs, tables and foot boards in of exhaust vents behind the grates in residents' rooms. 08/24/06 all cases Grates were removed and the interior The findings include: of all exhaust vents were checked for dust on interior surface and no others 1. The interior surfaces of exhaust vents in were found to have dust. 08/24/06 residents' rooms and common areas were soiled In-service conducted and documented with dust in the following areas: with all Maintenance Department on 08/28/06 proper cleaning procedures. . First Floor Rooms 145, 147,153, 169 and bathing The Maintenance Supervisor is aware to room in five (5) of nine (9) observations between monitor light dusting checks on monthly 11:10 AM and 12:30 PM on August 22, 2006. rounds. This information will be entered on the Quarterly QA report and monitored. 08/28/06 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. F 253 2 2. The base surfaces of mechanical lifts and The light dust identified on the mechanical bathtubs were soiled with accumulated dust on Lift and tube during tour the first and second floors between 4:00 PM and was removed in all cases. 4:45 PM on August 22, 2006 and 11:10 AM and 08/23/06 All lifts and tubs were checked for 12:10 PM on August 23, 2006. dust on flat surfaces and no others were found to have dust. 3. The top surfaces of tables and closets were 08/23/06 In-service conducted and documented soiled with dust and debris in rooms 145, 146, with all Light Duty Technicians on 247, 249, 253 and 256 in six (6) of 18 proper cleaning procedures. observations between 11:10 AM and 12:30 PM Housekeeping assignments updated to on August 22, 2006 and 8:37 AM and 9:30 AM on include weekly/monthly dusting of lifts and August 23, 2006. tubs. 09/06/06 The Housekeeping Supervisor is aware to 4. The frontal areas of chairs, tables and foot monitor light dusting checks on weekly boards were marred and scarred in residents' rounds. This information will be entered on the Quarterly QA report and monitored. rooms. 09/06/06 First Floor Rooms 146, 147, 151 and 153 in four ( 4) of nine (9) observations between 8:37 AM and

Health Regulation Administration

			1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 095038		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 08/23/2006		
METHODIST HOME 4901 CON					DDRESS, CITY, STATE, ZIP CODE NNECTICUT AVENUE, NW GTON, DC 20008				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	(EACH CORRECTIVE ACTION SH	OVIDER'S PLAN OF CORRECTION RRECTIVE ACTION SHOULD BE CROSS- ED TO THE APPROPRIATE DEFICIENCY)			
L 410	Continued From page 9 12:10 PM on August 22, 2006.  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.			L 410	<ol> <li>The light dust identified during tour was removed in all cases.</li> <li>All resident rooms were checked for dust on flat surfaces of closets and furnishings and no others were found to have dust.</li> <li>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.     </li> <li>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.</li> </ol>		08/22/06 08/25/06 09/06/06		
					<ol> <li>The identified surfaces, of clable legs and foot boards we cleaned/repaired.</li> <li>All resident rooms and combe surveyed by staff to deter and schedule cleaned/repaired.</li> <li>Condition of furniture will housekeeping and maintent.</li> <li>The Supervisors are aware to as discovered. This information entered on the Quarterly Quand monitored.</li> </ol>	mon areas to mon areas to rmine and red if identified, be added to daily ance rounds. o repair damage tion will be	09/29/06 09/29/06 09/29/06		