			ilconno FORI	D: 10/22/200 MAPPROVE
EFICIENCIES RRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		riple construction m ?	SURVEY
DER OR SUPPLIER		st		
GTON HOME		{ :	3720 UPTON STREET NW	
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIC DATE
TAL COMMEN	ITS	F 000		
bber 9 through ciencies were l ews, and interv aple included 2 83 residents the supplemental re- 10(e), 483.75( NFIDENTIALIT resident has the identiality of hi- resident has the identiality of hi- resident has the indentiality of hi- resident has the indentiality of hi- resident has the indentiality of hi- resident has the indentiality of hi- resident has the ept as provided ion, the resident ase of persona- idual outside the resident's right clinical records lent is transfer- ution; or record facility must ke ained in the resident is required	12, 2007. The following based on observations, record views with the facility staff. The 8 residents based on a census re first day of survey and one esident. I)(4) PRIVACY AND Y he right to personal privacy and s or her personal and clinical actudes accommodations, written and telephone bersonal care, visits, and and resident groups, but this e facility to provide a private dent. In paragraph (e)(3) of this in may approve or refuse the I and clinical records to any he facility. It to refuse release of personal s does not apply when the red to another health care d release is required by law. eep confidential all information sident's records, regardless of methods, except when		federal and state regulations, the facility has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or the dates indicated.	10/9/0 10/-9/0
	OR MEDICAR EFICIENCIES RECTION DER OR SUPPLIER GTON HOME SUMMARY ST (EACH DEFICIENC REGULATORY OR TAL COMMEN annual recertifi ober 9 through ciencies were leves, and interv ple included 2 33 residents the supplemental re 10(e), 483.75( NFIDENTIALIT resident has the identiality of hi rds. Sonal privacy ir ical treatment, munications, p tings of family s not require the for each resident ase of persona idual outside the resident's right clinical records and in the resident is transferr ution; or record facility must kee and in the resident facility must kee and in the resident facility must kee and in the resident facility must kee and in the resident for storage	RRECTION       IDENTIFICATION NUMBER:         095005         DER OR SUPPLIER         GTON HOME         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         TAL COMMENTS         annual recertification survey was conducted ober 9 through 12, 2007. The following ciencies were based on observations, record ews, and interviews with the facility staff. The ple included 28 residents based on a census 83 residents the first day of survey and one supplemental resident.         10(e), 483.75(I)(4) PRIVACY AND NFIDENTIALITY         resident has the right to personal privacy and identiality of his or her personal and clinical	OR MEDICARE & MEDICAID SERVICES         EFICIENCIES         RRECTION         (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (A)         095005         DER OR SUPPLIER         GTON HOME         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         TAL COMMENTS         FOOD         TAL COMMENTS         annual recertification survey was conducted ober 9 through 12, 2007. The following ciencies were based on observations, record ews, and interviews with the facility staff. The ple included 28 residents based on a census B3 residents the first day of survey and one supplemental resident. 10(e), 483.75(1)(4) PRIVACY AND VFIDENTIALITY         resident has the right to personal privacy and identiality of his or her personal and clinical rds.         conal privacy includes accommodations, ical treatment, written and telephone munications, personal care, visits, and tings of family and resident groups, but this is not require the facility to provide a private in for each resident.         rept as provided in paragraph (e)(3) of this on, the resident may approve or refuse the ise of personal and clinical records to any idual outside the facility.         resident's right to refuse release of personal clinical records does not apply when the lent is transferred to another health care ution; or record release is required by law.         facility must keep confidential all information ained in the resident's records, regardless of form or storage methods, except when	NT OF HEALTH AND HUMAN SERVICES       FORM         OR MEDICARE & MEDICALD SERVICES       (22 MULTIPLE CONSTRUCTION MUMBER.         It (1) PROVIDERSUPPLIERCUA INTEGENTIAL       (22 MULTIPLE CONSTRUCTION MUMBER.         It (2) PROVIDERSUPPLIERCUA INTEGENTIAL       (22 MULTIPLE CONSTRUCTION MUMBER.         It (2) PROVIDERSUPPLIERCUA INTEGENTIAL       (22 MULTIPLE CONSTRUCTION MUMBER.         It (2) PROVIDERS PLAN OF CORRECTION REACH DERICENCY WIST BE PRECEDED BY PLL REGULATORY OR LSC IDENTIFYING INFORMATION)       STREET ADDRESS. CITY, STATE, ZIP CODE TO SUMMARY STATEMENT OF DEFICIENCES (24 HORE) CONCY WIST BE PROPOREIZED BY PLL REGULATORY OR LSC IDENTIFYING INFORMATION)       IF 000         TALL COMMENTS       F 000         AIL COMMENTS       F 000         IAL COMMENTS       F 000         IAL COMMENTS       F 000         Interviews with the facility staff. The pei included 28 residents based on a census 33 residents the first to personal and clinical rds.       F 164         10(e), 483.75(1)(4) PRIVACY AND       F 164         FIEDENTIALITY       F 164         resident has the right to personal and clinical rds.       F 164         resident has the right to personal and clinical rds.       F 164         resident may approve or refuse the set of personal and clinical rds.       F 164         resident has the right to resident groups, but this is not regure the facility to provide a private in or active action sthouse the set o

Any deficiency statement enting 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.

÷

		AND HUMAN SERVICES						): 10/18/200 1 APPROVE
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES						0938-039
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		TIPLE CONSTRUCTION		X3) DATE S COMPL	
		095005	8. WI	NG_			10/1	2/2007
NAME OF P		· · · · · · · · · · · · · · · · · · ·		ST	REET ADDRESS, CITY,	STATE, ZIP CODE		
THE WA	SHINGTON HOME				3720 UPTON STREET WASHINGTON, DC	NW		
(X4) ID	SUMMARY STA		ID	L	PROVIDER	S PLAN OF CORRECTION	- N	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF	XI	(EACH CORRE CROSS-REFERE	CTIVE ACTION SHOUL NCED TO THE APPRON DEFICIENCY)	D 8E	(X5) COMPLETION DATE
F 164	Continued From pa	ige 1	F	164	3. Systemic Cha			
		NT is not met as evidenced			The facility has re policy and proced	viewed its' currently ure. Licensed staff		
	by: Based on observations and staff interviews, it was					on the provisions of		
Í	Based on observations and staff interviews, it was determined that facility staff failed to provide				483.10(e) and 48 Privacy and Confid	3.75 (I)(4) specifically dentiality provided		11/9/07
		resident during a dressing			during dressing ch			17
		resident prior to administering				Ŭ		
		ng eye pressure. Residents			4. Monitoring:			
	#12 and S1.					der and/or designee is intaining compliance. Tl	ho	
						des a random observatio		
	The findings include	e:				privacy and confidentiali		
						anges. The Clinical Mar		
Í		d to provide privacy for				ill complete a 10% audit		
	Resident #12 during	g a dressing change.				treatments weekly to Findings will be reported	d	
	During the initial to	Ir of the facility, on October 9,			to the QA Committ	ee for recommendations		
		was observed that during a			for changes in curr	ent policy or practice and		1.1
	dressing change be the right foot/ankle,	ing done by Employee #13 to the door to the resident's				r audits or action plans.		11/9/07
		e curtain was not pulled		_				
	around the resident	s bea.	-164	//		A = 41 = = (= )		
	The surveyor and fa	cility staff stood outside the	• • • •	C.	1. Corrective Employee #17 ha			
		serving the dressing change			re-educated on F			<b>.</b> .
		ree (3) minutes before			i.e. privacy during			10/12/07
		owledged the group outside			consultations.			1. 1.
	the door.				2. Identificati	on of Deficient		
					Practices & Cor			
		were made in the presence				eceiving ophthalmology		
1	of Employee #2 and	Linpioyee #3.				e the potential to be		
	A face-to-face inten	view was conducted on				thalmologist has been ate treatment area for		
		3:40 AM with Employee #2,				phthalmology services.		
		that the resident's door should			The Director of N	ursing and/or designee		
		uring the dressing change.				om observations of		
						mology services to ovided. Any and all		
		to provide privacy while				will be corrected at time		19/19/07
		ops and testing eye pressure			of discovery and r	eported to the QA		
	to Resident S1.				Committee for rec	ommendations.		
RM CMS-256	7(02-99) Previous Versions (	Dbsolete Event ID: WUZV11		Fac	ility ID: WASHHOME	lf continua	tion obset	

£. \_

11/0	6/2007 11:24	2029665679		NURSI	NG ADMIN OFF	ICE		E 02/03
	TMENT OF HEALTH				<b>4</b> 2010 - 100		FOR	U: 10/18/200 MAPPROVE O. 0938-039
TATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPI IDENTIFICATION N	IER/CLIA	(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION	N	(X3) DATE	
		09500	5	B. WING _		<u></u>	10	/12/2007
IAME OF I	PROVIDER OR SUPPLIER	<u>.                                    </u>		STF	REET ADDRESS, CIT	STATE, ZIP C	·]	
THE WA	SHINGTON HOME				720 UPTON STREE VASHINGTON, D			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENC MUST BE PRECEDED E SC IDENTIFYING INFOR	IY FULL	ID PREFIX TAG	(EACH CORI	R'S PLAN OF CO RECTIVE ACTIO ENCED TO THE DEFICIENCY)	APPROPRIATE	(X5) Completion Date
F 253 SS≂D	Continued From particular Employee #17 was 2007 at approximate and remove a base a computer and per- nurse's station. Em- Resident S1, sitting with one (1) residen him/her. Employee # and instilled eye dro Employee #17 retur- belongings at the nu- device, went back to that he/she was me Employee #17 retur- belongings at the nu- device, went back to that he/she was me Employee #17 retur- belongings at the nu- device, went back to that he/she was me Employee #17 retur- belongings at the nu- device, went back to that he/she was me Employee #17 retur- the resident's eyes. Employee #17 faile eye examination. A face-to-face interv conducted immediate Employee #17 states move the residents.' 483.15(h)(2) HOUSE The facility must pro- maintenance services sanitary, orderly, and This REQUIREMENT by: Based on observatio- tour of the facility, it w housekeeping and mo- not adequate to ensu- maintalned in a safe	observed on Octob ely 3:30 PM to enter ball type cap. He/s sonal belongings a aployee #17 approa in the common din it across the table fi #17 introduced him ops into the resident ned to his/her persu- asuring eye pressu- sured the pressure d to provide privacy iew with Employee rely after the observer d, "It is less trauma EKEEPING/MAINTE vide housekeeping as necessary to mail I comfortable interior to comfortable interior and the pressure of the table interior and the pressure of the table interior of the resident and e as necessary to mail a comfortable interior to solve the the facility we	r Unit 1A he placed t the ched ing area rom /herself l's eyes. onal etrieved a explained re. in both of during the #17 was ation. tic to ENANCE and ntain a or. denced onmental t s were /as	F 164 F 253 F <b>253</b>	1. Corrective Ac	viewed its' curret he Ophthalmoloc Administrator on 10(e) and 483.7 rivacy and confil ohthalmology sel ger and/or desig intaining compli- ncludes a rando or monitoring pris Clinical Manage lete a 10% audi sults to verify co- orted to the QA ns for changes I nd the need for pllance: 11/09/ pllance: 11/	ist was he entiality ices. ee is nce. 1 acy and and or of scheduled npliance. Committee current inher audits 7 7 d surfaces 354, and ctices e potential Manager tire facility I negative discovery	10]12/0 11/9/07 10/11/07 10/11/07
	demaged baseboard	····				·		·····
- UNIO-290	(02-99) FICVIOUS VEISIONS O	usulete Ev	ent ID; WUZV11	Facility	y ID: WASHHOME	. I c	continuation sheet	Page 3 of 19
					· .(	1		

€.

Ŀ

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	KANNER & MEDICAID SERVICES	(X2) MULTI	PLE CONSTRUCTION		(X3) DATE S COMPLI	
		095005	B. WING			10/1	2/2007
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	37	(EACH CORREC	Ŵ	D BE	(X5) COMPLET DATE
F 253	Continued From p marred/scarred fu were made in the Employee #3 on C AM and 10:30 AM The findings includ 1. Five (5) of 20 ba damaged surfaces rooms: 250, 312, 3 2. Three (3) of 20 damaged surfaces rooms: 312, 354 a 357. 3. Marred and/or c were observed in t Third Floor - splint four (4) of four (4) Second Floor- five dayroom and two ( sitting areas. Employees #2 and cited deficiencies a 483.20(c) QUARTI A facility must asse quarterly review ins and approved by C once every 3 mont This REQUIREME by: Based on staff inte	rage 3 rniture. These observations presence of Employee #2 and October 9, 2007 between 7:25 de: aseboards with marred and/or swere observed in the following 340, 354 and 367. walls with marred and/or swere observed in the following nd the hallway outside of room lamaged furniture surfaces he following areas: ered end table in the dayroom; arm chairs in the sitting area. (5) of five (5) arm chairs in the 2) of three (3) arm chairs in the 3 acknowledged the above at the time of the observations. ERLY REVIEW ASSESSMENT ess a resident using the strument specified by the State MS not less frequently than	F 253	3. Systemic Chang The facility has revie and procedure. The mainlenance staff wi by the Administrator provisions of 483.15 the maintenance of a and comfortable inter rounds have been ex weekly baseboard ob 4. Monitoring: The Director of Plant designee is responsit compliance. The QA environmental observ the interior. The hous maintenance team lea weekly environmental Administrator for mon Findings will be report	EFICIENCY) e(s): wed its' currently policy housekeeping and ll be inserviced or designee on the h)(2) specifically is sanitary, orderly, ior. Environmental panded to include servations. Operations and/or ole for maintaining Program includes the ation tool for monitoring sekeeping and ader will conduct randou rounds with the itoring compliance. red to the QA Committe for changes in current the need for further ans.	, , , , , ,	11/2/0

¥.

		AND HUMAN SERVICES			FOR	D: 10/18/20 M APPROV D. 0938-03
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		(X3) DATE	
· .		095005	B. WING		10	12/2007
NAME OF	PROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY STATE, ZIP CO		
THE WA	ASHINGTON HOME			3720 UPTON STREET NW WASHINGTON, DC 20016	·	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIC DATE
F 253	marred/scarred furr were made in the p	ge 3 niture. These observations resence of Employee #2 and tober 9, 2007 between 7:25	F 253 F <b>253</b>	1. Corrective Action(s)	observed in outside of	10/11/07
	damaged surfaces v rooms: 250, 312, 34 2. Three (3) of 20 w damaged surfaces v	eboards with marred and/or were observed in the following		<ol> <li>Identification of Deficient Pra &amp; Corrective Actions: Other marred or damaged surface potential to be affected. The Hous Manager and or designees will au facility to identify like findings. An negative findings will be corrected discovery and reported to the QA of for recommendations.</li> <li>Systemic Change(s): The facility has reviewed its' currer</li> </ol>	es have the sekeeping dited the y and all at time of Committee	10/15/0
F 276 SS=D	3. Marred and/or dat were observed in the Third Floor - splinter four (4) of four (4) ar Second Floor- five (5 dayroom and two (2) sitting areas. Employees #2 and 3 cited deficiencies at 6 483.20(c) QUARTER A facility must assess quarterly review instr	ed end table in the dayroom; m chairs in the sitting area. 5) of five (5) arm chairs in the of three (3) arm chairs in the acknowledged the above the time of the observations. RLY REVIEW ASSESSMENT is a resident using the ument specified by the State S not less frequently than	F 276	<ul> <li>and procedure. The housekeeping maintenance staff will be inserviced by the Administrator or designee or provisions of 483.15(h)(2) specificat the maintenance of a sanitary, order and comfortable interior. Environm rounds have been expanded to incluse weekly wall observations for marrin damaged surfaces.</li> <li>4. Monitoring: The Director of Plant Operations and designee is responsible for maintair compliance. The QA Program inclue environmental observation tool for maintenance. The housekeeping and team leader will conduct random we environmental counds with the Adminit / designee for monitoring compliance will be reported to the QA Committee of the compliance.</li> </ul>	and d the hthe erly, ental ude g or d/or hing des the monitoring maintenance rekly nistrator e. Findings	11/2/07
	This REQUIREMENT by: Based on staff intervi	I is not met as evidenced ew and record review for d records, it was determined		recommendations for changes in cu or practice and the need for further a or action plans. 5. Date of Compliance: 11/09/0	rrent policy audits and	11/9/07

£. .

.

۰.

4a

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES		·		FORM APPRO MB NO: 0938-0
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTIO	N (X	3) DATE SURVEY COMPLETED
		095005	B. WING	<u> </u>		10/12/2007
NAME OF	PROVIDER OR SUPPLIER		STRE	ET ADDRESS, CIT	Ý, STATE, ZIP CODE	
THE WA	SHINGTON HOME			20 UPTON STREE ASHINGTON, D		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	id Préfix Tag	(EACH COR	R'S PLAN OF CORRECTIO REGTIVE ACTION SHOULD RENCED TO THE APPROP DEFICIENCY)	BE COMPLE
F 253	were made in the p	age 3 niture. These observations resence of Employee #2 and ctober 9, 2007 between 7:25	F 253 F 253	the splintered et four arm chairs on the third floor dayroom and the	e Action(s) amaged furniture surfaces in ad table in the dayroom and t observed in the sitting area the five arm chairs in the two arm chairs in the discarded immediately.	
	damaged surfaces rooms: 250, 312, 34 2. Three (3) of 20 w damaged surfaces rooms: 312, 354 an	seboards with marred and/or were observed in the following		2. Identification & Corrective Ad Other furniture s to be affected. T and or designee identify marred of Any and all negative	n of Deficient Practices tions: urfaces have the potential the Housekeeping Manager s will audited the facility to or damaged furniture surfaces tive findings will be corrected and reported to the QA	
F 276 SS=D	were observed in th Third Floor - splinter four (4) of four (4) a Second Floor- five ( dayroom and two (2 sitting areas. Employees #2 and 3 cited deficiencies at 483.20(c) QUARTER A facility must asses quarterly review inst and approved by CM once every 3 months This REQUIREMEN by: Based on staff interv	red end table in the dayroom; rm chairs in the sitting area. 5) of five (5) arm chairs in the ) of three (3) arm chairs in the 8 acknowledged the above the time of the observations. RLY REVIEW ASSESSMENT as a resident using the rument specified by the State 4S not less frequently than	F 276	and procedure. maintenance sta by the Administra provisions of 483 the maintenance and comfortable rounds have bee weekly observati <b>4. Monitoring:</b> The Director of P is responsible for QA Program inclu- tool for monitoring and maintenance weekly environm and/or designee will be reported to recommendation practice and the action plans.	ange(s): eviewed its' currently policy The housekeeping and ff will be inserviced ator or designee on the .15(h)(2) specifically of a sanitary, orderly, interior. Environmental n expanded to include ons of furniture surfaces. lant Operations and/or design maintaining compliance. Th udes the environmental obset g the interior. The housekeep team leader will conduct ran ental rounds with the Adminis for monitoring compliance. Fo the QA Committee for s for changes in current policy need for further audits and or mpliance: 11/09/07	rvation ping Idom strator indings y or <b>11/9/0</b>

		H AND HUMAN SERVICES	<u>i, .,</u>			FOR	D: 10/18/200 M APPROVE D. 0938-039
STATEMEN AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILC	LTIPLE CONSTRUCTION	<b>I</b> *:	(X3) DATE COMP	SURVEY LETED
		095005	B. WING	i		10/	12/2007
NAME OF			s	TREET ADDRESS, CITY	, STATE, ZIP CODE		
THE WA	SHINGTON HOME			3720 UPTON STREE WASHINGTON, DO		_	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORF	ES PLAN OF CORREC ECTIVE ACTION SHO ENCED TO THE APP DEFICIENCY)	DULD BE	(X5) COMPLETION DATE
F 253	marred/scarred fu were made in the	rniture. These observations presence of Employee #2 and october 9, 2007 between 7:25	F 25	3			
SS=D	<ul> <li>damaged surfaces rooms: 250, 312, 3</li> <li>2. Three (3) of 20 y damaged surfaces rooms: 312, 354 at 357.</li> <li>3. Marred and/or d were observed in the Third Floor - splinte four (4) of four (4) at Second Floor- five dayroom and two (4) sitting areas.</li> <li>Employees #2 and cited deficiencies at 483.20(c) QUARTE A facility must asse quarterly review ins</li> </ul>	aseboards with marred and/or were observed in the following 40, 354 and 367. walls with marred and/or were observed in the following nd the hallway outside of room amaged furniture surfaces he following areas: ered end table in the dayroom; arm chairs in the sitting area. (5) of five (5) arm chairs in the 2) of three (3) arm chairs in the 3 acknowledged the above t the time of the observations. ERLY REVIEW ASSESSMENT ss a resident using the trument specified by the State MS not less frequently than	F 276 F <b>27</b>	Quarterly MDS for 2. Identification o & Corrective Action Other residents req	tor has since complete Resident #19. f Deficient Practices	; ·	10/19/07
	by: Based on staff inter	IT is not met as evidenced view and record review for ed records, it was determined		designee will audit of the to identify risks. An	ected at time of discove	S	

4c

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL	JLTIPLE CONSTRUCT		ATE SURVEY OMPLETED
		095005	B. WIN	G		10/12/2007
	PROVIDER OR SUPPLIER	·		STREET ADDRESS, C 3720 UPTON STR WASHINGTON,		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	( (EACH CC	DER'S PLAN OF CORRECTION DRRECTIVE ACTION SHOULD BE FERENCED TO THE APPROPRIAT DEFICIENCY)	
F 276 F 278 SS=D	that the facility sta Minimum Data Se Resident #19. The findings includ A review of Reside quarterly MDS was The following MDS record with the foll Quarterly MDS M Quarterly MDS M Quarterly MDS A There was no MDS 2007. According to the "N 2-15, "At a minimu assessments and a assessment are re Timing edits in th 92-day intervals be than 92 days in any interval. These 92 date at MDS Item F R2b of the next ass A face-to-face inter conducted on Octo 11:40 AM. He/She quarterly MDS was record was reviewed 483.20(g) - (j) RES The assessment m resident's status.	ff failed to complete a quarterly t (MDS) in July 2007 for le: ent #19's record revealed that a s not completed for July 2007. S assessments were in the owing completion dates: lovember 5, 2006 anuary 30, 2007 pril 25, 2007 S assessment after April 25, MDS 2.0 User's Manual", page m, three quarterly one comprehensive quired in each 12-month period e MDS standard system count cause there are never more y consecutive three-month days are measured from the R2b of one assessment to Item	F 2	<ul> <li>3. Systemic C The facility has and procedure, be inserviced b designee on the specifically the review assessing audit the clinical quarterly asses during the monit The MDS Coord in NSPAC MDS November 2007</li> <li>4. Monitoring: The Assistant D is responsible for QA Program indot the timely comp The Clinical Main medical record a Findings will be recommendation practice and the plans.</li> <li>5. Date of Comparison of the second second second second second second second second second second second second plans.</li> </ul>	s reviewed its' currently policy . The MDS Coordinators will by the Director of Nursing or e provisions of 483.20(c) timely completion of quarterly ments. The Clinical Managers will al record monthly for completed asment and report findings thly QA Committee Meeting. dinators have been enrolled 5 Certification Course for 7.	nce. 11/9/07
M CMS-25	67(02-99) Previous Versions		F	Facility ID: WASHHOME	If continuation s	sheet Page 5 of 1

TATEMEN	F OF DEFICIENCIES	KANDICAID SERVICES     (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION		(X3) DATE S	
ND PLAN C	OF CORRECTION		A. BUILDIN	G		COMPL	ETED
		095005	B. WING			10/1	2/2007
NAME OF P	ROVIDER OR SUPPLIER		STR	EET ADDRESS, CITY,	STATE, ZIP CODE		
THE WA	SHINGTON HOME			720 UPTON STREET ASHINGTON, DC			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRI	S PLAN OF CORRECT ECTIVE ACTION SHOU INCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 278	Continued From pa		F 278	1. Corrective	Action(s)		
	each assessment v participation of hea		F2780	<ul> <li>Resident #5 has s and a significant o completed for the</li> </ul>	nce been reassessed orrection has been proper coding of his		10/12/07
	A registered nurse assessment is com	must sign and certify that the pleted.		height in Section I 2. Identification	<2a. of Deficient Practices		
		o completes a portion of the sign and certify the accuracy of issessment.		affected. The Res will conduct a 100	ions: ave the potential to be ident Assessment Coor % audit of currently clini risks. Any and all nega	ical	10/19/07
	willfully and knowing false statement in a	d Medicaid, an individual who gly certifies a material and resident assessment is oney penalty of not more than		findings will be cor	rected at time of discov e QA Committee for	ery	
	\$1,000 for each ass willfully and knowing to certify a material resident assessmen	sessment; or an individual who gly causes another individual and false statement in a ht is subject to a civil money than \$5,000 for each		and procedure. The Coordinator and the be inserviced by the designee on the prespecifically resident	ge(s): ewed its' currently polic e Resident Assessmen e Registered Dietitian w e Director of Nursing or ovisions of 483.20(g)-(j) l assessments with spe n Section K2a. The MD	it vill cific	11/2/07
	Clinical disagreeme material and false s	nt does not constitute a tatement.		Coordinators have	been enrolled in NSPA Course for November 20	C	•
	by: Based on staff inter	IT is not met as evidenced view and record review for five ecords, it was determined that		designee is respon compliance. The G audit tool for monito	for of Nursing and/or sible for maintaining A Program includes an oring the accuracy of the Managers will conduct a	e	
	facility staff failed to Data Set (MDS) for include diagnoses for RN (Registered Nur failed to ensure that complete prior to sig	accurately code the Minimum height for two (2) residents, or two (2) residents, and the se) Assessment Coordinator all assessments were gning at Section R2b for one nts #5, 6, 11, 19 and 28.		random 10% medic monitoring compliar reported to the QA recommendations for policy or practice ar audits and or action	al record audit monthly nce. Findings will be Committee for or changes in current of the need for further		11/9/07
	The findings include	e:	1	5. Date of comp			

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: WASHHOME

If continuation sheet Page 6 of 19

ι. .

STATEMEN	RS FOR MEDICARE T OF DEFICIENCIES OF CORRECTION	K MEDICAID SERVICES     (X1) PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		OMB NC (X3) DATE S COMPL	
		095005	A. BUILDI B. WING				12/2007
	PROVIDER OR SUPPLIER			IREET ADDRESS, CITY, 3720 UPTON STREET	NW	<u> </u>	
(X4) ID PREFIX TAG	SUMMARY STA	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE	20016 S PLAN OF CORREC CTIVE ACTION SHO NCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETIC DATE
F 278	1. Facility staff faile Resident #5 on the A review of Resider admission MDS wa	d to code the height for admission MDS. nt-#5's record revealed that an s completed on August 9,	F 278 F 278	1. Corrective A Resident #6 has si and a significant co	rection has been roper coding of her 2a for the most		10/12/0
	According to the "M page 3-150, "Recor A face-to-face inten Employee #8 on Oc He/she acknowledg	ection K2a, "Height" was coded as "0". g to the "MDS 2.0 User's Manual" on 50, "Record the resident's height." -face interview was conducted with e #8 on October 11, 2007 at 2:30 PM. cknowledged that the height should have led. The record was reviewed October		<ul> <li>2. Identification of Deficient Practices</li> <li>&amp; Corrective Actions:</li> <li>Other residents have the potential to be affected. The Resident Assessment Coordinator will conduct a 100% audit of currently clinical records to identify risks. Any and all negative findings will be corrected at time of discovery and reported to the QA Committee for recommendations.</li> <li>2. Suptemic Change(5):</li> </ul>			10/19/
	admission, quarterly Resident #6. A review of Residen resident was admitte 16, 2005. Section K2a, "Heigh MDS assessments: Admission complete Significant change of Quarterly completed Quarterly completed Quarterly completed Quarterly completed	ompleted July 28, 2006 I December 27, 2006 I March 24, 2007		and procedure. Re Coordinator and the be inserviced by the designee on the pro specifically resident emphasis placed or Coordinators have I MDS Certification C 4. Monitoring: The Assistant Direct is responsible for m QA Program include the accuracy of the will conduct a randor monthly to monitorin	ewed its' currently poli	vill coffic DS C 007. The nitoring nagers I audit as will be	11/2/0
	Quarterly completed According to the "Mi page 3-150, "Record A face-to-face interv			for changes in curre need for further aud	Itiance: 11/09/07	id the	11/9/07

67(02-99) Previous Vers

acility ID:

If continuati neet r

	12001 221-1	029665679	NURSI	NG ADMIN OFFI			D: 10/18/20
		AND HUMAN SERVICES	lin	sed til	6,200		M APPROV 0. 0938-03
STATEMEN		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCT	ON	(X3) DATE	
		095005	B. WING		•	10/	12/2007
NAME OF	PROVIDER OR SUPPLIER			TREET ADDRESS, C		CODE	
THE WA	ASHINGTON HOME	, M		3720 UPTON STRI WASHINGTON,	1		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CO	ER'S PLAN OF I RRECTIVE ACT ERENCED TO T DEFICIENC	DN SHOULD BE	(X5) COMPLET DATE
F 278	He/she acknowledg should have been c	ed that the resident's height oded on the MDS and offered he missing heights. The	F 278 F 278	(B) Resident #11 and a significa	has since been re int correction has nclude her diagno	heen	10/12/0
	Chronic Renal Insuf change MDS for Re A review of Residen "Admission and Ann	t #11's record revealed an ual Physical Examination y 9, 2007. Included under		& Corrective , Other resident, the potential to Assessment C audit of current Any and all neg at time of disco	on of Deficient F Actions: s with a diagnoste be affected. The cordinator will cor ly clinical records ative findings will very and reported ecommendations	of "CRI" have Resident Juct a 100% o identify risks, se corrected to the QA	10/19/2
	A review of the signic completed August 2 was not included in S Diagnoses]. According to the "MD page 3-127, "Intent: infections which have resident's current AD statue, cognitive state medical treatments, r	1, 2007 revealed that "CRI" Section I [Disease DS 2.0 User's Manual" on To code those diseases or		and procedure, be inserviced b designee on the specifically resi- emphasis place coordinators ha MDS Certification 4. Monitoring: The Assistant Di	frange(s): reviewed Its' curr The MDS Coord y the Director of N provisions of 48 dent assessment: d on "diagnosis." ve been enrolled in Course for Nov rector of Nursing maintaining com	nator will rising or 20(g)-(j) with specific he MDS NSPAC mber 2007.	11/2/0
	Employees #2 and #8 approximately 10:15 a acknowledged that th CRI was not coded or reviewed October 11,	e resident's diagnosis of n the MDS. The record was 2007.		QA Program incl the accuracy of it will conduct a rar monthly to monito reported to the Q for changes in cu need for further a	des an audit tool e MDS. The Clin dom 10% medica ring compliance. A Committee for r rrent policy or pra	or monitoring cal Managers record audit rindings will be commendations lice and the plans.	11/09/0
	ensure that all assess	nt Coordinator failed to sments were complete on or to signing at Section R2b					

•

€ -

.....

1774

TATEMEN	T OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MU	LTIPLE CONSTRUCTION	(X3) DATE	O. 0938-039 SURVEY
NU FLAN (	or connection		A. BUILI	DING		
		095005	B. WING	· · · · · · · · · · · · · · · · · · ·	10	12/2007
NAME OF F	PROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP	CODE	<u> </u>
THE WA				3720 UPTON STREET NW WASHINGTON, DC 20016		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATÉ
F 278	A review of Resider the RT signed the A Section AA9b, on A Assessment Coord	ge 8 ht #19's record revealed that Assessment Tracking Form, pril 30, 2007. The RN inator signed the MDS, ril 25, 2007 indicating that all	F 27 F 278	1. Corrective Action(s) The interdisciplinary team has be on the provisions of the MDS 2.0 p.3-212 "The RN Assessment Co not sign and attest to completion until all other assessors have fini of the MDS."	Users Manual pordinator must of the assessment	10/15/0
	assessments were completed. According to the "MDS 2.0 User's Manual" page 3-212, "The RN Assessment Coordinator must not sign and attest to completion of the assessment until all other assessors have finished their portions of the MDS." The record was reviewed on October 11, 2007.			2. Identification of Deficient Pro & Corrective Actions: The interdisciplinary team has be on the provisions of the MDS 2.0 p.3-212 "The RN Assessment Co not sign and attest to completion until all other assessors have fini of the MDS."	en re-educated Users Manual pordinator must of the assessment	10/19/0-
	admission MDS ass A review of Resider revealed an admiss	d to include diagnoses on the sessment for Resident #28. at #28's closed record ion MDS completed July 19, no diagnoses coded in Section		3. Systemic Change(s): The facility has reviewed its' curre and procedure. The Clinical Man IDT will be inserviced by the DON on the provisions of 483.20(g)-(j) Manual p.3-212 specifically the si requirements for the Minimal Data Coordinators have been enrolled MDS Cadification Course for New	agers and the and or designee & MDS 2.0 Users ignature a Set. The MDS in NSPAC	11/2/07
1	completed by the ph following diagnoses degeneration, left fe hemiarthroplasty (su According to the "Nu Assessment" compl following diagnoses hemiarthroplasty afte	eted July 6, 2007, the were listed: left hip er left femoral fracture.		MDS Certification Course for Nov 4. Monitoring: The Assistant Director of Nursing is responsible for maintaining com QA Program includes an audit too the accuracy and signature requir for the Minimal Data Set. The Cli will conduct a random 10% medic monthly to monitoring compliance reported to the QA Committee for for changes in current policy or pr need for further audits and or activ	and/or designee opliance. The of for monitoring rements nical Managers ral record audit record audit Findings will be recommendations actice and the	11/9/07
t	The resident received physical and occupational therapy for improvement in walking, balance and gait as a result of the left femoral fracture.			5. Date of Compliance: 11/09	9/07	
	A face-to-face interv	iew was conducted with				}
M CMS-256	7(02-99) Previous Versions (	Obsolete Event ID: WUZV11	Fa	acility ID: WASHHOME	If continuation shee	Page 9 of 1
				( (		

₹″\_

and the second se

NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         THE WASHINGTON HOME       3720 UPTON STREET NW         (X4) ID       SUMMARY STATEMENT OF DEFICIENCIES         PREFIX       (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         F 278       Continued From page 8         A review of Resident #19's record revealed that the RT signed the Assessment Tracking Form, Section AA9b, on April 30, 2007. The RN Assessment Coordinator signed the MDS, Section R2b, on April 25, 2007 indicating that all			AND HUMAN SERVICES			0	RINTED: 10/18/200 FORM APPROVEI MB NO, 0938-039
NME OF PROVIDER OR SUPPLIER     UIII 20200       THE WASHINGTON HOME     STREET ADDRESS, CITY, STATE, ZP CODE       THE WASHINGTON HOME     JUNDAL STREET NW       WASHINGTON, DR 20016     SUMMARY STATEMENT OF DEFICIENCIES       OPENN TAG     SUMMARY STATEMENT OF DEFICIENCIES       PREX TAG     SUMMARY STATEMENT OF DEFICIENCIES       PREX STREET ADDRESS, CITY, STATE ZIP CODE     SUMME OF PRECINENCE ACTON SHOULD BE       Continued From page 8     Image: Summary Statement Coordinator MACHANA       Assessment Wassessment Coordinator must not sign and attest to completed July 19, 2007. There were no diagnoses on the admission MDS completed July 19, 2007. There were no diagnoses corded in Section 1, 2007. There were no di						ON (X3	
NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, City, STATE, ZIP CODE         THE WASHINGTON HOME       3720 UPTON STREET NW         Odd JD, PREVEX       IEACH DEFICIENCY MIST BE PRECEDED BY FULL (REGULATORY OR LSC IDENTIFYING INFORMATION)       PREVIX IEAC DORRECTION (REGULATORY OR LSC IDENTIFYING INFORMATION)       D         F 278       Continued From page 8       D       PREVIX (Resident #19's record revealed that the RT signed the Assessment Tracking Form, Section R2b, on April 20, 2007. The RN Assessment Coordinator signed the MDS, Section R2b, on April 20, 2007 indicating that all assessments were completed.       1. Corrective Actions!         According to the "MDS 2.0 User's Manual" page 3212, "The RM Assessment Coordinator must not sign and attest to completion of the assessment until all other assessors have finished their portions of the MDS." The record was reviewed on October 11, 2007.       3. Systemic Change(s): The Resident #28: closed record revealed an admission MDS completed July 19, 2007. There were no diagnoses coded in Section 1.       3. Systemic Change(s): The Resident #28: closed record reviewed framission MDS completed July 19, 2007. There were no diagnoses coded in Section 1.       1. Mentioning: The Assistan Director of Nursing is responsible for maintaining comparison of MeDS.         According to the history and physical examination completed by the physical on July 6, 2007, the following diagnoses were listed: macular degeneration, left femoral neck fracture, left hemiarthroplasty (surgery June 30, 2007)       1. Monitoring: The According to the "Nursing Admission Assessment" completed.       1. Monitoring: The According to the MOS. The Clincal Maginges will conduct and the dot provide and the			095005	B. WING _			10/12/2007
THE WASHINGTON HOME       WASHINGTON, pc 20016         040 iD PREFIX TAG       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WIST EN PRECEDED BY PLUL REGULATORY OR LSC IDENTIFYING INFORMATION)       D PAGE IX PREFIX TAG       PREFIX PRECENCE TO THE APPROPRIATE DEFICIENCY TAG       Constitution (EACH DEFICIENCY WIST EN PRECEDED BY PLUL REGULATORY OR LSC IDENTIFYING INFORMATION)       D PAGE IX PREFIX TAG       PREFIX PREFIX PREFIX       PREFIX PREFIX       PREFIX PREFIX       PREFIX (EACH DEFICIENCY WIST EN PRECEDED BY PLUL REGULATORY OR LSC IDENTIFYING INFORMATION)       Com- the Construction of the APPROPRIATE DEFICIENCY       Com- the Construction of the Construction of the the CT sign and attest to completion of the assessment control to the CA committee for recommendations.       1. Corrective Action(s) PRESIX       7/2/2         5. Facility staff failed to include diagnoses on the admission MDS assessment for Resident #28: closed record revealed an admission MDS completed July 19, 2007. There were no diagnoses coded in Section L.       3. System Change (s): The facility hare reviewed is currently policy and procedure. The Resident Assessment Coordinator Nue be inserviced by the Director of Nursing of defigeer on the provisions of 483.20(1)-by beifficially Section 1 Diagnoses. The Assistant Director of Nursing is responsible for manianiang compliance. The CA Program includes an addit tool for mointoing the currency of the MDS. The Chical Margers will conduct a random 10% maddical erecord auffit monthy to maintoing compliance.	NAME OF F	PROVIDER OR SUPPLIER					
PREFIX TAG       CACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFX TAG       CACH CORRECTVE ACTION SHOULD BE CROSS-REPERCISED TO THE APPROPRIATE DEFICIENCY       Continued From Should BE CROSS-REPERCISED TO THE APPROPRIATE DEFICIENCY       Construction Should BE CROSS-REPERCISED TO THE APPROPRIATE DEFICIENCY	THE WA	SHINGTON HOME				1.1	
A review of Resident #19's record revealed that the RT signed the Assessment Tracking Form, Section A3b, on April 30, 2007. The RN Assessment Coordinator signed the MDS, Section R2b, on April 25, 2007 indicating that all assessment completed. According to the "MDS 2.0 User's Manual" page 3-212, "The RN Assessment Coordinator must not sign and attest to completion of the assessment until all other assessors have finished their portions of the MDS." The record was reviewed on October 11, 2007. 5. Facility staff failed to include diagnoses on the admission MDS assessment for Resident #28. A review of Resident #28's closed record revealed an admission MDS completed July 19, 2007. There were no diagnoses coded in Section 1. According to the history and physical examination completed by the physician on July 6, 2007, the following diagnoses were listed: macular degeneration, left femoral neck fracture, left hemiarthroplasty (surgery June 30, 2007) According to the "Nursing Admission Assessment" completed July 6, 2007, the following diagnoses were listed: left hip	PREFIX	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	PREFIX	(EACH CO	RECTIVE ACTION SHOULD ERENCED TO THE APPROPR	BE COMPLÉTION
The resident received physical and occupational therapy for improvement in walking, balance and gait as a result of the left femoral fracture.		A review of Resider the RT signed the A Section AA9b, on A Assessment Coord Section R2b, on Ap assessments were According to the "M 3-212, "The RN Ass not sign and attest t assessment until all finished their portior was reviewed on Oc 5. Facility staff faile admission MDS ass A review of Residen revealed an admissi 2007. There were n I. According to the hist completed by the ph following diagnoses degeneration, left fer hemiarthroplasty (su According to the "Nu Assessment" complet following diagnoses hemiarthroplasty after The resident receive therapy for improven	At #19's record revealed that assessment Tracking Form, pril 30, 2007. The RN nator signed the MDS, ril 25, 2007 indicating that all completed. DS 2.0 User's Manual" page ressment Coordinator must o completion of the other assessors have as of the MDS." The record tober 11, 2007. It to include diagnoses on the essment for Resident #28. It #28's closed record on MDS completed July 19, o diagnoses coded in Section ory and physical examination ysician on July 6, 2007, the were listed: macular noral neck fracture, left rgery June 30, 2007) rsing Admission eted July 6, 2007, the were listed: left hip er left femoral fracture. d physical and occupational hent in walking, balance and		<ul> <li>Resident #28 ha</li> <li>2. Identificatio</li> <li>&amp; Corrective A</li> <li>Other residents</li> <li>Degeneration, le</li> <li>or left hemiarthrition</li> <li>to be affected. The coordinator (s) wa</li> <li>audit of currently</li> <li>Any and all negating at time of discover</li> <li>Committee for residents</li> <li>3. Systemic Ch</li> <li>The facility has real and procedure. The facility has real and procedure. The facility has real procedure. The MDS Coordinator will the of Nursing or des 483.20(g)-(j) spectifies the MDS Coordination of the M</li></ul>	as since been discharged. In of Deficient Practices ctions: with a diagnosis of "Macular fit femoral neck fracture, and oplasty have the potential The Resident Assessment fill conduct a 100% clinical records to identify risks tive findings will be corrected ery and reported to the QA commendations. ange(s): eviewed its' currently policy The Resident Assessment be inserviced by the Director ignee on the provisions of cifically Section I *Diagnoses." hators have been enrolled in tification Course for November ector of Nursing is responsible fi iance. The QA Program includo onitoring the accuracy of the M gers will conduct a random 10% dit monthly to monitoring compl ported to the QA Committee for for changes in current policy or eed for further audits and or act	or es DS. $\frac{11/2}{07}$ $\frac{11/9}{07}$
A face-to-face interview was conducted with DRM CMS-2567(02-99) Previous Versions Obsolete Event ID: WUZV11 Facility ID: WASHHOME If continuation sheet Page 1						   	

and a first of

a she waa waxaa ta wa

and the construction of the construction of the

9a.

		AND HUMAN SERVICES			FORM	): 10/18/20 MAPPROVI ). 0938-03
STATEMEN	F OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMPL	SURVEY
		095005	B. WING		- 10/	12/2007
	PROVIDER OR SUPPLIER			ET ADDRESS, CITY, STATE, 20 UPTON STREET NW		
THE WA		· · · · · · · · · · · · · · · · · · ·	W	ASHINGTON, DC 20016		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES WUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PRÉFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE	(X5) COMPLETI DATE
F 278 F 279 SS=D	Employee #2 on Oc He/she acknowledg diagnoses listed for was reviewed Octol 483.20(d), 483.20(k CARE PLANS A facility must use to to develop, review a comprehensive plan The facility must de plan for each reside objectives and time medical, nursing, ar needs that are ident assessment. The care plan must to be furnished to at highest practicable p psychosocial well-be §483.25; and any se be required under § due to the resident's §483.10, including th under §483.10(b)(4)	ctober 10, 2007 at 8:45 AM. ged that there were no Resident #28. The record ber 10, 2007. c)(1) COMPREHENSIVE the results of the assessment and revise the resident's in of care. velop a comprehensive care ent that includes measurable tables to meet a resident's ind mental and psychosocial tified in the comprehensive describe the services that are tain or maintain the resident's physical, mental, and eing as required under ervices that would otherwise 483.25 but are not provided a exercise of rights under ne right to refuse treatment	F 278	<ol> <li>Corrective Action(s Resident #6 has since bee and her individualized nee appropriately care planned need for oxygen therapy.</li> <li>Identification of Deficit &amp; Corrective Actions: Other residents requiring on have the potential to be aff Manager and or designeen the current clinical records Any and all negative finding at time of discovery and re- the QA Committee for records</li> <li>Systemic Change(s): The facility has reviewed its and procedure. The compri- evaluation process and the the 24 hour report will be the maintaining compliance. The team will be inserviced regatevelopment of comprehen utilizing the provisions of 48 483.20(k)(1) by the Director designee.</li> <li>Monitoring: The Assistant Director of Nu designee is responsible for compliance. The QA Prograudit tool for monitoring the implementation / adjustmen</li> </ol>	n reassessed ds have been to include her ent Practices xygen therapy ected. The Clinical will audit 100% of to identify risks. gs will be corrected corted to mmendations. s' currently policy ehensive nursing daily review of e mechanism for he interdisciplinary arding the sive care plans 13.20(d) and of Nursing or	10/15/ 10/14/ 11/2/07
	(2) of 28 sampled re that facility staff faile appropriate goals ar resident on oxygen t	view and record review for two sidents, it was determined d to initiate a care plan with d approaches for one (1) herapy and one (1) resident rapy. Residents #6 and 8.		<ul> <li>specific care planning. The will conduct a random 10% audit of care plans monthly compliance. Findings will b QA Committee for recomme changes in current policy or the need for further audits a plans.</li> <li>5, Date of Compliance:</li> </ul>	medical record to monitor e reported to the indations for practice and nd or action	

۹<u>۶</u> -

		HAND HUMAN SERVICES			FÓRI	d: 10/18/20 Mapprov D. 0 <u>938-03</u>
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		095005	B. WING		10/	12/2007
NAME OF I	PROVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·	STR	EET ADDRESS, CITY, STATE, ZIP		
THE WA	SHINGTON HOME			20 UPTON STREET NW ASHINGTON, DC 20016		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETH DATE
F 279	Continued From pa	age 10	F 279	· · · · · · · · · · · · · · · · · · ·		
		ed to initiate a care plan with and approaches for Resident ygen therapy.	F279(2)	<ol> <li>Corrective Action(s) Resident #8 has since been rea her individualized needs have b care planned to include her nee therapy.</li> </ol>	een appropriately	10/15/0
	physician's order da directing, "Oxygen cannula) for POX ( measurement) less The care plan, last not updated to inclu		· ·	<ol> <li>Identification of Deficient P &amp; Corrective Actions: Other residents on anticoagulan potential to be affected. The Clii or designee will audit 100% of th records to identify risks. Any an- will be corrected at time of disco the QA Committee for recommer</li> <li>Systemic Change(s):</li> </ol>	ts have the nical Manager and le current clinical d all negative findings very and reported to	10/19/
	Employee #9 on Od He/she acknowledg been a care plan fo The record was rev 2. Facility staff failed	view was conducted with ctober 11, 2007 at 9:30 AM. jed that there should have r the use of oxygen therapy. iewed October 11, 2007. d to initiate a care plan with nd approaches for Resident		The facility has reviewed its' curr and procedure. The comprehens evaluation process and the daily the 24 hour report will be the med maintaining compliance. The inte learn will be inserviced regarding of comprehensive care plans utili provisions of 483.20(d) and 483.2 Director of Nursing or designee.	sive nursing review of chanism for erdisciplinary the development zing the	11/2/0
	(Coumadin). According to the ad physician on July 6, receiving Coumadin A review of the resid July 6, 2007 and rev revealed that there	mission orders signed by the 2007, the resident was		4. Monitoring: The Assistant Director of Nursing is responsible for maintaining corr QA Program includes an audit too the development and implemental of resident specific care planning. Managers will conduct a random 1 audit of care plans monthly to mor Findings will be reported to the QA recommendations for changes in co practice and the need for further au plans.	pliance. The I for monitoring ion / adjustments The Clinical 0% medical record nitor compliance. Committee for current policy or	17/9/0
	A face-to-face interv Employee #11 on O	view was conducted with ctober 10, 2007 at 3:00 PM. ed that a care plan for		5. Date of Compliance: 11/09/	/07	

If continuation sheet Page 11 of 19 

STATEMEN	RS FOR MEDICAL T OF DEFICIENCIES OF CORRECTION	XE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE	O. 0938-03 SURVEY LETED
		095005	B. WING		10	/12/2007
	PROVIDER OR SUPPLIEI	₹	37	EET ADDRESS, CITY, S 720 UPTON STREET	STATE, ZIP CODE NW	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE ICED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET DATE
F 279 F 281 SS=D	anticoagulant the for Resident #8. October 10, 2007 483.20(k)(3)(i) CC The services prov must meet profes This REQUIREMI by: Based on observa it was determined his/her hands price	rapy should have been initiated The record was reviewed DMPREHENSIVE CARE PLANS rided or arranged by the facility sional standards of quality. ENT is not met as evidenced ations during the survey period, that facility staff failed to wash r to instilling eye drops and ure for Resident S1.	F 279 F 281	regarding the "Gui in Health Care Set by the CDC. 2 Identification & Corrective Action Other residents new Consultations have The ophthalmologis Administrator imme designated a privat provision of ophtha	since been re-educated delines for Hand Hygiene tings," developed n of Deficient Practices	10/12/0
	Employee #17 wa 2007 at approxima and removing a ba placed a compute the nurse's station Resident S1, sittin with one (1) reside him/her. Employee and instilled eye d Employee #17 retu- belongings at the device, went back that he/she was m Employee #17 me the resident's eyes Employee #17 fai during the entire o	s observed on October 10, ately 3:30 PM entering Unit 1A aseball type cap. He/she r and personal belongings at Employee #17 approached g in the common dining area ent across the table from e #17 introduced him/herself rops into the resident's eyes. urned to his/her personal nurse's station and retrieved a to the resident and explained leasuring eye pressure. easured the pressure in both of		conduct random ob ophthalmology sen hand sanitation pric Any and all negativ at time of discovery Committee for reco <b>3. Systemic Chan</b> The facility has rev and procedure. The redirected by the A inserviced by the N provisions of 483.20 Care Plans and "Gu	servations of scheduled vices to monitor proper or to service delivery. e findings will be corrected and reported to the QA mmendations. ge(s): ewed its' currently policy e Ophthalmologist was dministrator and will be HA or designee on the D(k)(3)(i) Comprehensive idelines for Hand Hygiene ngs, developed by the	10/12/0

€.

	TMENT OF HEALTH AND HUMAN SERVICES	an teathers	eneri - Pengilan ri <mark>gi</mark> si - P	PRINTE	D: 10/22/2007
	RS FOR MEDICARE & MEDICAID SERVICES				APPROVED 0.0938-0391
STATEMEN	T OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA DF CORRECTION IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE COMPL	SURVEY .
} .	. 095005	B. WING		10/	12/2007
}	PROVIDER OR SUPPLIER SHINGTON HOME	S	TREET ADDRESS, CITY, S 3720 UPTON STREET N WASHINGTON, DC 2	TATE, ZIP CODE IW	12/2007
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIATE EFICIENCY)	(X5) COMPLETION DATE
F 281 F 323 SS=E	Continued From page 12 According to "Guideline for Hand Hygiene in Health Care Settings," developed by the Center for Disease Control, October 25, 2002, page 34, "Decontaminate hands before having direct contact with patients." 483.25(h) ACCIDENTS AND SUPERVISION The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 28 F 32:	The Clinical Manage responsible for mair QA Program include tool for monitoring p The Clinical Manage complete a 10% aut ophthalmology cons compliance. Finding QA Committee for re changes in current p need for further aud	sults monthly to verify gs will be reported to the	"/9/07
	<ul> <li>This REQUIREMENT is not met as evidenced by:</li> <li>Based on observations during the initial tour of the facility, it was determined that facility staff failed to maintain an accident free environment as evidenced by a buckled front lobby carpet, damaged skid strips in residents' showers, a broken over-bed light cover and wall plate and loose rubber molding in a resident's room. These observations were made in the presence of Employees #2 and 3 on October 9, 2007 from 7:25 AM until 10:10 AM.</li> <li>The findings include:</li> <li>An employee was observed on October 9, 2007 at 10:10 AM to trip over the buckled front lobby wall-to-wall carpet.</li> <li>Four (4) of 15 resident showers were observed with damaged skid strips that were lifting from the floor in the following areas: Third floor first hallway, A367, A220 and B220.</li> </ul>				
]	67(02-99) Previous Versions Obsolete Event ID: WUZV11		cility ID: WASHHOME	If continuation sheet	

		TH AND HUMAN SERVICES			FORM	D: 10/22/20 MAPPROV
	RS FOR MEDICAL T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MILLI TH		OMB NC (X3) DATE S	0. 0938-03
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPL	ETED
		095005	B. WING	·	10/	12/2007
NAME OF I	PROVIDER OR SUPPLIEF	र	STR	EET ADDRESS, CITY, STATE, ZIP CO		
THE WA	SHINGTON HOME		•	20 UPTON STREET NW ASHINGTON, DC 20016		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLET DATE
F 281	Continued From	bage 12	F 281			+
	According to "Gui Health Care Setti for Disease Contr	deline for Hand Hygiene in ngs," developed by the Center ol, October 25, 2002, page 34, ands before having direct				
F 323 SS=E	483.25(h) ACCID The facility must e environment rema as is possible; and	ENTS AND SUPERVISION ensure that the resident ains as free of accident hazards d each resident receives sion and assistance devices to	F 323 F <b>32<sup>3</sup> (')</b>	<ol> <li>Corrective Action(s)         The front lobby carpet has since bee by hardwood floors.     </li> <li>Identification of Deficient Pract &amp; Corrective Actions:         Other carpeted areas in the facility h potential to be affected. The Directo Operations will inspect all carpeted a identify risks. Any/all negative findin corrected at time of discovery.     </li> </ol>	<b>ices</b> ave the r of Plant areas to	10/18/0 10/12/0
	by: Based on observative the facility, it was of failed to maintain a evidenced by a build damaged skid strip broken over-bed li loose rubber mold observations were	ENT is not met as evidenced ations during the initial tour of determined that facility staff an accident free environment as ickled front lobby carpet, ps in residents' showers, a ght cover and wall plate and ing in a resident's room. These made in the presence of 1 3 on October 9, 2007 from 0 AM.		<ol> <li>Systemic Change(s): The facility has reviewed its' currently and procedure. The environmental s staff have been inserviced by the Ad or designee on the provisions of 483 specifically accidents and supervisio Environmental rounds have been ex include carpet assessment, repair, m and or replacement.</li> <li>Monitoring: The Director of Plant Operations and is responsible for maintaining compli QA Program includes the environment</li> </ol>	services Iministrator 1.25(h) panded to naintenance, d/or designee iance. The ental observation	11/2/2
	2007 at 10:10 AM lobby wall-to-wall of 2. Four (4) of 15 m with damaged skid	as observed on October 9, to trip over the buckled front carpet. esident showers were observed I strips that were lifting from the ing areas: Third floor first		<ul> <li>tool for monitoring the interior. The l and maintenance team leader will co weekly environmental rounds with the for monitoring compliance. Findings to the QA Committee for recomment changes in current policy or practice for further audits and or action plans</li> <li>5. Date of Compliance: 11/09/0</li> </ul>	onduct random the Administrator s will be reported dations for the need	1/7/0

.

¢,

13a

	RS FOR MEDICAR	E & MEDICAID SERVICES			<u> </u>	<u>IO. 0938-03</u> 9
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 095005	(X2) MULTIF A. BUILDING B. WING		COM	E SURVEY PLETED
			STR	EET ADDRESS, CITY, S		
,	SHINGTON HOME		37	20 UPTON STREET	ŃW	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	id Préfix Tág	(EACH CORRE CROSS-REFEREI	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE
F 281	Continued From p	page 12	F 281			
	According to "Guid Health Care Settir for Disease Contro	deline for Hand Hygiene in lgs," developed by the Center ol, October 25, 2002, page 34, ands before having direct		1. Corrective Ac		
F 323 SS≃E	483.25(h) ACCIDE	ENTS AND SUPERVISION	F 323	The damaged skid s shower rooms 367A, been replaced.	trips observed in 220A, and 220B have	10/4/0=
33-E	environment rema as is possible; and adequate supervis prevent accidents.	i each resident receives ion and assistance devices to	F323(2)	& Corrective Action Other resident show potential to be affect and Maintenance tea	<b>is:</b> ers rooms have the ed. The Housekeeping im leader will inspect dentify risks. Any and	10/18/0
	by: Based on observat the facility, it was of failed to maintain a evidenced by a build damaged skid strip broken over-bed lig loose rubber moldi observations were	NT is not met as evidenced tions during the initial tour of letermined that facility staff an accident free environment as ckled front lobby carpet, os in residents' showers, a ght cover and wall plate and ng in a resident's room. These made in the presence of 3 on October 9, 2007 from		and procedure. The staff have been inser or designee on the p specifically accidents Environmental round include the assessme	wed its' currently policy environmental services viced by the Administrator rovisions of 483.25(h)	11/2/07
	7:25 AM until 10:10 The findings includ	) AM.		The Director of Plant designee is responsit compliance. The QA environmental observer	ble for maintaining Program includes the ation tool for monitoring	
	2007 at 10:10 AM lobby wall-to-wall c			weekly environmenta for monitoring compli	sekeeping m leader will conduct random I rounds with the Administrator ance. Findings will be reported for recommendations for	11/9/07
	with damaged skid	esident showers were observed strips that were lifting from the g areas: Third floor first 0 and B220.			licy or practice and the need or action plans.	

٩.

136

	T OF DEFICIENCIES	E & MEDICAID SERVICES	(Y2) MIL	TIPLE CONSTRUCTION	(X3) DATE	0.0938-039
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD			LETED
			B. WING	,	`	
· .		ć 095005			10/	12/2007
AME OF F	PROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CO	DE	
HE WA	SHINGTON HOME			3720 UPTON STREET NW WASHINGTON, DC 20016		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 281	Continued From p		F 28	1		
	According to "Guid Health Care Settir for Disease Contro	deline for Hand Hygiene in lgs," developed by the Center ol, October 25, 2002, page 34, ands before having direct	F 20			
	contact with patier	nts."	F 00	1. Corrective Action(s) The broken plastic cover on the over		10/10/0
F 323 SS=E	483.25(h) ACCIDE 	ENTS AND SUPERVISION	F 32:	in Room 307B has since been repla	ced.	
	environment rema as is possible; and	nsure that the resident ins as free of accident hazards each resident receives ion and assistance devices to	F323	& Corrective Actions: The over bed lights in other residen the potential to be affected. The Ho and Maintenance team leader has in resident room over bed light plastic identify risks. Any and all negative f be corrected at time of discovery.	usekeeping ispected all covers to	10/12/1
	by: Based on observation the facility, it was of failed to maintain a evidenced by a bud damaged skid strip broken over-bed lig loose rubber moldi observations were Employees #2 and 7:25 AM until 10:10 The findings includ 1. An employee wa 2007 at 10:10 AM to lobby wall-to-wall c 2. Four (4) of 15 re- with damaged skid	e: os observed on October 9, o trip over the buckled front arpet. esident showers were observed strips that were lifting from the g areas: Third floor first	· ·	<ol> <li>Systemic Change(s): The facility has reviewed its' current and procedure. The environmental staff have been inserviced by the Ac or designee on the provisions of 483 specifically accidents and supervisio Environmental rounds have been ex include the assessment, repair, main and or replacement of over bed light covers in resident rooms.</li> <li>Monitoring: The Director of Plant Operations and Designee is responsible for maintain The QA Program includes the enviro Observation tool for monitoring the in specifically the plastic covers of the o The housekeeping and maintenance will conduct random weekly environm with the Administrator for monitoring Findings will be reported to the QA C for recommendations and or changes policy or practice and the need for fu and or action plans.</li> <li>Date of Compliance: 11/09/07</li> </ol>	services ministrator .25(h) n. panded to itenance, plastic //or ing compliance. nmental iterior over bed lights. team leader nental rounds compliance. ommittee s in current ther audits	11 /2/07 11 /2/07

heet Page 13

۰.

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED 10/12/2007	
		095005	B. WING_	······································		
NAME OF	PROVIDER OR SUPPLIEF	ι		REET ADDRESS, CITY, STATE, ZIP	CODE	
THE WA	SHINGTON HOME			720 UPTON STREET NW WASHINGTON, DC 20016	<u></u>	· · · · · · · · · · · · · · · · · · ·
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTA CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE
F 281 F 323 SS=E	According to "Guid Health Care Settin for Disease Contro "Decontaminate h contact with patien 483.25(h) ACCIDE The facility must e environment rema as is possible; and	deline for Hand Hygiene in ngs," developed by the Center ol, October 25, 2002, page 34, ands before having direct nts." ENTS AND SUPERVISION ensure that the resident ins as free of accident hazards d each resident receives sion and assistance devices to	F 281 F 323 F 32 <sup>2/4</sup>	<ol> <li>Corrective Action(s)         The damaged wall plate cover obso 336 has since been replaced.     </li> <li>Identification of Deficient Prace &amp; Corrective Actions:         The wall plate covers throughout the the potential to be affected. The He and Maintenance team leader will convironmental rounds to identify ris negative findings will be corrected a     </li> </ol>	; ctices ne facility have pusekeeping conduct ks. Any and all	10/11/07
	by: Based on observa the facility, it was of failed to maintain a evidenced by a bu- damaged skid strip broken over-bed lig loose rubber moldi observations were Employees #2 and 7:25 AM until 10:10 The findings includ 1. An employee wa 2007 at 10:10 AM lobby wall-to-wall of 2. Four (4) of 15 re with damaged skid	le: as observed on October 9, to trip over the buckled front arpet. esident showers were observed strips that were lifting from the g areas: Third floor first		<ol> <li>Systemic Change(s): The facility has reviewed its' curren and procedure. The environmental staff have been inserviced by the A or designee on the provisions of 48 specifically accidents and supervisi Environmental rounds have been er include the assessment, repair, mai and or replacement of wall plate con the facility.</li> <li>Monitoring: The Director of Plant Operations an is responsible for maintaining comp QA Program includes the environment tool for monitoring the interior speci- plate covers. The housekeeping an team leader will conduct random we rounds with the Administrator for mot Findings will be reported to the QA recommendations for changes in cu- plans.</li> <li>Date of Compliance: 11/09/0</li> </ol>	tly policy services dministrator 3.25(h) on. xpanded to intenance, vers throughout d/or designee liance. The ental observation fically the wall ad maintenance sekly environmental ponitoring compliance. Committee for irrent policy or dits and or action	11/2/07 11/9/07
ORM CMS-25	67(02-99) Previous Version	s Obsolete Event ID: WUZV11	Faci	lity ID: WASHHOME	continuation sheet	Page 13 of 19
						13d

		HAND HUMAN SERVICES			FOR	D: 10/22/200 M APPROVE D. 0938-039
TATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IULTIPLE CONSTRUCȚIO I DING	· · · · · · · · · · · · · · · · · · ·	SURVEY
		095005	B, WI	1G	10/	12/2007
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY	• • .	
THE WA	SHINGTON HOME			3720 UPTON STREE WASHINGTON, DO		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	X (EACH CORF	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIOI DATE
F 281	Health Care Setting for Disease Contro	eline for Hand Hygiene in gs," developed by the Center l, October 25, 2002, page 34, nds₋before having direct	F2	281 1. Corrective		
F 323 SS=E	483.25(h) ACCIDEI The facility must en environment remain as is possible; and	NTS AND SUPERVISION sure that the resident hs as free of accident hazards each resident receives on and assistance devices to	F 3 F 3 <sup>2</sup>	<ul> <li>way of Room 230</li> <li>2. Identification of &amp; Corrective Action of the control of the control of the control of the conduct environment of the conduct envit environment of</li></ul>	molding observed in the door has since been replaced. of Deficient Practices ons: ing in door ways throughout the tential to be affected. The Maintenance team leader will antal rounds to identify risks. Any dings will be corrected at time of	10/11/0
	by: Based on observation the facility, it was defined to maintain an evidenced by a buck damaged skid strips broken over-bed ligh loose rubber moldin observations were molding	IT is not met as evidenced ons during the initial tour of termined that facility staff a accident free environment as kied front lobby carpet, in residents' showers, a at cover and wall plate and g in a resident's room. These hade in the presence of 3 on October 9, 2007 from AM.		and procedure. Th staff have been ins or designee on the specifically acciden Environmental roun include the assess and or replacement ways throughout the <b>4. Monitoring:</b> The Director of Plan is responsible for m	ewed its' currently policy e environmental services erviced by the Administrator provisions of 483.25(h) ts and supervision. ds have been expanded to nent, repair, maintenance, rubber molding in door	11/2/07
	2007 at 10:10 AM to lobby wall-to-wall ca 2. Four (4) of 15 res with damaged skid s	observed on October 9, trip over the buckled front rpet. sident showers were observed trips that were lifting from the areas: Third floor first		tool for monitoring the molding in door way housekeeping and n conduct random were with the Administrate Findings will be report recommendations for practice and the neet plans.	e interior specifically the rubber s throughout the facility. The naintenance team leader will ekly environmental rounds or for monitoring compliance. rted to the QA Committee for r changes in current policy or d for further audits and or action tance: 11/09/07	11/9/07
	7(02-99) Previous Versions (			Facility ID: WASHHOME	If continuation sheet I	

13e

w,

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI	FIPLE CONSTRUCTION	4	(X3) DATE COMPI	
		095005	B. WING			10/12/2007	
	PROVIDER OR SUPPLIER			REET ADDRESS, CIT 3720 UPTON STREE WASHINGTON, D	TNW		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORF	R'S PLAN OF CORREC RECTIVE ACTION SHO RENCED TO THE APP DEFICIENCY)	DULD BE	(X5) COMPLETIC DATE
F 323	Continued From pa	ge 13 of the over-bed light was	F 323				
	observed broken in over-bed lights obs	room 307B in one (1) of 20 erved.					
		r was observed damaged and om 336 in one (1) of 20 wall ed.					
	5. The rubber mold doorway of room 23 room doorways obs	ng was observed loose in the 0 in one (1) of 20 resident erved.					
F 371 SS=E	cited deficiencies at	3 acknowledged the above the time of the observations. ARY CONDITIONS - FOOD	F 371	The 25 servings of	mandarin oranges, 9 p		
	The facility must sto serve food under sa	pre, prepare, distribute, and initary conditions.		Jello, 9 serving of a fresh fruit salad, 17 salad, 20 cups of ic	ing of diet Jello, 61 sen upple sauce, 15 serving servings of fresh gard e tea, and 4 serving of arded post observation	gs of en fruit	10/9/0
	by: Based on observation determined that fact prepare food under evidenced by: unlab	IT is not met as evidenced ons of the main kitchen, it was lity staff failed to store and sanitary conditions as eled and undated food, stored in the walk-in		& Corrective Action Other meal prep ite meal distribution and be affected. The For Food Services Sup- items prior to storage	ms prepared for sched d storage have the pot bod Services Manager ervisor will inspect any/ ge for proper labels, dat negative findings will be	ential to and or 'all food tes, and	10/9/
	and an uncovered d were made in the pr	ored wet and ready for re-use umpster. These observations esence of Employees #5 and 07 between 6:55 AM and		and procedure. The inserviced by the Re on the provisions of	ge(s): ewed its' currently polic e dietary services staff egistered Dietitian or de 483.35(i)(2) specificall food prep, and storage	will be esignee y	n/z/o;
RM CMS-25	67(02-99) Previous Versions		Fac	ility ID: WASHHOME	If continu	uation sheet	Page 14 of

	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: /)	A. BUILDING	G	(X3) DATE SURVEY COMPLETED	
		<sup>2</sup> 095005	B. WING		10/	12/2007
	PROVIDER OR SUPPLIE	R	37	EET ADDRESS, CITY, STATE, ZIP 720 UPTON STREET NW /ASHINGTON, DC 20016		
(X4) ID	SUMMARY S			PROVIDER'S PLAN OF		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PRÈFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLETE
F 441 SS=D	<ol> <li>The following is and/or unlabeled</li> <li>25 servings of ma 9 packages of co 54 servings of die 61 servings of Je 9 servings of app 15 servings of fre 20 cups of iced te 4 servings of fruit</li> <li>Seven (7) heac moldy and wilted</li> <li>The following it for re-use:</li> <li>of 14 sheet pal Five (5) of 14 hote Five (5) of five (5) Two (2) of two (2)</li> <li>The roll away d contain bags of tra 483.65(a) INFECT</li> <li>The facility must e infection control p safe, sanitary, and to prevent the dev</li> </ol>	tems were observed undated in the walk-in refrigerator: andarin oranges okies et Jello llo lesauce sh fruit salad sh garden salad a cocktail ls of lettuce were observed in the walk-in refrigerator. ems were stored wet and ready ns el pans ½ hotel pans roasting pans umpster was observed to ash and was uncovered. d 15 acknowledged these e of the observations. TION CONTROL establish and maintain an rogram designed to provide a l comfortable environment and elopment and transmission of	F 371	<ul> <li>4. Monitoring: The Dietitian will complete the I Report weekly for maintaining of Dietary Inspection Report now conditions, food prep, and stora Findings will be reported to the recommendations for changes or practice and the need for furt or action plans.</li> <li>5. Date of Compliance: 11.</li> </ul>	compliance. The includes sanitary age of food items. QA Committee for in current policy ther audits and	11/9/0
	disease and infect an infection control	elopment and transmission of ion. The facility must establish of program under which it ols, and prevents infections in				

÷.

If continuation sheet Pa 

•

	T OF DEFICIENCIES	E & MEDICAID SERVICES	(X2) MH	TIPLE CONSTRUCTION	<u> </u>	(X3) DATE S	). 0938-039
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ę	· • • •	COMPL	
	•	A CONTRACTOR					7
		ė 095005	B, WING			10/*	2/2007
NAME OF P	ROVIDER OR SUPPLIER	·	s	TREET ADDRESS, CITY,	STATE, ZIP CODE		•
THE WA	SHINGTON HOME			3720 UPTON STREET WASHINGTON, DC			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PRÉFIX TAG	(EACH CORR	S PLAN OF CORREC ECTIVE ACTION SHO NCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 371	Continued From pa		F 37	1			
	Commod Prom p			1. Corrective Ac	tion(s) ed and wilted lettuce of	hoopied	
	1. The following ite	ms were observed undated	F3110	in the walk-in refrige	rator was discarded im		10/9/07
		the walk-in refrigerator:	41				. / ./*
		÷ ,		2. Identification of & Corrective Action			
	25 servings of man				is prepared / stored for	distribution .	
ļ	9 packages of cool				be affected. The Food		11
ĺ	54 servings of diet 61 servings of Jello				ervices Supervisor will		10/9/0
	9 servings of apple				o storage for proper lat all negative findings wi		
	15 servings of fresh			corrected at time of d		iii de	
	17 servings of fresh						
	20 cups of iced tea	-		3. Systemic Change			
	4 servings of fruit c	ocktail 👻		and procedure. The	ved its' currently policy dietary services staff wi	ill be	11/2/0
		of lettuce were observed the walk-in refrigerator.		the provisions of 483	istered Dietitian or des 35(i)(2) specifically san and storage of food ite	nitary	11/2/07
	3. The following iter	ms were stored wet and ready		4. Monitoring:			
}	for re-use:			The Dietitian will com Report weekly for ma	plete the Dietary Inspec ntaining compliance. T	[he	
	10 of 14 sheet pans				port includes sanitary c		1.1.
	Five (5) of 14 hotel			will be reported to the	rage of food items. Fin	ndings	11/9/07
	Five (5) of five (5) $\frac{1}{2}$				changes in current polic	су	.,,,,
	Two (2) of two (2) ro	basting pans		or practice and the ne	ed for further audits and		
	4 The roll away dur	mpster was observed to		or action plans.			
		h and was uncovered.		5. Date of Complia	ance: 11/09/07		
	Employees #5 and 1	15 acknowledged these					
	findings at the time						
	483.65(a) INFECTIO		F 441				I
	The facility must est	ablish and maintain an					
	infection control pro	gram designed to provide a					
	safe, sanitary, and c	comfortable environment and					
		opment and transmission of					
	an infection control	n. The facility must establish program under which it is, and prevents infections in					

age 15 of 1 /Sa 

ATEMEN	RS FOR MEDICAR	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	( · · ·	AULTIPI	E CONSTRUCTION	-1	(X3) DATE S COMPL	
	•	A second second				·		-
		095005	B. WI	NG	· · · · ·		10/1	2/2007
AME OF P	ROVIDER OR SUPPLIER		•		ET ADDRESS, CITY			
	SHINGTON HOME				0 UPTON STREET			
		· .		W/	SHINGTON, DC	20016		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	ix	(EACH CORR	S PLAN OF CORRE ECTIVE ACTION SH INCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 371	Continued From p	age 14	F	371				
		ms were observed undated the walk-in refrigerator:	F371	(3)	hotel pans, and the	<b>ction(s)</b> 5 hotel pans, the 5 2 roasting pans stor d stored appropriatel	ed wet	10/9/07
	25 servings of mar 9 packages of coo 54 servings of diet 61 servings of Jello 9 servings of apple 15 servings of fres 17 servings of fres 20 cups of iced tea	kies Jello sauce h fruit salad h garden salad			& Corrective Actio Other sheet pans w potential to be affect and or Food Service pans post wash for	f Deficient Practice: ns: ashed and stored ha ted. The Food Servi es Supervisor will ins proper drying and sto indings will be corr	ive the ices Manager pect sheet orage.	10/9/07
	moldy and wilted in	of lettuce were observed the walk-in refrigerator. ms were stored wet and ready			and procedure. The staff will be inservice	ewed its' currently po dietary services ed by the Registered provisions of 483.35( conditions, food prej	Dietitian i)(2)	11/2/07
	contain bags of tras	pans ⁄4 hotel pans			4. Monitoring: The Dietitian will cor Report weekly for m Dietary Inspection R food prep, and the p i.e. pot and pan item QA Committee for re current policy or pra and or action plans.	aintaining complianc eport includes sanita roper storage of food s. Findings will be re commendations for	e. The ary conditions, d and utensils eported to the changes in	11/9/07
		of the observations.	F 4	41	5. Date of Comp	liance: 11/09/07		
	infection control pro safe, sanitary, and to prevent the deve disease and infection an infection control	tablish and maintain an ogram designed to provide a comfortable environment and lopment and transmission of on. The facility must establish program under which it ls, and prevents infections in						
V CMS-256	7(02-99) Previous Versions	Obsolete Event ID: WUZV1	1	Facility	ID: WASHHOME	If conti	nuation sheet I	Page 15 of 1

÷.

ENTER		H AND HUMAN SERVICES <u>E &amp; MEDICAID SERVICES</u> (X1) PROVIDER/SUPPLIER/CLIA	(73) 84			FORM APPRON MB NO. 0938-0 DATE SURVEY
	OF DEFICIENCIES	IDENTIFICATION NUMBER:	A. BUIL	٢		COMPLETED
	· .	095005	B. WING	3		10/12/2007
ME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY		
HE WAS	SHINGTON HOME			3720 UPTON STREE WASHINGTON, DO		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER	S PLAN OF CORRECTION	BE COMPLET
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PRÉFIX TAG		ECTIVE ACTION SHOULD ENCED TO THE APPROPR DEFICIENCY)	
F 371	Continued From p	age 14	F 37	71		
		-		1. Corrective A		
	1. The following ite	ems were observed undated	F 371	The temporary roll	away dumpster has been re	moved.
		n the walk-in refrigerator:	P1"	2 Identification o	f Deficient Practices	IDIIC
		<b>-</b>	•	& Corrective Actio		
· }	25 servings of mai				I away dumpsters have the	
	9 packages of coo				ted. The Director of Plant C	Ops
	54 servings of diet				psters to identify risk. Any /	ali 18/15/
	61 servings of Jell				ill be corrected at time of	14
	9 servings of apple			discovery.		
	15 servings of fres			3. Systemic Chan	ae(s):	
	17 servings of fres				ewed its' currently policy	
	20 cups of iced tea			and procedure. Th	maintenance and dietary	
	4 servings of fruit of				ed by the Registered Dietitia	an ulala
	2 Cover (7) heads	of lettuce were observed			provisions of 483.35(i)(2)	190
		the walk-in refrigerator.		storage of food item	conditions, food prep, and s.	
	3 The following ite	ms were stored wet and ready		4. Monitoring:		
	for re-use:	ino were stored wet and ready			mplete the Dietary Inspectio	
					aintaining compliance. The	
	10 of 14 sheet pan	s .			eport includes sanitary cond	
	Five (5) of 14 hotel				ge of food items. Findings to committee for recommendat	
	Five (5) of five (5)				nt policy or practice and the	
	Two (2) of two (2) I				its and or action plans.	
	4. The roll away du	mpster was observed to		5. Date of Comp	liance: 11/09/07	
		sh and was uncovered.				
	Employees #6 and	15 acknowledged these				
		of the observations.				
	483.65(a) INFECT		F 44	1		
SS=D	400.00(a) ini EO II	ONCONTROL	1 44	•		
	The facility must es	tablish and maintain an				
		ogram designed to provide a				
		comfortable environment and				
		lopment and transmission of				
		on. The facility must establish				
		program under which it				
		ils, and prevents infections in				
CMS-256	7(02-99) Previous Versions	Obsolete Event ID: WUZV1	1 F	acility ID: WASHHOME	If continuation	n sheet Page 15 of
		· _ · · · · · · · · · · · · · · · · · ·				- -
					· ·	15c

,

	TMENT OF HEALTH AND HUN RS FOR MEDICARE & MEDICA					· ·	FORM	. 10/22/200 APPROVEL . 0938-039
STATEMEN	OF DEFICIENCIES (X1) PROVIDI	ER/SUPPLIER/CLIA CATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION		(X3) DATE S COMPLE	URVEY
		095005	B. WIN	ig			10/1	2/2007
	ROVIDER OR SUPPLIER			37	EET ADDRESS, CITY, 20 UPTON STREET	NW .		
	· ·			W	ASHINGTON, DC			Ţ····
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF D (EACH DEFICIENCY MUST BE PRE REGULATORY OR LSC IDENTIFYIN	CEDED BY FULL	id Prefi Tag		(EACH CORRI	S PLAN OF CORREC ECTIVE ACTION SHO INCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 371	Continued From page 14		F 3	371				
	1. The following items were ob- and/or unlabeled in the walk-in							
	25 servings of mandarin orange 9 packages of cookies	es						1
	54 servings of diet Jello 61 servings of Jello 9 servings of applesauce 15 servings of fresh fruit salad							
	17 servings of fresh garden sal 20 cups of iced tea 4 servings of fruit cocktail	ad						
	2. Seven (7) heads of lettuce w moldy and wilted in the walk-in							
	3. The following items were sto for re-use:	red wet and ready						
	10 of 14 sheet pans Five (5) of 14 hotel pans Five (5) of five (5) ¼ hotel pans Two (2) of two (2) roasting pans							
	<ol> <li>The roll away dumpster was of contain bags of trash and was up</li> </ol>							
	Employees #5 and 15 acknowle findings at the time of the obser 483.65(a) INFECTION CONTRO	vations.	F 44	\$1				
SS=D	The facility must establish and r infection control program desigr safe, sanitary, and comfortable to prevent the development and disease and infection. The facil an infection control program und investigates, controls, and preve	naintain an ned to provide a environment and transmission of ity must establish der which it			<ol> <li>Corrective Employee #13 ha facility's policy, pro- maintaining a sand</li> </ol>	s been re-educated on ocedure, and practice for	the or	10/10/07
	7(02-99) Previous Versions Obsolete	Event ID: WUZV11	<u> </u>	Facilit	y ID: WASHHOME	If continu	ation sheet P	200 15 of 10

STATEMEN	T OF DEFICIENCIES OF CORRECTION	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION	(X3) DATI	IO. 0938-03 E SURVEY PLETED
		095005	B. WING		10	/12/2007
	PROVIDER OR SUPPLIER			REET ADDRESS, CITY, S 3720 UPTON STREET WASHINGTON, DC	NW	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETI DATE
F 441	the facility; decides isolation should be resident; and main corrective actions is Based on observation the environmental facility staff failed to environment as ev- observed in the hall made in the preser The findings includ During initial tour of at 8:35 AM, it was of bag containing infe- the hallway in front Employee #13 was A face-to-face inter Employee #13 on C He/she stated, "I ju hallway in front of the ago." A face-to-face inter Employee #16 on C He/she stated that remove the red biol room and immediat room in the approp- that the red biohaza left on the floor.	s what procedures, such as applied to an individual tains a record of incidents and related to infections. NT is not met as evidenced ion and staff interview during tour, it was determined that o maintain a sanitary denced by a red biohazard bag lway. This observation was nee of Employees #2 and 3. e: f the facility on October 9, 2007 observed that a red biohazard ctious waste was observed in of an isolation room. inside the resident's room. view was conducted with October 9, 2007 at 8:40 AM. st placed the bag here [in the ne isolation room] a second view was conducted with October 10, 2007 at 12:00 PM. the facility's practice was to nazard bag from the isolation ely place it in the soiled utility riate biohazard container and ard bag should not have been	F 441	<ol> <li>Identification &amp; Corrective Actio Other residents record changes with known the potential to be a of Nursing and/or de impromptu observat rounds to randomly and proper destruction Any and all negative at time of discovery Committee for record</li> <li>Systemic Chang The facility has revie and procedure. Lice on the provisions of specifically to mainta comfortable environed development and tra infection.</li> <li>Monitoring: The Clinical Manager responsible for maint QA Program includes tool for monitoring sa Clinical Manager and a 10% audit of sched weekly to verify compreported to the QA C for changes in current the need for further a</li> </ol>	eiving dressing isolation needs have ffected. The Director signee will conduct ions of scheduled wound monitor sanitary conditions on of contaminated materials. findings will be corrected and reported to the QA nmendations. <b>re(s):</b> wed its' currently policy insed staff will be inserviced 483.65(a) specifically sin a safe, sanitary, and nent and to prevent the insmission of disease and r and/or designee is aining compliance. The s a random observation initary conditions The tor designee will complete ule wound treatments pliance. Findings will be ommittee for recommendations t policy or practice and	10]157 11/2/0 11/9/0
F 445 SS=C	403.00(C) INFECT	ON CONTROL - LINENS	F 445			

¢.

. . .

STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING		(X3) DATE	D. 0938-03 SURVEY LETED
		095005	B. WING		10/	12/2007
		TATEMENT OF DEFICIENCIES	37 W	EET ADDRESS, CITY, STATE, ZI 20 UPTON STREET NW ASHINGTON, DC 20016 PROVIDER'S PLAN OF		(X5) COMPLETIO
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	DATE
F 445	transport linens so infection.	bage 16 andle, store, process, and b as to prevent the spread of ENT is not met as evidenced	F 445	1. Corrective Action(s) Employee #14 and #3 have be on the facility's policy, procedu and practice for monitoring the required to process linens to pr of infection.	re, protocol, and temperatures	10/11/02
	by: Based on observa of manufacturer's that facility staff fa program to ensure facility and resider manufacturer's rec	ation, staff interview and review manuals, it was determined iled to develop a monitoring wash water temperatures for at laundry were within the commended range for each in the washing cycle.		2. Identification of Deficien & Corrective Actions: A monitoring tool has been dev implemented which correspond manufacturers recommended to ranges for processing linens to spread of infection. The laundr randomly selects wash cycles a to monitor compliance for appro- utilization, temperature requirent variances.	eloped and s with the emperatures prevent the y supervisor nd machines priate chemical	10/11/0
	was conducted on Employee #14 stat of towels. I am go A list describing ea	the laundry being processed October 9, 2007 at 8:40 AM. ted, "I am going to start a load ing to select Cycle #1." ach formula and items washed as posted on the door to the		3. Systemic Change(s): The facility has reviewed its' cur and procedure. A comprehensi program has been implemented monitored the QA Program for n compliance. Laundry staff will b on the provision 483(65(c) speci control for linens and the new m	ve monitoring and will be naintaining e inserviced fically infection	10/15/
	computer program attached to the fro information display program designed step in the cycle ai degrees Fahrenhe			4. Monitoring: The laundry supervisor and or di- responsible for maintaining comp QA Program now includes a mor- maintaining compliance. The La and or designee will complete we to verify compliance. Findings w to the QA Committee for recomm for changes in current policy or p the need for further audits or acti	pliance. The hitoring tool for undry Supervisor bekly audits ill be reported hendations ractice and	11/9/07
	set on Cycle #1 an beginning of the wa	bservation, the machine was d was currently in the ash cycle. The temperature omputer screen was 95		5. Date of Compilance: 11/0	9/07	

s. .

cility

ntinuation sheet

۰ ۲.

DEPAR	TMENT OF HEALTH AND HUMAN SER	VICES			FORMAPPROVED
	RS FOR MEDICARE & MEDICAID SERV	/ICES			MB NO. 0938-0391
	F OF DEFICIENCIES (X1) PROVIDER/SUPPLIE DF CORRECTION IDENTIFICATION NU	MBER:	MULTIPLE CONSTRUCTION	(X)	B) DATE SURVEY COMPLETED
	095005	B. Wil	NG		10/12/2007
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CI		
THE WA	SHINGTON HOME		3720 UPTON STRE WASHINGTON, I		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY REGULATORY OR LSC IDENTIFYING INFORM/	FULL PREF	TX (EACH COF	ER'S PLAN OF CORRECTION REECTIVE ACTION SHOULD RENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
F 445	Continued From page 17	F	445		
	The surveyor asked Employee #14 what temperature was required for this step. stated, "It has to be 160 degrees to was use different chemicals, too." Employee unable to state the length of time the wat temperature for the wash cycle had to rea 160 degrees F. Upon further inquiry, there was no evide the laundry staff or the laundry supervise aware of the temperature ranges for the chemicals used in the facility's laundry.	He/she h. We #14 was ater emain at ence that or were			
	The surveyor asked for the chemicals us the temperature range recommended by manufacturer for the chemicals used in facility's laundry. Employee #14 stated the/she did not have that information, but ask the supervisor.	y the the hat			
· . [	The surveyor asked Employee #3 if tem were being monitored for each step. En #3 stated that the computer program pre-determined the temperature for each and was set by the representative from t chemical company for the chemicals util the facility.	nployee n cycle he			
	A listing of the manufacturer's recomment for temperature ranges for the chemicals not be located by Employee #3 at the time observation.	s could			
	Employee #3 requested information from facility's chemical supplier regarding the manufacturer's recommended temperatu for each chemical used. Information was received by the facility via facsimile from	ure range			
ORM CMS-256	67(02-99) Previous Versions Obsolete Eve	ent ID:WUZV11	Facility ID: WASHHOME	If continuation	n sheet Page 18 of 19

÷.

۰. *،* 

	MENT OF HEALT						FORN OMB NC	1 APPRO\ ). 0938-0
TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SU	IPPLIER/CLIA		LTIPLE CONSTRUCTION		(X3) DATE SI COMPLE 10/1: E	SURVEY
	Concernon	1 3		A. BUILD	DING	;		
			5005	B. WING	I	<u> </u>	10/1	12/2007
NAME OF PI		ι <u>Γ</u>	· · · ·	s	TREET ADDRESS, CITY,			
THE WAS					3720 UPTON STREET			
<u> </u>				1D	WASHINGTON, DC	S PLAN OF CORRE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDE LSC IDENTIFYING INF	ED BY FULL	PREFIX TAG	(EACH CORRI	CTIVE ACTION SHO NCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLET DATE
Í	Continued From p facility's chemical 8:50 AM		ber 10, 2007 at	F 44	5			
	Employee #3 ackr were not monitore							
			}					
				•				
		, ·						
							. 1	
								1
RM CMS-2567	7(02-99) Previous Versions	s Obsolete	Event ID: WUZV11	 Fa	cility ID: WASHHOME	If contin	uation sheet P	age 19 of
						·. ·.		
						N.		

.

÷.