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

Received 10/31/07

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095005	A. BUILDING _____ B. WING _____	10/12/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WASHINGTON HOME	3720 UPTON STREET NW WASHINGTON, DC 20016

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An annual recertification survey was conducted October 9 through 12, 2007. The following deficiencies were based on observations, record reviews, and interviews with the facility staff. The sample included 28 residents based on a census of 183 residents the first day of survey and one (1) supplemental resident.	F 000	The Washington Home is filing this Plan of Correction for the purposes of Regulatory Compliance. The facility is submitting this plan of correction to comply with applicable laws and not as an admission or statement of agreement with respect to the alleged deficiencies herein. To remain in compliance with all 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.	
F 164 SS=D	483.10(e), 483.75(l)(4) PRIVACY AND CONFIDENTIALITY The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.	F 164	F164(1) 1. Corrective Action(s) Employee #13 has since been re-educated on Residents Rights i.e. privacy provided during dressing changes. 2. Identification of Deficient Practices & Corrective Actions: Other residents receiving dressing changes have the potential to be affected. The Director of Nursing and/or designee will conduct impromptu observations of scheduled wound rounds to randomly monitor privacy provided during dressing changes. Any and all negative findings will be corrected at time of discovery and reported to the QA Committee for recommendations.	10/9/07 10/9/07

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

[signature], Administrator 10/31/07

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 164	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, it was determined that facility staff failed to provide privacy for one (1) resident during a dressing change and one (1) resident prior to administering eye drops and testing eye pressure. Residents #12 and S1. The findings include: 1. Facility staff failed to provide privacy for Resident #12 during a dressing change. During the initial tour of the facility, on October 9, 2007 at 8:35 AM, it was observed that during a dressing change being done by Employee #13 to the right foot/ankle, the door to the resident's room was open. The curtain was not pulled around the resident's bed. The surveyor and facility staff stood outside the resident ' s room observing the dressing change for approximately three (3) minutes before Employee #13 acknowledged the group outside the door. These observations were made in the presence of Employee #2 and Employee #3. A face-to-face interview was conducted on October 9, 2007 at 8:40 AM with Employee #2, who acknowledged that the resident's door should have been closed during the dressing change. 2. Facility staff failed to provide privacy while administering eye drops and testing eye pressure to Resident S1.	F 164	**3. Systemic Change(s):** The facility has reviewed its' currently policy and procedure. Licensed staff will be inserviced on the provisions of 483.10(e) and 483.75 (l)(4) specifically Privacy and Confidentiality provided during dressing changes. **4. Monitoring:** The Clinical Manager and/or designee is responsible for maintaining compliance. The QA Program includes a random observation tool for monitoring privacy and confidentiality during dressing changes. The Clinical Manager and or designee will complete a 10% audit of schedule wound treatments weekly to verify compliance. Findings will be reported to the QA Committee for recommendations for changes in current policy or practice and the need for further audits or action plans. **5. Date of Compliance: 11/09/07** F-164(2) **1. Corrective Action(s)** Employee #17 has since been re-educated on Residents Rights i.e. privacy during ophthalmology consultations. **2. Identification of Deficient Practices & Corrective Actions:** Other residents receiving ophthalmology consultations have the potential to be affected. The ophthalmologist has been designated a private treatment area for the provision of ophthalmology services. The Director of Nursing and/or designee will conduct random observations of scheduled ophthalmology services to monitor privacy provided. Any and all negative findings will be corrected at time of discovery and reported to the QA Committee for recommendations.	11/9/07 11/9/07 10/12/07 10/19/07

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F 164	Continued From page 2 Employee #17 was observed on October 10, 2007 at approximately 3:30 PM to enter Unit 1A and remove a baseball type cap. He/she placed a computer and personal belongings at the nurse's station. Employee #17 approached Resident S1, sitting in the common dining area with one (1) resident across the table from him/her. Employee #17 introduced him/herself and instilled eye drops into the resident's eyes. Employee #17 returned to his/her personal belongings at the nurse's station and retrieved a device, went back to the resident and explained that he/she was measuring eye pressure. Employee #17 measured the pressure in both of the resident's eyes. Employee #17 failed to provide privacy during the eye examination. A face-to-face interview with Employee #17 was conducted immediately after the observation. Employee #17 stated, "It is less traumatic to move the residents."	F 164	**3. Systemic Change(s):** The facility has reviewed its' current policy and procedure. The Ophthalmologist was inserviced by the Administrator on the provisions of 483.10(e) and 483.10(l)(4) specifically privacy and confidentiality provided during ophthalmology services. **4. Monitoring:** The Clinical Manager and/or designee is responsible for maintaining compliance. The QA Program includes a random Observation tool for monitoring privacy and confidentiality. The Clinical Manager and or designee will complete a 10% audit of scheduled ophthalmology consults to verify compliance. Findings will be reported to the QA Committee for recommendations for changes in current policy or practice and the need for further audits and or action plans. **5. Date of Compliance: 11/09/07**	10/12/07 11/9/07
F 253 SS=D	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations during the environmental tour of the facility, it was determined that housekeeping and maintenance services were not adequate to ensure that the facility was maintained in a safe manner as evidenced by: damaged baseboards and walls; and	F 253 F 253(1)	**1. Corrective Action(s)** Marred and or damaged baseboard surfaces observed in rooms 250, 312, 340, 354, and 367 has since been repaired. **2. Identification of Deficient Practices & Corrective Actions:** Other baseboard surfaces have the potential to be affected. The Housekeeping Manager and or designee will audited the entire facility to identify like findings. Any and all negative findings will be corrected at time of discovery and reported to the QA Committee for recommendations.	10/11/07 10/11/07

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F 253	Continued From page 3 marred/scarred furniture. These observations were made in the presence of Employee #2 and Employee #3 on October 9, 2007 between 7:25 AM and 10:30 AM. - - The findings include: 1. Five (5) of 20 baseboards with marred and/or damaged surfaces were observed in the following rooms: 250, 312, 340, 354 and 367. 2. Three (3) of 20 walls with marred and/or damaged surfaces were observed in the following rooms: 312, 354 and the hallway outside of room 357. 3. Marred and/or damaged furniture surfaces were observed in the following areas: Third Floor - splintered end table in the dayroom; four (4) of four (4) arm chairs in the sitting area. Second Floor- five (5) of five (5) arm chairs in the dayroom and two (2) of three (3) arm chairs in the sitting areas. Employees #2 and 3 acknowledged the above cited deficiencies at the time of the observations.	F 253	3. Systemic Change(s): The facility has reviewed its' currently policy and procedure. The housekeeping and maintenance staff will be inserviced by the Administrator or designee on the provisions of 483.15(h)(2) specifically the maintenance of a sanitary, orderly, and comfortable interior. Environmental rounds have been expanded to include weekly baseboard observations. 4. Monitoring: The Director of Plant Operations and/or designee is responsible for maintaining compliance. The QA Program includes the environmental observation tool for monitoring the interior. The housekeeping and maintenance team leader will conduct random weekly environmental rounds with the Administrator for monitoring compliance. Findings will be reported to the QA Committee for recommendations for changes in current policy or practice and the need for further audits and or action plans. 5. Date of Compliance: 11/09/07	11/2/07 11/9/07
F 276 SS=D	483.20(c) QUARTERLY REVIEW ASSESSMENT A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review for one (1) of 28 sampled records, it was determined	F 276		

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F 276 SS=D	483.20(c) QUARTERLY REVIEW ASSESSMENT A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review for one (1) of 28 sampled records, it was determined	F 276	**4. Monitoring:** The Director of Plant Operations and/or designee is responsible for maintaining compliance. The QA Program includes the environmental observation tool for monitoring the interior. The housekeeping and maintenance team leader will conduct random weekly environmental rounds with the Administrator and/or designee for monitoring compliance. Findings will be reported to the QA Committee for recommendations for changes in current policy or practice and the need for further audits and or action plans. 5. Date of Compliance: 11/09/07	11/9/07

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F 276 SS=D	483.20(c) QUARTERLY REVIEW ASSESSMENT A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review for one (1) of 28 sampled records, it was determined	F 276 F276	**1. Corrective Action(s)** The MDS Coordinator has since completed a Quarterly MDS for Resident #19. **2. Identification of Deficient Practices & Corrective Actions:** Other residents requiring a Quarterly MDS to be completed in July have the potential to be affected. The Clinical Manager and / or designee will audit current resident records to identify risks. Any and all negative findings will be corrected at time of discovery and reported to the QA Committee for recommendations.	10/19/07 10/22/07

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F 276	Continued From page 4 that the facility staff failed to complete a quarterly Minimum Data Set (MDS) in July 2007 for Resident #19. The findings include: A review of Resident #19's record revealed that a quarterly MDS was not completed for July 2007. The following MDS assessments were in the record with the following completion dates: Quarterly MDS November 5, 2006 Quarterly MDS January 30, 2007 Quarterly MDS April 25, 2007 There was no MDS assessment after April 25, 2007. According to the "MDS 2.0 User's Manual" , page 2-15, "At a minimum, three quarterly assessments and one comprehensive assessment are required in each 12-month period ...Timing edits in the MDS standard system count 92-day intervals because there are never more than 92 days in any consecutive three-month interval. These 92 days are measured from the date at MDS Item R2b of one assessment to Item R2b of the next assessment." A face-to-face interview with Employee #8 was conducted on October 11, 2007 at approximately 11:40 AM. He/She acknowledged that the quarterly MDS was not present in the record. The record was reviewed on October 11, 2007.	F 276	**3. Systemic Change(s):** The facility has reviewed its' currently policy and procedure. The MDS Coordinators will be inserviced by the Director of Nursing or designee on the provisions of 483.20(c) specifically the timely completion of quarterly review assessments. The Clinical Managers will audit the clinical record monthly for completed quarterly assessment and report findings during the monthly QA Committee Meeting. The MDS Coordinators have been enrolled in NSPAC MDS Certification Course for November 2007. **4. Monitoring:** The Assistant Director of Nursing and/or designee is responsible for maintaining compliance. The QA Program includes an audit tool for monitoring the timely completion of quarterly review assessments. The Clinical Managers will conduct a random 10% medical record audit monthly to monitoring compliance. Findings will be reported to the QA Committee for recommendations for changes in current policy or practice and the need for further audits and or action plans. **5. Date of Compliance: 11/09/07**	11/2/07 11/9/07
F 278 SS=D	483.20(g) - (j) RESIDENT ASSESSMENT The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate	F 278		

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F 278	Continued From page 5 each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review for five (5) of 28 sampled records, it was determined that facility staff failed to accurately code the Minimum Data Set (MDS) for height for two (2) residents, include diagnoses for two (2) residents, and the RN (Registered Nurse) Assessment Coordinator failed to ensure that all assessments were complete prior to signing at Section R2b for one (1) resident Residents #5, 6, 11, 19 and 28. The findings include:	F 278 F278(1)	**1. Corrective Action(s)** Resident #5 has since been reassessed and a significant correction has been completed for the proper coding of his height in Section K2a. **2. Identification of Deficient Practices & Corrective Actions:** 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. **3. Systemic Change(s):** The facility has reviewed its' currently policy and procedure. The Resident Assessment Coordinator and the Registered Dietitian will be inserviced by the Director of Nursing or designee on the provisions of 483.20(g)-(j) specifically resident assessments with specific emphasis placed on Section K2a. The MDS Coordinators have been enrolled in NSPAC MDS Certification Course for November 2007. **4. Monitoring:** The Assistant Director of Nursing and/or designee is responsible for maintaining compliance. The QA Program includes an audit tool for monitoring the accuracy of the MDS. The Clinical Managers will conduct a random 10% medical record audit monthly to monitoring compliance. Findings will be reported to the QA Committee for recommendations for changes in current policy or practice and the need for further audits and or action plans. **5. Date of Compliance: 11/09/07**	10/12/07 10/19/07 11/2/07 11/9/07

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F 278	Continued From page 6 1. Facility staff failed to code the height for Resident #5 on the admission MDS. A review of Resident #5's record revealed that an admission MDS was completed on August 9, 2007. Section K2a, "Height" was coded as "0". According to the "MDS 2.0 User's Manual" on page 3-150, "Record the resident's height." A face-to-face interview was conducted with Employee #8 on October 11, 2007 at 2:30 PM. He/she acknowledged that the height should have been coded. The record was reviewed October 11, 2007. 2. Facility staff failed to code the height on the admission, quarterly and annual MDS for Resident #6. A review of Resident #6's record revealed that the resident was admitted to the facility on December 16, 2005. Section K2a, "Height" was blank on the following MDS assessments: Admission completed December 27, 2005 Significant change completed March 16, 2006 Quarterly completed June 13, 2006 Significant change completed July 28, 2006 Quarterly completed December 27, 2006 Quarterly completed March 24, 2007 Quarterly completed June 25, 2007. According to the "MDS 2.0 User's Manual" on page 3-150, "Record the resident's height." A face-to-face interview was conducted with Employee #18 on October 9, 2007 at 2:00 PM.	F 278 F278(2)	**1. Corrective Action(s)** Resident #6 has since been reassessed and a significant correction has been completed for the proper coding of her height in Section K2a for the most current assessment. **2. Identification of Deficient Practices & Corrective Actions:** 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. **3. Systemic Change(s):** The facility has reviewed its' currently policy and procedure. Resident Assessment Coordinator and the Registered Dietitian will be inserviced by the Director of Nursing or designee on the provisions of 483.20(g)-(j) specifically resident assessments with specific emphasis placed on Section K2a. The MDS Coordinators have been enrolled in NSPAC MDS Certification Course for November 2007. **4. Monitoring:** The Assistant Director of Nursing and/or designee is responsible for maintaining compliance. The QA Program includes an audit tool for monitoring the accuracy of the MDS. The Clinical Managers will conduct a random 10% medical record audit monthly to monitoring compliance. Findings will be reported to the QA Committee for recommendations for changes in current policy or practice and the need for further audits and or action plans. **5. Date of Compliance: 11/09/07**	10/12/07 10/19/07 11/2/07 11/9/07

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PRINTED: 10/16/200
FORM APPROVE
OMB NO. 0938-039

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095005	A. BUILDING _____ B. WING _____	10/12/2007

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F 278	Continued From page 7 He/she acknowledged that the resident's height should have been coded on the MDS and offered no explanation for the missing heights. The record was reviewed October 9, 2007. 3. Facility staff failed to include a diagnosis of Chronic Renal Insufficiency on the significant change MDS for Resident #11. A review of Resident #11's record revealed an "Admission and Annual Physical Examination Form" dated January 9, 2007. Included under diagnoses was, "CRI" (Chronic Renal Insufficiency). A review of the significant change MDS completed August 21, 2007 revealed that "CRI" was not included in Section I [Disease Diagnoses]. According to the "MDS 2.0 User's Manual" on page 3-127, "Intent: To code those diseases or infections which have a relationship to the resident's current ADL (Activities of Daily Living) statue, cognitive status, mood or behavior status, medical treatments, nursing monitoring or risk of death." A face-to-face interview was conducted with Employees #2 and #8 on October 11, 2007 at approximately 10:15 AM. They both acknowledged that the resident's diagnosis of CRI was not coded on the MDS. The record was reviewed October 11, 2007. 4. The RN Assessment Coordinator failed to ensure that all assessments were complete on the quarterly MDS prior to signing at Section R2b for Resident #19.	F 278 F 278(3)	**1. Corrective Action(s)** Resident #11 has since been reassessed and a significant correction has been completed to include her diagnosis of "CRI" Chronic Renal Insufficiency. **2. Identification of Deficient Practices & Corrective Actions:** Other residents with a diagnosis of "CRI" 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. **3. Systemic Change(s):** The facility has reviewed its' currently policy and procedure. The MDS Coordinator will be inserviced by the Director of Nursing or designee on the provisions of 483.20(g)-(l) specifically resident assessments with specific emphasis placed on "diagnosis." The MDS coordinators have been enrolled in NSPAC MDS Certification Course for November 2007. **4. Monitoring:** The Assistant Director of Nursing and/or designee is responsible for maintaining compliance. The QA Program includes an audit tool for monitoring the accuracy of the MDS. The Clinical Managers will conduct a random 10% medical record audit monthly to monitoring compliance. Findings will be reported to the QA Committee for recommendations for changes in current policy or practice and the need for further audits and or action plans. **5. Date of Compliance: 11/09/07**	10/12/07 10/19/07 11/2/07 11/09/07

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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 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. 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 I. 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 hemiarthroplasty after left femoral fracture. The resident received physical and occupational therapy for improvement in walking, balance and gait as a result of the left femoral fracture. A face-to-face interview was conducted with	F 278 F278(4)	**1. Corrective Action(s)** The interdisciplinary team has been re-educated on the provisions of the MDS 2.0 Users Manual p.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." **2. Identification of Deficient Practices & Corrective Actions:** The interdisciplinary team has been re-educated on the provisions of the MDS 2.0 Users Manual p.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." **3. Systemic Change(s):** The facility has reviewed its' currently policy and procedure. The Clinical Managers and the IDT will be inserviced by the DON and or designee on the provisions of 483.20(g)-(j) & MDS 2.0 Users Manual p.3-212 specifically the signature requirements for the Minimal Data Set. The MDS Coordinators have been enrolled in NSPAC MDS Certification Course for November 2007. **4. Monitoring:** The Assistant Director of Nursing and/or designee is responsible for maintaining compliance. The QA Program includes an audit tool for monitoring the accuracy and signature requirements for the Minimal Data Set. The Clinical Managers will conduct a random 10% medical record audit monthly to monitoring compliance. Findings will be reported to the QA Committee for recommendations for changes in current policy or practice and the need for further audits and or action plans. **5. Date of Compliance: 11/09/07**	10/15/07 10/19/07 11/2/07 11/9/07

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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 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. 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 I. 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 hemiarthroplasty after left femoral fracture. The resident received physical and occupational therapy for improvement in walking, balance and gait as a result of the left femoral fracture. A face-to-face interview was conducted with	F 278 F278(5)	**1. Corrective Action(s)** Resident #28 has since been discharged. **2. Identification of Deficient Practices & Corrective Actions:** Other residents with a diagnosis of "Macular Degeneration, left femoral neck fracture, and or left hemiarthroplasty have the potential to be affected. The Resident Assessment Coordinator(s) 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. **3. Systemic Change(s):** The facility has reviewed its' currently policy and procedure. The Resident Assessment Coordinator will be inserviced by the Director of Nursing or designee on the provisions of 483.20(g)-(j) specifically Section I "Diagnoses." The MDS Coordinators have been enrolled in NSPAC MDS Certification Course for November 2007. **4. Monitoring:** The Assistant Director of Nursing is responsible for maintaining compliance. The QA Program includes an audit tool for monitoring the accuracy of the MDS. The Clinical Managers will conduct a random 10% medical record audit monthly to monitoring compliance. Findings will be reported to the QA Committee for recommendations for changes in current policy or practice and the need for further audits and or action plans. **5. Date of Compliance: 11/9/07**	10/19/07 11/2/07 11/9/07

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F 278	Continued From page 9 Employee #2 on October 10, 2007 at 8:45 AM. He/she acknowledged that there were no diagnoses listed for Resident #28. The record was reviewed October 10, 2007.	F 278	**1. Corrective Action(s)** Resident #6 has since been reassessed and her individualized needs have been appropriately care planned to include her need for oxygen therapy.	10/15/07
F 279 SS=D	483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on staff interview and record review for two (2) of 28 sampled residents, it was determined that facility staff failed to initiate a care plan with appropriate goals and approaches for one (1) resident on oxygen therapy and one (1) resident on anticoagulant therapy. Residents #6 and 8. The findings include:	F 279 F279(1)	**2. Identification of Deficient Practices & Corrective Actions:** Other residents requiring oxygen therapy have the potential to be affected. The Clinical Manager and or designee will audit 100% of the current 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. **3. Systemic Change(s):** The facility has reviewed its' currently policy and procedure. The comprehensive nursing evaluation process and the daily review of the 24 hour report will be the mechanism for maintaining compliance. The interdisciplinary team will be inserviced regarding the development of comprehensive care plans utilizing the provisions of 483.20(d) and 483.20(k)(1) by the Director of Nursing or designee. **4. Monitoring:** The Assistant Director of Nursing and/or designee is responsible for maintaining compliance. The QA Program includes an audit tool for monitoring the development and implementation / adjustments of resident specific care planning. The Clinical Managers will conduct a random 10% medical record audit of care plans monthly to monitor compliance. Findings will be reported to the QA Committee for recommendations for changes in current policy or practice and the need for further audits and or action plans. **5. Date of Compliance: 11/09/07**	10/19/07 11/2/07 11/9/07

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F 279	Continued From page 10 1. Facility staff failed to initiate a care plan with appropriate goals and approaches for Resident #6, who was on oxygen therapy. A review of Resident #6's record revealed a physician's order dated September 28, 2007, directing, "Oxygen 2L via nc (2 liters per nasal cannula) for POX (pulse oxygenation measurement) less than 92%." The care plan, last reviewed August 7, 2007, was not updated to include appropriate goals and approaches for the use of oxygen therapy. A face-to-face interview was conducted with Employee #9 on October 11, 2007 at 9:30 AM. He/she acknowledged that there should have been a care plan for the use of oxygen therapy. The record was reviewed October 11, 2007. 2. Facility staff failed to initiate a care plan with appropriate goals and approaches for Resident #8, who was on anticoagulant therapy (Coumadin). According to the admission orders signed by the physician on July 6, 2007, the resident was receiving Coumadin 1 mg daily. A review of the resident's care plan initiated on July 6, 2007 and reviewed on July 19, 2007, revealed that there was no evidence that facility staff initiated goals and approaches for the use of Coumadin. A face-to-face interview was conducted with Employee #11 on October 10, 2007 at 3:00 PM. He/she acknowledged that a care plan for	F 279	F279(2) **1. Corrective Action(s)** Resident #8 has since been reassessed and her individualized needs have been appropriately care planned to include her need for anticoagulant therapy. **2. Identification of Deficient Practices & Corrective Actions:** Other residents on anticoagulants have the potential to be affected. The Clinical Manager and or designee will audit 100% of the current 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. **3. Systemic Change(s):** The facility has reviewed its' currently policy and procedure. The comprehensive nursing evaluation process and the daily review of the 24 hour report will be the mechanism for maintaining compliance. The interdisciplinary team will be inserviced regarding the development of comprehensive care plans utilizing the provisions of 483.20(d) and 483.20(k)(1) by the Director of Nursing or designee. **4. Monitoring:** The Assistant Director of Nursing and/or designee is responsible for maintaining compliance. The QA Program includes an audit tool for monitoring the development and implementation / adjustments of resident specific care planning. The Clinical Managers will conduct a random 10% medical record audit of care plans monthly to monitor compliance. Findings will be reported to the QA Committee for recommendations for changes in current policy or practice and the need for further audits and or action plans. **5. Date of Compliance: 11/09/07**	10/15/07 10/19/07 11/2/07 11/9/07

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F 279	Continued From page 11 anticoagulant therapy should have been initiated for Resident #8. The record was reviewed October 10, 2007.	F 279		
F 281 SS=D	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations during the survey period, it was determined that facility staff failed to wash his/her hands prior to instilling eye drops and testing eye pressure for Resident S1. The findings include: Employee #17 was observed on October 10, 2007 at approximately 3:30 PM entering Unit 1A and removing a baseball type cap. He/she placed a computer and personal belongings at the nurse's station. Employee #17 approached Resident S1, sitting in the common dining area with one (1) resident across the table from him/her. Employee #17 introduced him/herself and instilled eye drops into the resident's eyes. Employee #17 returned to his/her personal belongings at the nurse's station and retrieved a device, went back to the resident and explained that he/she was measuring eye pressure. Employee #17 measured the pressure in both of the resident's eyes. Employee #17 failed to wash his/her hands during the entire observation. A package of sanitizing hand wipes was present on the table adjacent to where the resident was sitting.	F 281	**1. Corrective Action(s)** Employee #17 has since been re-educated regarding the "Guidelines for Hand Hygiene in Health Care Settings," developed by the CDC. **2 Identification of Deficient Practices & Corrective Actions:** Other residents receiving ophthalmology consultations have the potential to be affected. The ophthalmologist was redirected by the Administrator immediately and has been designated a private treatment area for the provision of ophthalmology services. The Director of Nursing and/or designee will conduct random observations of scheduled ophthalmology services to monitor proper hand sanitation prior to service delivery. Any and all negative findings will be corrected at time of discovery and reported to the QA Committee for recommendations. **3. Systemic Change(s):** The facility has reviewed its' currently policy and procedure. The Ophthalmologist was redirected by the Administrator and will be inserviced by the NHA or designee on the provisions of 483.20(k)(3)(i) Comprehensive Care Plans and "Guidelines for Hand Hygiene in Health Care Settings," developed by the Center for Disease Control.	10/12/07 10/19/07 10/12/07

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F 281	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."	F 281	**4. Monitoring:** The Clinical Manager and/or designee is responsible for maintaining compliance. The QA Program includes a random observation tool for monitoring proper hand sanitation. The Clinical Manager and or designee will complete a 10% audit of scheduled ophthalmology consults monthly to verify compliance. Findings will be reported to the QA Committee for recommendations for changes in current policy or practice and the need for further audits and or action plans. **5. Date of Compliance: 11/09/07**	11/9/07
F 323 SS=E	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. This REQUIREMENT is not met as evidenced by: 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. The findings include: 1. An employee was observed on October 9, 2007 at 10:10 AM to trip over the buckled front lobby wall-to-wall carpet. 2. 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.	F 323		

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F 281	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."	F 281		
F 323 SS=E	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. This REQUIREMENT is not met as evidenced by: 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. The findings include: 1. An employee was observed on October 9, 2007 at 10:10 AM to trip over the buckled front lobby wall-to-wall carpet. 2. 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.	F 323 F323(1)	**1. Corrective Action(s)** The front lobby carpet has since been replaced by hardwood floors. **2. Identification of Deficient Practices & Corrective Actions:** Other carpeted areas in the facility have the potential to be affected. The Director of Plant Operations will inspect all carpeted areas to identify risks. Any/all negative findings will be corrected at time of discovery. **3. Systemic Change(s):** The facility has reviewed its' currently policy and procedure. The environmental services staff have been inserviced by the Administrator or designee on the provisions of 483.25(h) specifically accidents and supervision. Environmental rounds have been expanded to include carpet assessment, repair, maintenance, and or replacement. **4. Monitoring:** The Director of Plant Operations and/or designee is responsible for maintaining compliance. The QA Program includes the environmental observation tool for monitoring the interior. The housekeeping and maintenance team leader will conduct random weekly environmental rounds with the Administrator for monitoring compliance. Findings will be reported to the QA Committee for recommendations for changes in current policy or practice and the need for further audits and or action plans. **5. Date of Compliance: 11/09/07**	10/18/07 10/12/07 11/2/07 11/9/07

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F 281	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."	F 281		
F 323 SS=E	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. This REQUIREMENT is not met as evidenced by: 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. The findings include: 1. An employee was observed on October 9, 2007 at 10:10 AM to trip over the buckled front lobby wall-to-wall carpet. 2. 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.	F 323 F323(2)	**1. Corrective Action(s)** The damaged skid strips observed in shower rooms 367A, 220A, and 220B have been replaced. **2. Identification of Deficient Practices & Corrective Actions:** Other resident showers rooms have the potential to be affected. The Housekeeping and Maintenance team leader will inspect all shower rooms to identify risks. Any and all negative findings will be corrected at time of discovery. **3. Systemic Change(s):** The facility has reviewed its' currently policy and procedure. The environmental services staff have been inserviced by the Administrator or designee on the provisions of 483.25(h) specifically accidents and supervision. Environmental rounds have been expanded to include the assessment, repair, maintenance, and or replacement of skid strips in resident showers. **4. Monitoring:** The Director of Plant Operations and/or designee is responsible for maintaining compliance. The QA Program includes the environmental observation tool for monitoring the interior. The housekeeping and maintenance team leader will conduct random weekly environmental rounds with the Administrator for monitoring compliance. Findings will be reported to the QA Committee for recommendations for changes in current policy or practice and the need for further audits and or action plans. **5. Date of Compliance: 11/09/07**	10/11/07 10/18/07 11/2/07 11/9/07

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095005	A. BUILDING _____ B. WING _____	10/12/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WASHINGTON HOME	3720 UPTON STREET NW WASHINGTON, DC 20016

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F 281	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."	F 281		
F 323 SS=E	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. This REQUIREMENT is not met as evidenced by: 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. The findings include: 1. An employee was observed on October 9, 2007 at 10:10 AM to trip over the buckled front lobby wall-to-wall carpet. 2. 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.	F 323 F323(3)	**1. Corrective Action(s)** The broken plastic cover on the over bed light in Room 307B has since been replaced. **2. Identification of Deficient Practices & Corrective Actions:** The over bed lights in other resident rooms have the potential to be affected. The Housekeeping and Maintenance team leader has inspected all resident room over bed light plastic covers to identify risks. Any and all negative findings will be corrected at time of discovery. **3. Systemic Change(s):** The facility has reviewed its' currently policy and procedure. The environmental services staff have been inserviced by the Administrator or designee on the provisions of 483.25(h) specifically accidents and supervision. Environmental rounds have been expanded to include the assessment, repair, maintenance, and or replacement of over bed light plastic covers in resident rooms. **4. Monitoring:** The Director of Plant Operations and/or Designee is responsible for maintaining compliance. The QA Program includes the environmental Observation tool for monitoring the interior specifically the plastic covers of the over bed lights. The housekeeping and maintenance team leader will conduct random weekly environmental rounds with the Administrator for monitoring compliance. Findings will be reported to the QA Committee for recommendations and or changes in current policy or practice and the need for further audits and or action plans. **5. Date of Compliance: 11/09/07**	10/10/07 10/12/07 11/2/07 11/9/07

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F 281	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."	F 281		
F 323 SS=E	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. This REQUIREMENT is not met as evidenced by: 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. The findings include: 1. An employee was observed on October 9, 2007 at 10:10 AM to trip over the buckled front lobby wall-to-wall carpet. 2. 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.	F 323	F323(4) **1. Corrective Action(s)** The damaged wall plate cover observed in Room 336 has since been replaced. **2. Identification of Deficient Practices & Corrective Actions:** The wall plate covers throughout the facility have the potential to be affected. The Housekeeping and Maintenance team leader will conduct environmental rounds to identify risks. Any and all negative findings will be corrected at time of discovery. **3. Systemic Change(s):** The facility has reviewed its' currently policy and procedure. The environmental services staff have been inserviced by the Administrator or designee on the provisions of 483.25(h) specifically accidents and supervision. Environmental rounds have been expanded to include the assessment, repair, maintenance, and or replacement of wall plate covers throughout the facility. **4. Monitoring:** The Director of Plant Operations and/or designee is responsible for maintaining compliance. The QA Program includes the environmental observation tool for monitoring the interior specifically the wall plate covers. The housekeeping and maintenance team leader will conduct random weekly environmental rounds with the Administrator for monitoring compliance. Findings will be reported to the QA Committee for recommendations for changes in current policy or practice and the need for further audits and or action plans. **5. Date of Compliance: 11/09/07**	10/11/07 10/12/07 11/2/07 11/9/07

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F 281	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."	F 281		
F 323 SS=E	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. This REQUIREMENT is not met as evidenced by: 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. The findings include: 1. An employee was observed on October 9, 2007 at 10:10 AM to trip over the buckled front lobby wall-to-wall carpet. 2. 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.	F 323 F323(5)	**1. Corrective Action(s)** The loose rubber molding observed in the door way of Room 230 has since been replaced. **2. Identification of Deficient Practices & Corrective Actions:** Other rubber molding in door ways throughout the facility have the potential to be affected. The Housekeeping and Maintenance team leader will conduct environmental rounds to identify risks. Any and all negative findings will be corrected at time of discovery. **3. Systemic Change(s):** The facility has reviewed its' currently policy and procedure. The environmental services staff have been inserviced by the Administrator or designee on the provisions of 483.25(h) specifically accidents and supervision. Environmental rounds have been expanded to include the assessment, repair, maintenance, and or replacement rubber molding in door ways throughout the facility. **4. Monitoring:** The Director of Plant Operations and/or designee is responsible for maintaining compliance. The QA Program includes the environmental observation tool for monitoring the interior specifically the rubber molding in door ways throughout the facility. The housekeeping and maintenance team leader will conduct random weekly environmental rounds with the Administrator for monitoring compliance. Findings will be reported to the QA Committee for recommendations for changes in current policy or practice and the need for further audits and or action plans. **5. Date of Compliance: 11/09/07**	10/11/07 10/19/07 11/2/07 11/9/07

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F 323	Continued From page 13 3. The plastic cover of the over-bed light was observed broken in room 307B in one (1) of 20 over-bed lights observed. 4. A wall plate cover was observed damaged and hanging loose in room 336 in one (1) of 20 wall plate covers observed. 5. The rubber molding was observed loose in the doorway of room 230 in one (1) of 20 resident room doorways observed. Employees #2 and 3 acknowledged the above cited deficiencies at the time of the observations.	F 323		
F 371 SS=E	483.35(i)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by: Based on observations of the main kitchen, it was determined that facility staff failed to store and prepare food under sanitary conditions as evidenced by: unlabeled and undated food, moldy,wilted lettuce stored in the walk-in refrigerator, pans stored wet and ready for re-use and an uncovered dumpster. These observations were made in the presence of Employees #5 and 15 on October 9, 2007 between 6:55 AM and 10:30 AM. The findings include:	F 371	**1. Corrective Action(s)** The 25 servings of mandarin oranges, 9 packages of cookies, 54 serving of diet Jello, 61 serving of Jello, 9 serving of apple sauce, 15 servings of fresh fruit salad, 17 servings of fresh garden salad, 20 cups of ice tea, and 4 serving of fruit cocktails were discarded post observation. **2. Identification of Deficient Practices & Corrective Actions:** Other meal prep items prepared for scheduled meal distribution and storage have the potential to be affected. The Food Services Manager and or Food Services Supervisor will inspect any/all food items prior to storage for proper labels, dates, and initials. Any and all negative findings will be corrected at time of discovery. **3. Systemic Change(s):** The facility has reviewed its' currently policy and procedure. The dietary services staff will be inserviced by the Registered Dietitian or designee on the provisions of 483.35(i)(2) specifically sanitary conditions, food prep, and storage of food items.	10/9/07 10/9/07 11/2/07

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F 371	Continued From page 14 1. The following items were observed undated and/or unlabeled in the walk-in refrigerator: 25 servings of mandarin oranges 9 packages of cookies 54 servings of diet Jello 61 servings of Jello 9 servings of applesauce 15 servings of fresh fruit salad 17 servings of fresh garden salad 20 cups of iced tea 4 servings of fruit cocktail 2. Seven (7) heads of lettuce were observed moldy and wilted in the walk-in refrigerator. 3. The following items were stored wet and ready for re-use: 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 4. The roll away dumpster was observed to contain bags of trash and was uncovered. Employees #5 and 15 acknowledged these findings at the time of the observations.	F 371	**4. Monitoring:** The Dietitian will complete the Dietary Inspection Report weekly for maintaining compliance. The Dietary Inspection Report now includes sanitary conditions, food prep, and storage of food items. Findings will be reported to the QA Committee for recommendations for changes in current policy or practice and the need for further audits and or action plans. **5. Date of Compliance: 11/09/07**	11/9/07
F 441 SS=D	483.65(a) INFECTION CONTROL The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 371	Continued From page 14 1. The following items were observed undated and/or unlabeled in the walk-in refrigerator: 25 servings of mandarin oranges 9 packages of cookies 54 servings of diet Jello 61 servings of Jello 9 servings of applesauce 15 servings of fresh fruit salad 17 servings of fresh garden salad 20 cups of iced tea 4 servings of fruit cocktail 2. Seven (7) heads of lettuce were observed moldy and wilted in the walk-in refrigerator. 3. The following items were stored wet and ready for re-use: 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 4. The roll away dumpster was observed to contain bags of trash and was uncovered. Employees #5 and 15 acknowledged these findings at the time of the observations.	F 371 F371(2)	**1. Corrective Action(s)** The 7 heads of molded and wilted lettuce observed in the walk-in refrigerator was discarded immediately. **2. Identification of Deficient Practices & Corrective Actions:** Other meal prep items prepared / stored for distribution have the potential to be affected. The Food Services Manager and Food Services Supervisor will inspect any / all food items prior to storage for proper labels, dates, and initials. Any and all negative findings will be corrected at time of discovery. **3. Systemic Change(s):** The facility has reviewed its' currently policy and procedure. The dietary services staff will be inserviced by the Registered Dietitian or designee on the provisions of 483.35(i)(2) specifically sanitary conditions, food prep, and storage of food items. **4. Monitoring:** The Dietitian will complete the Dietary Inspection Report weekly for maintaining compliance. The Dietary Inspection Report includes sanitary conditions, food prep, and the storage of food items. Findings will be reported to the QA Committee for recommendations for changes in current policy or practice and the need for further audits and or action plans. **5. Date of Compliance: 11/09/07**	10/9/07 10/9/07 11/2/07 11/9/07
F 441 SS=D	483.65(a) INFECTION CONTROL The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in	F 441		

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F 371	Continued From page 14 1. The following items were observed undated and/or unlabeled in the walk-in refrigerator: 25 servings of mandarin oranges 9 packages of cookies 54 servings of diet Jello 61 servings of Jello 9 servings of applesauce 15 servings of fresh fruit salad 17 servings of fresh garden salad 20 cups of iced tea 4 servings of fruit cocktail 2. Seven (7) heads of lettuce were observed moldy and wilted in the walk-in refrigerator. 3. The following items were stored wet and ready for re-use: 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 4. The roll away dumpster was observed to contain bags of trash and was uncovered. Employees #5 and 15 acknowledged these findings at the time of the observations.	F 371 F371(3)	**1. Corrective Action(s)** The 10 sheet pans, 5 hotel pans, the 5 "5-1/4" hotel pans, and the 2 roasting pans stored wet were re-washed and stored appropriately. **2. Identification of Deficient Practices & Corrective Actions:** Other sheet pans washed and stored have the potential to be affected. The Food Services Manager and or Food Services Supervisor will inspect sheet pans post wash for proper drying and storage. Any and all negative findings will be corrected at time of discovery. **3. Systemic Change(s):** The facility has reviewed its' currently policy and procedure. The dietary services staff will be inserviced by the Registered Dietitian or designee on the provisions of 483.35(i)(2) specifically sanitary conditions, food prep, and storage of food items. **4. Monitoring:** The Dietitian will complete the Dietary Inspection Report weekly for maintaining compliance. The Dietary Inspection Report includes sanitary conditions, food prep, and the proper storage of food and utensils i.e. pot and pan items. Findings will be reported to the QA Committee for recommendations for changes in current policy or practice and the need for further audits and or action plans. 5. **Date of Compliance: 11/09/07**	10/9/07 10/9/07 11/2/07 11/9/07
F 441 SS=D	483.65(a) INFECTION CONTROL The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in	F 441		

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F 371	Continued From page 14 1. The following items were observed undated and/or unlabeled in the walk-in refrigerator: 25 servings of mandarin oranges 9 packages of cookies 54 servings of diet Jello 61 servings of Jello 9 servings of applesauce 15 servings of fresh fruit salad 17 servings of fresh garden salad 20 cups of iced tea 4 servings of fruit cocktail 2. Seven (7) heads of lettuce were observed moldy and wilted in the walk-in refrigerator. 3. The following items were stored wet and ready for re-use: 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 4. The roll away dumpster was observed to contain bags of trash and was uncovered. Employees #5 and 15 acknowledged these findings at the time of the observations.	F 371 F371(4)	**1. Corrective Action(s)** The temporary roll away dumpster has been removed. **2. Identification of Deficient Practices & Corrective Actions:** Other temporary roll away dumpsters have the potential to be affected. The Director of Plant Ops will inspect all dumpsters to identify risk. Any / all negative findings will be corrected at time of discovery. **3. Systemic Change(s):** The facility has reviewed its' currently policy and procedure. The maintenance and dietary staff will be inserviced by the Registered Dietitian or designee on the provisions of 483.35(i)(2) specifically sanitary conditions, food prep, and storage of food items. **4. Monitoring:** The Dietitian will complete the Dietary Inspection Report weekly for maintaining compliance. The Dietary Inspection Report includes sanitary conditions, food prep, and storage of food items. Findings will be reported to the QA Committee for recommendations for changes in current policy or practice and the need for further audits and or action plans. **5. Date of Compliance: 11/09/07**	10/15/07 10/15/07 11/2/07 11/9/07
F 441 SS=D	483.65(a) INFECTION CONTROL The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in	F 441		

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F 371	Continued From page 14 1. The following items were observed undated and/or unlabeled in the walk-in refrigerator: 25 servings of mandarin oranges 9 packages of cookies 54 servings of diet Jello 61 servings of Jello 9 servings of applesauce 15 servings of fresh fruit salad 17 servings of fresh garden salad 20 cups of iced tea 4 servings of fruit cocktail 2. Seven (7) heads of lettuce were observed moldy and wilted in the walk-in refrigerator. 3. The following items were stored wet and ready for re-use: 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 4. The roll away dumpster was observed to contain bags of trash and was uncovered. Employees #5 and 15 acknowledged these findings at the time of the observations.	F 371		
F 441 SS=D	483.65(a) INFECTION CONTROL The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in	F 441	1. **Corrective Action(s)** Employee #13 has been re-educated on the facility's policy, procedure, and practice for maintaining a sanitary environment.	10/10/07

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F 441	Continued From page 15 the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview during the environmental tour, it was determined that facility staff failed to maintain a sanitary environment as evidenced by a red biohazard bag observed in the hallway. This observation was made in the presence of Employees #2 and 3. The findings include: During initial tour of the facility on October 9, 2007 at 8:35 AM, it was observed that a red biohazard bag containing infectious waste was observed in the hallway in front of an isolation room. Employee #13 was inside the resident's room. A face-to-face interview was conducted with Employee #13 on October 9, 2007 at 8:40 AM. He/she stated, "I just placed the bag here [in the hallway in front of the isolation room] a second ago." A face-to-face interview was conducted with Employee #16 on October 10, 2007 at 12:00 PM. He/she stated that the facility's practice was to remove the red biohazard bag from the isolation room and immediately place it in the soiled utility room in the appropriate biohazard container and that the red biohazard bag should not have been left on the floor.	F 441	**2. Identification of Deficient Practices & Corrective Actions:** Other residents receiving dressing changes with known isolation needs have the potential to be affected. The Director of Nursing and/or designee will conduct impromptu observations of scheduled wound rounds to randomly monitor sanitary conditions and proper destruction of contaminated materials. Any and all negative findings will be corrected at time of discovery and reported to the QA Committee for recommendations. **3. Systemic Change(s):** The facility has reviewed its' currently policy and procedure. Licensed staff will be inserviced on the provisions of 483.65(a) specifically specifically to maintain a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. **4. Monitoring:** The Clinical Manager and/or designee is responsible for maintaining compliance. The QA Program includes a random observation tool for monitoring sanitary conditions. The Clinical Manager and or designee will complete a 10% audit of schedule wound treatments weekly to verify compliance. Findings will be reported to the QA Committee for recommendations for changes in current policy or practice and the need for further audits or action plans. **5. Date of Compliance: 11/09/07**	10/15/07 11/2/07 11/9/07
F 445 SS=C	483.65(c) INFECTION CONTROL - LINENS	F 445		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095005	A. BUILDING _____ B. WING _____	10/12/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 445	Continued From page 16 Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and review of manufacturer's manuals, it was determined that facility staff failed to develop a monitoring program to ensure wash water temperatures for facility and resident laundry were within the manufacturer's recommended range for each chemical utilized in the washing cycle. The findings include: An observation of the laundry being processed was conducted on October 9, 2007 at 8:40 AM. Employee #14 stated, "I am going to start a load of towels. I am going to select Cycle #1." A list describing each formula and items washed for that formula was posted on the door to the washing area. The washer being observed was equipped with a computer program displayed on a digital screen attached to the front of the washer. Among the information displayed was the formula/cycle (a program designed for each type of laundry), the step in the cycle and the water temperature in degrees Fahrenheit (F). At the time of the observation, the machine was set on Cycle #1 and was currently in the beginning of the wash cycle. The temperature displayed on the computer screen was 95 degrees F.	F 445	1. **Corrective Action(s)** Employee #14 and #3 have been re-educated on the facility's policy, procedure, protocol, and and practice for monitoring the temperatures required to process linens to prevent the spread of infection. 2. **Identification of Deficient Practices & Corrective Actions:** A monitoring tool has been developed and implemented which corresponds with the manufacturers recommended temperatures ranges for processing linens to prevent the spread of infection. The laundry supervisor randomly selects wash cycles and machines to monitor compliance for appropriate chemical utilization, temperature requirements, and variances. 3. **Systemic Change(s):** The facility has reviewed its' currently policy and procedure. A comprehensive monitoring program has been implemented and will be monitored the QA Program for maintaining compliance. Laundry staff will be inserviced on the provision 483.65(c) specifically infection control for linens and the new monitoring program. 4. **Monitoring:** The laundry supervisor and or designee is responsible for maintaining compliance. The QA Program now includes a monitoring tool for maintaining compliance. The Laundry Supervisor and or designee will complete weekly audits to verify compliance. Findings will be reported to the QA Committee for recommendations for changes in current policy or practice and the need for further audits or action plans. 5. **Date of Compliance: 11/09/07**	10/11/07 10/11/07 10/15/07 11/9/07

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F 445	Continued From page 17 The surveyor asked Employee #14 what temperature was required for this step. He/she stated, "It has to be 160 degrees to wash. We use different chemicals, too." Employee #14 was unable to state the length of time the water temperature for the wash cycle had to remain at 160 degrees F. Upon further inquiry, there was no evidence that the laundry staff or the laundry supervisor were aware of the temperature ranges for the chemicals used in the facility's laundry. The surveyor asked for the chemicals used and the temperature range recommended by the manufacturer for the chemicals used in the facility's laundry. Employee #14 stated that he/she did not have that information, but would ask the supervisor. The surveyor asked Employee #3 if temperatures were being monitored for each step. Employee #3 stated that the computer program pre-determined the temperature for each cycle and was set by the representative from the chemical company for the chemicals utilized by the facility. A listing of the manufacturer's recommendations for temperature ranges for the chemicals could not be located by Employee #3 at the time of the observation. Employee #3 requested information from the facility's chemical supplier regarding the manufacturer's recommended temperature range for each chemical used. Information was received by the facility via facsimile from the	F 445		

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F 445	Continued From page 18 facility's chemical supplier on October 10, 2007 at 8:50 AM. Employee #3 acknowledged that temperatures were not monitored for the washing cycle.	F 445		