STATEMENT	F OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN		OMB NO. (X3) DATE SI COMPLE	URVEY
		095022	B. WING	·	05/1	9/2006
	Rovider or Supplier	CILITY	2	REET ADDRESS, CITY, STATE, ZIP COD 425 25TH STREET SE VASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SHOI REFERENCED TO THE APPROPRIA	ULD BE CROSS-	(X5) COMPLETI DATE
F 000	An annual recertific on May 15 through deficiencies were b reviews and intervi- residents. The san based on a census	TS cation survey was conducted 19, 2006. The following based on observations, record ews with facility staff and nple included 30 records of 324 residents on the first 17 supplemental records.	F 000	not constitute an admission deficiencies alleged did in fact e Plan of Correction is filed as ex the facility's desire to comply regulatory requirement of resp these citations and to continue t quality resident care.	that the xist. This vidence of with the onding to	
F 221 SS=D	The resident has the physical restraints in discipline or conven- treat the resident's This REQUIREMENT Based on record res (5) of 30 sampled restraint reduction of restraint Residents #1, 6, 12 The findings includ According to the fa Physical Restraints dated August, 2008 Emergency Restraints dated August, 2008 Emergency Restraints regulation and door gradual process tow 1. Facility staff faile restraint elimination	he right to be free from any imposed for purposes of nience, and not required to medical symptoms. NT is not met as evidenced by eview and staff interview for five residents, it was determined led to address the possible nts according to facility policy. 2, 13 and 15. e: cility ' s policy, "Nursing s", policy #1404399A.000, 5, page 2 under "Non- ints," #4, " The IDC (re) team will review the at least monthly or as state ument a systematic and ward reducing restraint " ed to complete the monthly in for Resident #1.	F 221	 PHYSICAL RESTRAINTS Residents #1, 6, 12, 13, and 15 1. Residents cited at the time of the have had their restraint elements and care plans update facility's IDT team will assorresidents for restraint reduct month to ensure that the resident the least restrictive and most appendevice possible. 2. All other residents with restrate been evaluated using the facility's IDT team will assess for reduction each month to ensure residents are in the least restriction each month to ensure residents are in the least restriction each month to ensure residents are in the least restriction each month to ensure residents are in the least restriction each month to ensure residents are in the least restriction of the nursing staff and IDT is were inserviced on the restraint restraint restraint. The Clinical Managers on of will monitor their residents to enthe facility's restraint reduction followed with assessments done to the restraint restrai	imination ated. The ess these ion each nts are in popopriate unts have s restraint heir care d. The restraint that the ctive and c. members reduction ding and gers and each unit sure that policy is	6/30/0 6/30/0
BORATOR	DIRECTOR'S ORPROVI	DER/SUPELIER REPRESENTATIVE'S SIGN		Administrator	alal	(X6) DATE

		HAND HUMAN SERVICES				FORM	06/15/2006 APPROVED 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		TIPLE CONSTRUCTION	(X3) DATE S COMPLE	
		095022	B. WI	NG_		05/1	9/2006
	ROVIDER OR SUPPLIER	CILITY			TREET ADDRESS, CITY, STATE, ZIP CODE 2425 25TH STREET SE WASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOUL REFERENCED TO THE APPROPRIATE	D BE CROSS-	(X5) COMPLETION DATE
F 221	care plan was upda According to care p Safety Device" und	age 1 nt #1's record revealed that the ated on April 18, 2006. blan problem #9, "Use of der "Approaches" the ked, "Evaluate use of restraint	The results of her monitoring, along with any action plans for improvement, will be presented at the quarterly Quality				6 20 (26
	form was present in January 10, 2006. restraint elimination A face-to-face inter charge nurse on M she acknowledged	nation- Monthly Assessment" In the record and was dated There were no additional In forms in the record. There was conducted with the ay 17, 2006 at 9:30 AM. He/ that the restraint elimination bleted after January 2006. The ed May 15, 2006.					
	facility staff failed to possible elimination The care plan for F Device " with an or 2005 and most rec included the followi). Evaluate use of Address the possib	dent #6's record revealed that o reevaluate the resident for n of a seatbelt restraint. Problem #20, " Use of Safety rigination date of March 13, ently updated April 2006 ing: " Seatbelt (button release restraint every month. ble reduction/discontinuation of erdisciplinary team] conference					
	form dated August resident a candidat program? No. " T assessment form for	nation- Monthly Assessment " 1, 2005 included: "Is the le for restraint release his was the only monthly ound in the chart. e summaries were reviewed					
FORM CMS-25	567(02-99) Previous Versions	S Obsolete Event ID: D95S11	Fa	cility	y ID: WASHNURS If cor	tinuation shee	t Page 2 of 96

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 06/15/2006 FORM APPROVED OMB NO 0938-0391

<u>CENTER</u>	AS FOR MEDICARE	<u>& MEDICAID SERVICES</u>		_		<u>OMR NO</u>	<u>0938-039</u> 1
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SU COMPLE	
l		095022	- B. Wil	NG		05/1	9/2006
NAME OF P	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE		
WASHIN	GTON NURSING FAC	CILITY		4	425 25TH STREET SE VASHINGTON, DC 20020		
					PROVIDER'S PLAN OF CORREC		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE	BE CROSS-	(X5) COMPLETION DATE
F 221	Continued From pa	ige 2	F	221			
		ovember 1, 2005 and January 06. The summaries failed to					
	discontinuation of t	o the possible reduction/ he restraint. riewed on May 16, 2006.					
		dent #12's record revealed that					
	facility staff failed to	o reevaluate the resident for n of a seatbelt restraint.					
	Device " with an or illegible], 2005 and 21, 2006 included t	roblem #13, " Use of Safety rigination April [date was most recently updated March he following: " Seatbelt (
		Address the possible reduction/ estraint at IDT conference "					
	form dated June 14 resident a candidat	hination- Monthly Assessment " 4, 2005 included: " Is the e for restraint release					
	assessment form form	his was the only monthly ound in the chart.					
	for July 5, Septemb and March 21, 200 include reference to discontinuation of t	e summaries were reviewed ber 28 and December 27, 2005 6. The summaries failed to bothe possible reduction/ he restraint. viewed on May 16, 2006.					
		ed to do a monthly restraint ible elimination or reduction for					
	problem # 8 use of	t # 13's record, " re Plan updated April 13, 2006 safety device seatbelt (button Approaches were to evaluate					

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

Facility ID: WASHNURS

If continuation sheet Page 3 of 96

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL			(X3) DATE S COMPLE		
		095022	B. WIN			05/1	9/2006	
	PROVIDER OR SUPPLIER			242	ET ADDRESS, CITY, STATE, ZIP CODE 25 25TH STREET SE		9/2006	
	·	ATEMENT OF DEFICIENCIES	Ì.	/	ASHINGTON, DC 20020 PROVIDER'S PLAN OF CORR			
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOU REFERENCED TO THE APPROPRIAT	LD BE CROSS-	(X5) COMPLETIC DATE	
F 221	Continued From p	age 3	F 2	21				
I		t every month, address the /discontinuation of restraint at						
·	16, 2006 indicated on every morning, for geri chair with	g monthly notes dated January , "Up in geri chair with lap tray February 28, 2006 has order ap tray to be used when						
	in Geri chair every 27, 2006 has Geri tray on to be remo	ed in chair, March 15, 2006 up day with lap tray on, and April chair when out of bed with lap ved for repositioning and There was no evidence in the						
	record that the res	ident was assessed monthly for and possible elimination.						
	charge nurse on N she acknowledged assessment for th	rview was conducted with the lay 19, 2006 at 10:00 AM. He/ I that there was no monthly e reduction or elimination of ord. The record was reviewed						
	facility staff failed I	ident #15's record revealed that o reevaluate the resident for n of a seatbelt restraint.						
	Device " with an c 2005 and most rec included the follow Evaluate use of re reduction/discontir	Problem #11, "Use of Safety rigination date of March 13, cently updated April 2006 ing: "Seatbelt (velcro) straint. Address the possible ination of restraint at IDT					·	
		limination- Monthly ns dated November 9, 2005 06 included: "Is the resident a						

Second and the second se

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

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PRINTED: 06/15/2006 FORM APPROVED OMB NO. 0938-0391

						. 0300-033
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. Built	LTIPLE CONSTRUCTION	(X3) DATE S COMPL	
		095022	B. WING	B. WING		9/2006
	PROVIDER OR SUPPLIER	CILITY		STREET ADDRESS, CITY, STATE, ZIP C 2425 25TH STREET SE WASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION SI REFERENCED TO THE APPROPT	HOULD BE CROSS-	(X5) COMPLETION DATE
F 221 F 253 SS=E	candidate for restra was listed for Nove was no answer for the only monthly as chart. The IDT conference for July 5 and Octo March 28, 2006. The reference to the poor discontinuation of the reviewed May 16, 2005 The facility must primaintenance service	aint release program? "No" ember 9, 2005; however, there January 3, 2006. These were ssessment forms found in the es summaries were reviewed ober 4, 2005 and January 3 and The summaries failed to include ossible reduction/ the restraint. The record was	F 22	 483.15(h)(2) HOUSEKEEPING/MAINTENANCE Door Jambs The door jambs cited at the time of the survey have been repaired and/or painted. All door jambs have been evaluated and repaired/repainted as needed. The Maintenance Supervisor will evaluate the door jambs on a monthly basis, scheduling repainting or repair as needed. He will report his findings to the Director of Maintenance. 		6 30/26 6 30/26 6 30/26 6 30/26
	Based on observat it was determined t maintenance servic ensure that the fac and sanitary manne entrance and bathr marred and damag abundance of pers damaged Venetian accumulated dust i stored under the si curtains; soiled and and damaged base heads; damaged h	NT is not met as evidenced by ions during the survey period, hat housekeeping and ces were not adequate to ility was maintained in a safe er as evidence by: marred oom doors; soiled HVAC units; jed wall surfaces; an onal items in residents' rooms; blinds; urine odors; n the gas dryer; supplies nk; soiled and/or torn privacy d stained ceiling tiles; soiled eboards; soiled sprinkler tVAC units; soiled exhaust el bars in the Rehabilitation		 HVAC units 1. The HVAC units cited the survey have been thorood 2. All HVAC units have be and cleaned when necessary 3. The Housekeeping Supert the HVAC units on a magnetic scheduling their cleaning will report his findings to the Environmental Services. 4. The Director of Services will oversee the magnetic schedul of the magnetic scheduling the sch	ughly cleaned. been evaluated y. visors evaluate nonthly basis, as needed. He the Director of Environmental onitoring. The along with any ement, will be	6 70 00 6 70 00 6 70 00 6 70 00

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

Event ID: D95S11 Facility ID: WASHNURS

·		& MEDICAID SERVICES				<u>. 0938-039</u>
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILI		(X3) DATE S COMPLE	
		095022	B. WINC	3	05/1	9/2006
NAME OF P	ROVIDER OR SUPPLIER	 		STREET ADDRESS, CITY, STATE, ZIP CODE		
WASHIN	GTON NURSING FAC			2425 25TH STREET SE WASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHOU REFERENCED TO THE APPROPRIAT	LD BE CROSS-	(X5) COMPLETION DATE
F 253	Continued From pa	nge 5	F 25	53 .		
	Department; mops floor; soiled wheeld	and buckets stored on the hairs, straight back chairs and		Improvement Committee, which by the Administrator.	is chaired	
	dining room table le surfaces of geri cha observed in the pre	egs; and worn and torn arm airs. These findings were sence of the Directors of Maintenance and nursing staff	·	Wall surfaces 1. The wall surfaces cited at the till survey have been repaired and/or 2. All wall surfaces have been e and repaired/repainted as needed 3. The Main Surfaces have been e	painted.	63010
1. Entrance were marre	The findings includ	e:		evaluate the wall surfaces	sor will	10/070/08
		throom doors and door jams frontal and rear surfaces in		 needed. He will report his finding Director of Maintenance. The Director of Maintenance. 	epair as as to the	6 70 9
-		and tub room in two (2) of 10 ay 15, 2006 from 11:20 AM to		monitoring, along with any action for improvement, will be presented quarterly Quality	s of his plans d at the	6/20/0
	room and shower re	5, 110, 122, 146, 160, supply com in seven (7) of 15 ay 17, 2006 from 8:40 AM to		Committee, which is chaired by Administrator.	vement vy the	
	shower room and p observations on Ma	, 211, 215, 233, 237, 245, antry in eight (8) of 16 ay 17, 2006 from 11:33 AM to		1. The abundance of personal items at the time of the survey have organized and/or removed and store 2. All residents with an abund	s cited been d.	5/19/0
		2, 232, and 238 in three (3) of ns on May 17, 2006 from 2:33		their items reorganized or store needed.	d as will	5/19/0 6/20/0 6/20/0
		, 313, 323 and 327 in four (4) ions on May 18, 2006 from 8:		on a monthly basis, scheduling reorganization and/or storing as nee He will report his findings to the Dire of Maintenance.	ctor	670/0
	3 South rooms: 312 in five (5) of nine (9	2, 326, 340, 348 and tub room		4. The Director of Maintenance	will	470104

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

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Event ID: D95S11 Facility ID: WASHNURS

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	T OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CONSTRUCTION	(X3) DATE S COMPL	
		095022	B. WIN	IG	05/	19/2006
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2 2425 25TH STREET SE WASHINGTON, DC 20020		1372000
(X4) ID PREFIX TAG	EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		IN SHOULD BE CROSS-	(X5) COMPLETI DATE
F 253	2006 from 1:48 PM Laundry room in on May 18, 2006 at 5:5 2. HVAC units were 1 North rooms: 105 and dining room in May 15, 2006 from 1 South rooms, 106 in six (6) of 12 obse from 11:33 AM to 2: 2 North rooms: 203 253 in seven (7) of 2006 from 2:33 PM 2 South rooms: 226 of seven (7) observa :33 PM to 4:54 PM. 3 North rooms: 309, (5) of 11 observation AM to 11:45 PM. 3 South rooms: 312 six (6) observations PM to 4:54 PM. 3. Wall surfaces wea the following areas: 1 North rooms: 105, toilet room, linen ro	to 4:54 PM. e (1) of one (1) observation on 60 PM. soiled in the following areas: , 111, 113, 139, 141, 151, 159 eight (8) of 13 observations on 11:20 AM to 1:30 PM. , 110, 114, 142, 144, and 154 rvations on May 17, 2006 30 PM. , 209, 215, 225, 233, 245 and 14 observations on May 17,	F 2	 oversee the monitoring. monitoring, along with for improvement, will b quarterly Quality Committee, which is Administrator. Venetian blinds The Venetian blinds ci the survey have been replaced as needed. All Venetian blir evaluated and repaired/re The Maintenance evaluate the Venetian bli 	any action plans e presented at the Improvement chaired by the ited at the time of repaired and/or ads have been placed as needed. Supervisor will nds on a monthly eir repair or He will report his of Maintenance. Maintenance will The results of his any action plans e presented at the Improvement chaired by the ed at the time of addressed and cility have been ce of odors and usekeeping, and will evaluate the a monthly basis,	6/20/0 6/20/0 6/20/0 6/20/0 6/20/0 6/20/0

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		AND HUMAN SERVICES		·	FORM	: 06/15/200 APPROVE . 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	a. Buildii	TIPLE CONSTRUCTION	(X3) DATE S COMPLE	
		095022	B. WING		05/1	9/2006
	ROVIDER OR SUPPLIER		:	REET ADDRESS, CITY, STATE, ZIP CODE 2425 25TH STREET SE WASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHOU REFERENCED TO THE APPROPRIAT	LD BE CROSS-	(X5) COMPLETIC DATE
F 253	 South rooms: 106, 154, toilet room ar observations on Ma 11:30 AM. North rooms: 203 nine (9) observation AM to 2:30 PM. South rooms: 210 four (4) of seven (7 2006 from 2:33 PM North rooms: 313 dining room in four May 18, 2006 from An abundance of residents' rooms be in the following area; of two (2) observations be in the following area; North rooms: 111 of 10 observations to 1:30 PM. South room 106 i observations on Ma 11:30 PM. North rooms: 209 	 5, 114, 116, 122, 132, 142, 146 and dining room in 10 of 10 ay 17, 2006 from 8:40 AM to 6, 233 and 237 in three (3) of as on May 17, 2006 from 11:33 6, 212, 220, and tub room in observations on May 17, to 4:54 PM. 6, 353, hallway on H side and (4) of nine (9) observations on 8:30 AM to 11:45 PM f personal items were in eside the bed and on the floor as: room 210 and 348 in two (2) tions on May 17, 2006 at 2:38 06 at 1:50 PM. were damaged in the following , 113, 123, and 145 in four (4) May 15, 2006 from 11:20 AM n one (1) of seven (7) ay 17, 2006 from 8:40 AM to e, 211, 225, 233 and 245 in five ervations on May 17, 2006 :30 PM. 	F 253	their findings to their r	espective facility providing reusable) ents. This ty by the or control. intenance ersee the dors. The g with any , will be Quality is chaired ted at the horoughly uated and ay rs evaluate a frequent as needed. e Director fronmental pring. The g with any t, will be y Quality	6/20/2 5/14/0 16/20/2 16/20/2 10/20/2

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		HAND HUMAN SERVICES		100,500- 7)17107	FORM	: 06/15/200 APPROVE
	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE S COMPL	URVEY
		095022	B. WING	· · · · · · · · · · · · · · · · · · ·	05/1	9/2006
	ROVIDER OR SUPPLIER GTON NURSING FAC	:ILITY	2	REET ADDRESS, CITY, STATE, ZIP CODE 425 25TH STREET SE VASHINGTON, DC 20020	+	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETION DATE
	 , 154, toilet room all observations on Ma 11:30 AM. 2 North rooms: 203 nine (9) observation AM to 2:30 PM. 2 South rooms: 210 four (4) of seven (7) 2006 from 2:33 PM 3 North rooms: 313 dining room in four May 18, 2006 from 4. An abundance of residents' rooms be in the following areat) of two (2) observations be in the following areat? 1 North rooms: 111, of 10 observations in to 1:30 PM. 1 South room 106 in observations on Ma 11:30 PM. 2 North rooms: 209, 	5, 114, 116, 122, 132, 142, 146 nd dining room in 10 of 10 ay 17, 2006 from 8:40 AM to , 233 and 237 in three (3) of is on May 17, 2006 from 11:33 0, 212, 220, and tub room in) observations on May 17, to 4:54 PM. , 353, hallway on H side and (4) of nine (9) observations on 8:30 AM to 11:45 PM personal items were in side the bed and on the floor is: room 210 and 348 in two (2 tions on May 17, 2006 at 2:38 06 at 1:50 PM. vere damaged in the following 113, 123, and 145 in four (4) May 15, 2006 from 11:20 AM in one (1) of seven (7) y 17, 2006 from 8:40 AM to 211, 225, 233 and 245 in five rvations on May 17, 2006	F 253	or cleaning as needed. They will their findings to their resp department heads. The implemented a new practice of pro- disposable (rather than ret incontience products to its residents was done both for acceptability residents and staff as well as odor of 4. The Directors of Nursing, Maint and Housekeeping will overse monitoring of the presence of odor results of their monitoring, along w action plans for improvement, w presented at the quarterly of Improvement Committee, which is a by the Administrator. Interior of the dryer 1. The interior of the dryer cited time of the survey have been thow cleaned. 2. All dryers have been evaluated	bective facility viding usable) a. This by the ontrol. enance see the s. The ith any vill be Quality chaired at the oughly ed and r - 1/r / s le valuate requent needed. Director umental g. The ith any will be Quality	6 200/26 5 19 26 2 19 26 2 19 26 2 20 26
DRM CMS-256	7(02-99) Previous Versions	Obsolete Event ID: D95\$11	Facility ID	D: WASHNURS If contin	uation sheet	Page 8 of 96

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		HAND HUMAN SERVICES				FÖRM	: 06/15/2006 APPROVED . 0938-0391
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		IPLE CONSTRUCTION	(X3) DATE S COMPLE	
		095022	B. WI	NG	· · · · · · · · · · · · · · · · · · ·	05/1	9/2006
	ROVIDER OR SUPPLIER	CILITY		2	REET ADDRESS, CITY, STATE, ZIP CODE 2425 25TH STREET SE WASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES (MUST BE PRECEEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOUL REFERENCED TO THE APPROPRIATE	D BE CROSS-	(X5) COMPLETION DATE
F 253	 2 South rooms 226 (3) of 11 observation PM to 4:54 PM. 3 North rooms: 313 (5) of 10 observation Am to 11:45 PM. 3 South rooms: 32 observations on Massaches 54 PM. 6. Urine odors were facility in the follow period: first and this elevator, second flow Rehabilitation Department. 	5, 232 and dining room in three ons on May 17, 2006 from 2:33 3, 327, 349, 335 and 353 in five ons on May 18, 2006 from 8:30 6 and 334 in two (2) of five (5) ay 18, 2006 from 1:48 PM to 4: e detected throughout the ing areas during the survey rd floor hallways near the main	F	253	 All areas noted at the time of the where supplies were inappropriate have been cleaned and supplies an appropriate place. Other similar areas have been of for inappropriately stored supplies areas were cleaned when necessing supplies moved to a safe and sec 3. The Housekeeping Supervisors the storage of supplies on a month scheduling their cleaning and org as needed. He will report his find the Director of Environmental Sec 4. The Director of Environmental Sec 5. The Housekee the monitor results of his monitoring, along action plans for improvement, presented at the quarterly Improvement Committee, which is by the Administrator. 	ely stored stored in evaluated lies. The sary and ure area. evaluate hly basis, anization ndings to ervices. onmental ing. The with any will be Quality	5/19/46 10/14 10/20/14 10/20/14 10/20/14 10/20/14
	 dust in one (1) of o 2006 at 5:50 PM. 8. Supplies were st following areas: 3 S Rehabilitation Depa (3) of 11 observation period. 9. Soiled and/or tor observed in the foll 116, 132, 145, 209 Rehabilitation Depa observations through 	gas dryer had accumulated ine (1) observation on May 18, tored under the sink in the South janitor's closet, artment and room 334 in three ons throughout the survey on privacy curtains were lowing areas: residents' rooms , 225, 233 and 313 and the artment in eight (8) of 26 ghout the survey period. re soiled and stained in the			 Privacy curtains 1. The privacy curtains cited at of the survey have been th cleaned and repaired when neces 2. All privacy curtains ha evaluated and clean/repaired necessary. 3. The Housekeeping Supervisors the condition of the privacy curt monthly basis, scheduling their and repair as needed. He will n findings to the Director of Envir Services. 4. The Director of Envir Services will oversee the monitor results of his monitoring, along 	oroughly ssary. ve been d when s evaluate ains on a cleaning eport his onmental onmental ing. The	6 200 16 6 200 06 6 200 06 6 200 06

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

Event ID: D95S11 Facility ID: WASHNURS

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		I AND HUMAN SERVICES				FORM	06/15/2006 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI		IPLE CONSTRUCTION	(X3) DATE SI COMPLE	URVEY
		095022	B. Wit	₩G		05/1	9/2006
	Rovider or Supplier Gton Nursing Fac			2	REET ADDRESS, CITY, STATE, ZIP CODE 2425 25TH STREET SE NASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE [BE CROSS-	(X5) COMPLETION DATE
F 253	following areas: 1 North rooms: 113 shower room, toiled 15 observations on to 1:30 PM, 1 South rooms: 104 room, supply room 17 observations on to 11:30 AM. 2 North rooms: 203 , dining room, pant and soiled utility room May 17, 2006 from 2 South rooms: 210 in four (4) of 10 observations on M 11:45 PM. 3 South rooms: 305) observations on M 11:45 PM. 3 South room 312 if observations on Ma 54 PM. 11. Baseboards we following areas: 1 North rooms: 123 lounge in five (5) of 2006 from 11:20 Al 1 South rooms: 110	 a, 123, 145, 149, 159, hallway, room and pantry in nine (9) of May 15, 2006 from 11:20 AM 4, 132, 142, 146, 160, toilet and dining room in eight (8) of May 17, 2006 from 8:40 AM b, 205, 211, 215, 225, 233, 237 ry, Rehabilitation Department om in 11 of 13 observations on 11:33 AM to 2:30 PM. c), 212, 238, and janitor's closet servations on May 17, 2006 from 8:30 AM to 2:30 PM. c) and 349 in two (2) of seven (7 May 18, 2006 from 8:30 AM to 4: an one (1) of six (6) ay 18, 2006 from 1:48 PM to 4: are soiled and damaged in the s, 125, 145, dining room and 11 observations on May 15, 	F	253	 presented at the quarterly (Climprovement Committee, which is of by the Administrator. Ceiling Tiles The ceiling tiles cited at the times survey have been replaced. All ceiling tiles have been ev and replaced when necessary. The Maintenance Supervisor events the ceiling tiles on a daily scheduling their replacement as the will report his findings to the I of Maintenance. The Director of Maintenance oversee the monitoring. The result monitoring, along with any action for improvement, will be presented. 	e of the aluated valuates basis, needed. Director nee will ts of his on plans ed at the ovement by the me of the replaced. evaluated cessary. ekeeping ards on a eaning or vill report	5 19 06 12 20 06 12 20 06 12 20 06 12 20 06 12 20 06 14 20 06 14 20 06 14 20 06

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

Facility ID: WASHNURS

If continuation sheet Page 10 of 96

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		AND HUMAN SERVICES				FORM	: 06/15/200 APPROVE . 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL		PLE CONSTRUCTION G	(X3) DATE S COMPLE	
		095022	B. WING	G	· · · · · · · · · · · · · · · · · · ·	05/1	9/2006
	ROVIDER OR SUPPLIER			24	EET ADDRESS, CITY, STATE, ZIP CODE 425 25TH STREET SE		
				N 	ASHINGTON, DC 20020		1
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE	BE CROSS-	(X5) COMPLETIC DATE
F 253	Continued From pa	age 10	F 2	53	4. The Directors of Housekeepin	ng and	
	from 8:40 AM to 11	:30 AM.			Maintenance will oversee the moni The results of his monitoring, alor	ioring. ig with	
	2 North rooms: 233	3, 237, 245 and soiled utility			any action plans for improvement,	will be	6/201
	room in four (4) of 11 observations on May 17,			•	presented at the quarterly of Improvement Committee, which is	Quanty	
	2006 from 11:33 A	M to 2:30 PM.			by the Administrator.	••••••••••••••••••••••••••••••••••••••	
	2 South rooms: 22	0, 238 and dining room in three		ł			
	(3) of six (6) observ	vations on May 17, 2006 from			Sprinkler Heads 1. The sprinkler heads cited at the	time of	5 9
	2:33 PM to 4:54 PM	И.			the survey have been dusted.		
		I and dining room in two (2) of			All sprinkler heads have been ev	/aluated	5/19
	seven (7) observat 30 AM to 11:45 PM	ions on May 18, 2006 from 8:			and dusted when necessary. 3. The Maintenance Supervisor ev	valuates	
	30 AIVI 10 (1.45 PIV	I.			the sprinkler heads on a monthl	y basis,	lad
	3 South room 302	in one (1) of nine (9)			scheduling their dusting as need will report his findings to the Dir	ed. He	0 70 0
	observations on Ma 54 PM.	ay 18, 2006 from 1:48 PM to 4:			Maintenance.		
					4. The Director of Maintenar	nce will	
		s were soiled with dust and 0 and 151 in two (2) of 22			oversee the monitoring. The resument monitoring, along with any activ	on plans	(1)
		g the survey period.			for improvement, will be present	ed at the	0301
					quarterly Quality Impr		
	areas:	re damaged in the following		Ì	Committee, which is chaired Administrator.	by the	
	1 North rooms: 111	1, 113, 145, 151 and the dining			The second state of the se		
		11 observations on May 15,			Damaged HVAC units 1. The HVAC units cited at the	e time of	6 90
	2006 from 11:20 A				the survey have been repaired or	replaced.	
	1 South rooms 142	and 146 in two (2) of six (6)			2. All HVAC units have been and repaired or replaced as	deemed	4700
		ay 17, 2006 from 8:40 AM to			necessary. 3. The Maintenance Supervisor	evaluates	5 19 0 10 70 10 10 70 10 10 70 10 10 70 10 10 70 10
	2 South rooms 210	, 236 and the dining room in			the interior of the HVAC ur monthly basis, scheduling their	nts on a repair or	1010
	three (3) of nine (9)) observations on May 17,		Í	monuny vasis, scheduling men	p ,	السمين الم
	2006 at 3:30 PM.					Л	1egre
	3 North rooms 309	and the dining room in two (2)		ļ	,		

Event ID: D95S11 Facility ID: WASHNURS

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CENTE	RS FOR MEDICARE	AND HUMAN SERVICES		Nerisa Ninon	OMB NC	APPROVE 0938-039
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD		(X3) DATE S COMPL	
		095022	B. WING		05/1	9/2006
iame of F	ROVIDER OR SUPPLIER			IREET ADDRESS, CITY, STATE, ZIP CO 2425 25TH STREET SE	DE	
WASHIN	GTON NURSING FAC	ILITY		WASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SHO REFERENCED TO THE APPROPRI	DULD BE CROSS-	(X5) COMPLETIO DATE
F 253	from 8:40 AM to 11 2 North rooms: 233	30 AM. , 237, 245 and soiled utility 1 observations on May 17,	F 25	4. The Directors of Houseke Maintenance will oversee the m The results of his monitoring, any action plans for improvement presented at the quarterly Improvement Committee, which by the Administrator.	along with ent, will be Quality	6 137010
	 (3) of six (6) observ 2:33 PM to 4:54 PM 3 North rooms: 321 seven (7) observations 30 AM to 11:45 PM. 3 South room 302 in observations on Material Statement of the seven of	and dining room in two (2) of ons on May 18, 2006 from 8: n one (1) of nine (9) y 18, 2006 from 1:48 PM to 4: were soiled with dust and and 151 in two (2) of 22		Committee, which is chain	n evaluated or evaluates othly basis, eeded. He Director of enance will esults of his action plans ented at the oprovement	5 halor 120106 120106 120106
	areas: 1 North rooms: 111, room in five (5) of 1 2006 from 11:20 AM 1 South rooms 142 observations on Ma 11:30 AM. 2 South rooms 210,	113, 145, 151 and the dining 1 observations on May 15,	May 15,1. The HVAC units cited at the time of the survey have been repaired or replaced. 2. All HVAC units have been evaluated and repaired or replaced as deemed necessary. 3. The Maintenance Supervisor evaluates the interior of the HVAC units on a monthly basis, scheduling their repair or		colledy	6 19 06 6 90 106 6 90 106

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		AND HUMAN SERVICES			FORM	: 06/15/200 APPROVE . 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI	TIPLE CONSTRUCTION	(X3) DATE S COMPLE	
		095022	B. WING		05/1	9/2006
	ROVIDER OR SUPPLIER	ILITY		IREET ADDRESS, CITY, STATE, ZIP CODE 2425 25TH STREET SE WASHINGTON, DC 20020	<u> </u>	
(X4) ID PREFIX TAG	EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHOU REFERENCED TO THE APPROPRIAT	LD BE CROSS-	(X5) COMPLETIC DATE
F 253	of eight (8) observa 30 AM to 11:45 AM 14. The interior sur soiled in the followi	ations on May 18, 2006 from 8: I. faces of exhaust vents were	F 25	4. The Director of Maintenance will oversee the monitoring. The results of his monitoring, along with any action plans for improvement, will be presented at the quarterly Quality Improvement Committee, which is chaired by the Administrator.		6/270/0
·	five (5) of 11 obser 11:20 AM to 1:30 F 1 South rooms: 110 room in five (5) of r 17, 2006 from 8:40	vations on May 15, 2006 from M. D, 114, 142, 160 and toilet hine (9) observations on May AM to 11:30 AM.		 Interior surfaces of the exhaust 1. The interior surfaces of the vents cited at the time of the subeen cleaned. 2. All interior surfaces of exh have been evaluated and cleaned. 	ces of the exhaust of the survey have es of exhaust vents	
	three (3) of five (5) from 11:33 AM to 2 2 South rooms: 212 12 observations on	9, 233, and staff bathroom in observations on May 17, 2006 2:30 PM. 2, 232 and 238 in three (3) of May 17, 2006 from 2:33 PM		3. The Maintenance Superviso the interior surfaces of the ext on a quarterly basis, scheduroutine cleaning as needed. He his findings to the Di Maintenance.	aust vents iling their will report rector of	6 701 6 7010 6 70010
• • •	 to 4:54 PM. 3 North rooms: 305, 309, 335 and 353 in four (4) of eight (8) observations May 18, 2006 from 8:30 AM to 11: 45 AM. 3 South rooms: 312, 326 and 334 in three (3) of seven (7) observations on May 18, 2006 1:48 PM 	ations May 18, 2006 from 8:30 2, 326 and 334 in three (3) of		4. The Director of Mainte oversee the monitoring. The re- monitoring, along with any a for improvement, will be prese quarterly Quality In Committee, which is chain Administrator.	sults of his ction plans ented at the pprovement	6 301
·	Rehabilitation Depa stained in one (1) of 17, 2006 at 12:30 F 16. Mops and buck the floor in the janit	es of parallel bars in the artment were soiled and of one (1) observation on May PM. ets were soiled and stored on or's closet on 1 North, 2 North, nd 3 South in five (5) of six (6)		 Flat surfaces of the parallel ba 1. The flat surfaces of the p cited at the time of the survey cleaned. 2. All therapy equipment wa for cleanliness and cleaned as 3. The Housekeeping Supervis 	rs arallel bars have been s evaluated necessary. or evaluates	5 19) (1) 0 0 6 3 0 0

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Facility ID: WASHNURS

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nd plan c	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A BUILD	TIPLE CONSTRUCTION	(X3) DATE S COMPLI	ETED	
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	ROVIDER OR SUPPLIER	CILITY		IREET ADDRESS, CITY, STATE, ZIP C 2425 25TH STREET SE WASHINGTON, DC 20020			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION SI REFERENCED TO THE APPROP	HOULD BE CROSS-	(X5) COMPLETIO DATE	
F 253	Continued From pa	age 14.	F 25	 Improvement Committee, where we have a series of geri-chairs of geri-chairs and the surfaces of geri-the time of the survey have be a surface of geries been evaluated and represent of geries of geries. 3. The Maintenance Supervesting the arm surfaces of geries of geries of geries of geries of geries and the surface of geries of geries of geries. The Maintenance Supervesting basis, scheduling their represent of Maintenance. 4. The Director of Maintenance. 4. The Director of Maintenance of Maintenance. 5. The Maintenance of Maintenance of Maintenance. 6. The Director of Maintenance of Maintenance. 7. The Maintenance of Maintenance of Maintenance. 8. The Director of Maintenance of Maintenance. 9. The Maintenance of Maintenance of Maintenance. 	chairs cited at been replaced. ri-chairs have blaced when isor evaluates rs on a routine lacement as indings to the ntenance will results of his action plans esented at the Improvement	7 2 06 17 2 06 17 2 06 17 2 06	

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

PRINTED: 06/15/2006 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) № A. BU		IPLE CONSTRUCTION	(X3) DATE S COMPLE	
		095022	B. WI	NG		05/1	9/2006
	Rovider or Supplier	ILITY		2	REET ADDRESS, CITY, STATE, ZIP CODE 425 25TH STREET SE VASHINGTON, DC 20020	:	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	XI	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHOU REFERENCED TO THE APPROPRIAT	LD BE CROSS-	(X5) COMPLETION DATE
F 253	 observations during 17. Wheelchairs we frame surfaces and following areas: 1 South rooms: 106 13 observations on 11:30 AM. 2 North rooms: 209 observations on Ma 30 PM. 2 South room 338 if observations on Ma 30 PM. 2 South rooms: 305 of eight (8) observations on Ma 54 PM. 3 North rooms: 326 of eight (8) observations on Ma 30 AM to 11:45 AM. 18. Residents' strait seat surfaces in thr North on May 18, 2 and three (3) of 14 on May 15, 2006 from 19. Dining room table and food in the 3 Notservations on Ma 11:45 PM. 	g the survey period. ere soiled on the spoke and arms were worn in the 5, 110 and 146 in three (3) of May 17, 2006 at 8:40 AM to and 215 in two (2) of 11 ay 18, 2006 at 11:33 AM to 2: n one (1) of five (5) ay 17, 2006 from 2:33 PM to 4: i, 321, 349, and 357 in four (4) itions on May 18, 2006 from 8:	F	253	 the rehabilitation equipment on a basis, scheduling their cleaning a He will report his findings to the of Environmental Services. 4. The Director of Envir Services will oversee the monito results of his monitoring, along action plans for improvement presented at the quarterly Improvement Committee, which by the Administrator. Storage of mops and buckets The storage problems of a buckets cited at the time of the have been corrected. All janitor's closets he evaluated for the proper storage and buckets and inservices with on the storage to ensure comp The Housekeeping Sevaluates the janitor's closets for more and buckets. Inservicing done for the floor maintenar regarding proper storage. He whis findings to the Dir Maintenance. The Director of Envisional Services will oversee the monitor results of his monitoring, along action plans for improvement presented at the quarterly Improvement Committee, which by the Administrator. 	as needed. e Director ronmental ring. The with any , will be Quality is chaired mops and he survey ave been e of mops vere given liance. Supervisor on a daily he storage ng will be ance staff will report rector of ronmental oring. The g with any t, will be y Quality	b 30100 b 30100 b 30106 b 30106 b 30106 b 30106

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Facility ID: WASHNURS

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		AND HUMAN SERVICES				FORM	06/15/2006 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU			(X3) DATE SI COMPLE	JRVEY
		095022	B. WI	NG_	· · · · · · · · · · · · · · · · · · ·	05/1	9/2006
NAME OF P	ROVIDER OR SUPPLIER			1	REET ADDRESS, CITY, STATE, ZIP CODE	•	
WASHIN	GTON NURSING FAC	ILITY		1	425 25TH STREET SE VASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE [BE CROSS-	(X5) COMPLETION DATE
F 253	Continued From pa worn in rooms 220 period.	ge 13 and 253 during the survey	F	253	 Solled Wheelchairs and Straigh Chairs 1. The wheelchairs and straigh chairs cited at the time of the surve been cleaned. 2. All wheelchairs and straight back have been evaluated and cleaned ro and as needed. 	at back by have c chairs utinely ervisor ht back g their shedule ings to ag will s of his a plans d at the vement by the l at the edd. e been ary. aluates outine eeded. irector mental thany ill be	6 20 06 6 20 06

Facility ID: WASHNURS

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	RS FOR MEDICARE	AND HUMAN SERVICES			TIPLE CONSTRUCTION	FORM OMB NO	: 06/15/2006 APPROVED . 0938-0391
	t of deficiencies of correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU			(X3) DATE S COMPLI	
		095022	B. WI	NG_	·	05/1	9/2006
	ROVIDER OR SUPPLIER	ILITY			REET ADDRESS, CITY, STATE, ZIP CODE 2425 25TH STREET SE WASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	id Pref Tag	FIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE	BE CROSS-	(X5) COMPLETION DATE
F 272 SS=D	The facility must co a comprehensive, a reproducible assess functional capacity. A facility must make assessment of a re specified by the Sta include at least the Identification and d Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior Psychosocial well-t Physical functioning Continence; Disease diagnosis Dental and nutrition Skin conditions; Activity pursuit; Medications; Special treatments Discharge potential Documentation of s the additional assess resident assessme Documentation of p This REQUIREMENT: Based on observation review for three (3) was determined that	and uct initially and periodically accurate, standardized sment of each resident's e a comprehensive sident's needs, using the RAI ate. The assessment must following: emographic information; patterns; being; g and structural problems; and health conditions; all status; and procedures; ; summary information regarding ssment performed through the	F		 483.20 (b) COMPREHENSIVE ASSESS Residents #6, 8 an 15 1. Those conditions which w assessed at the time of the surv been corrected. 2. The RAPs of all residen reviewed to ensure that each received a comprehensive assess that all areas of the MDS process compliance. 3. Inservicing was done for t responsible for the MDS/Care µ process. The Clinical Manag ADONs will monitor for complia assessment of conditions triggere MDS. They will report their fin the DON. 4. The Director of Nursing will the monitoring. The results monitoring, along with any active for improvement, will be present quarterly Quality Impr Committee, which is chaired Administrator. 	ere not ey have ts were resident nent and were in the staff planning ers and ance on d on the dings to oversee of this on plans ed at the overnent	le 270 06 le 290 06 le 270 06

Facility ID: WASHNURS

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CENTE	RS FOR MEDICARE	AND HUMAN SERVICES			<u> </u>	FORM OMB NO.	06/15/2006 APPROVED 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	IULTIF	PLE CONSTRUCTION	(X3) DATE SI COMPLE	
		095022	B. WI	۹G		05/1	9/2006
	PROVIDER OR SUPPLIER	CILITY		24	EET ADDRESS, CITY, STATE, ZIP CODE 125 25TH STREET SE 125 ASHINGTON, DC 20020		
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F 272	Continued From pa	age 15	F	272		e	
		Section V, "Resident col" (RAPs). Residents #6, 8,	·				
	The findings includ	e:					
	page 4 -1, "The go interdisciplinary tea comprehensive ass functional status provide a compreh- the MDS is used fo identify potential re preferences. The I frameworks for ado	MDS 2.0 User's Manual " bal of the RAPS is to guide the im through a structured sessment of a resident's The MDS alone does not ensive assessment. Rather, ir preliminary screening to sident problems, strengths and RAPs are problem-oriented ditional assessment based on on items (triggered conditions).			· · ·		
	Minimum Data Set revealed that the R indicate which RAF	ident #6's annual MDS () completed April 25, 2006 N (Registered Nurse) failed to ? (Resident Assessment areas were addressed in the					
	Resident Assessm have any RAP prot addressed in the ca Person Completing VB4 (Care Plan De signed by the RN a	Planning Decision), of the ent Protocol Summary, did not blem areas checked to be are plan. VB3 (Signature of Care Planning Decision) and cision Completion Date) were s completed on April 25, 2006. viewed on May 16, 2006.					
	assessments on th	d to perform additional e identified (triggered) items in ent Assessment Protocol " for			• •		
ORM CMS-25	67(02-99) Previous Versions	Obsolete Event ID: D95S11	–– Fa	cility If	D: WASHNURS If contin	uation sheet	Page 16 of 9

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vider or supplier On Nursing Fac	ILITY	2	REET ADDRESS, CITY, STATE, ZIP CO 425 25TH STREET SE VASHINGTON, DC 20020		
(EACH DEFICIENCY	MUST BE PRECEEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SH	IOULD BE CROSS-	(X5) COMPLETI DATE
ontinued From pa	ge 16	F 272		· .	
esident #8.					
ompleted October arrative Report" o ognitive Loss - Tri oder CP (care plan dwelling Catheter	6, 2005 revealed a "RAP containing the following: " gger continue to be addressed n) #4; Urinary Incontinence/ - trigger is addressed under	•			
ne facility failed to	perform additional				
as conducted on I le acknowledged rther assessment	May 16, 2006 at 3:30 PM. He/ that the RAPs did not include s on the identified (triggered)				
vealed that the RI	N failed to indicate which RAP et inggered and failed to date				
ection VAa (RAP)	problem area check if		· · · · · · · · · · · · · · · · · · ·		
ted and Section \	/B3 and VB4 were not signed				
	(EACH DEFICIENCY REGULATORY OR LE Dentinued From pa esident #8. review of the sign ompleted October arrative Report" of ognitive Loss - Tri der CP (care plan dwelling Catheter P #5; Falls - Trigg ne facility failed to sessments for the essesments for the ms. face-to-face internas conducted on N re acknowledged other assessment eas. The record v A review of Reside vealed that the RI oblem areas were 32 and VB4 and s action VAa (RAP p ggered) did not ha ecked. ection VB2 (RAPS ited and Section V d dated. The record	review of the significant change MDS ompleted October 6, 2005 revealed a "RAP arrative Report" containing the following: " ognitive Loss - Trigger continue to be addressed of CP (care plan) #4; Urinary Incontinence/ dwelling Catheter - trigger is addressed under P #5; Falls - Trigger is addressed under CP #3." the facility failed to perform additional sessments for the above identified (triggered) ms. face-to-face interview with the charge nurse as conducted on May 16, 2006 at 3:30 PM. He/ the acknowledged that the RAPs did not include rther assessments on the identified (triggered) eas. The record was reviewed May 16, 2006. A review of Resident #15's annual MDS vealed that the RN failed to indicate which RAP oblem areas were triggered and failed to date 32 and VB4 and sign at VB3. the annual MDS dated March 28, 2006 at ection VAa (RAP problem area check if ggered) did not have any RAP problems ecked.	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG Dontinued From page 16 F 272 esident #8. Ferview of the significant change MDS ompleted October 6, 2005 revealed a "RAP arrative Report" containing the following: " ognitive Loss - Trigger continue to be addressed ider CP (care plan) #4; Urinary Incontinence/ dwelling Catheter - trigger is addressed under P #5; Falls - Trigger is addressed under CP #3." ne facility failed to perform additional seessments for the above identified (triggered) ms. face-to-face interview with the charge nurse as conducted on May 16, 2006 at 3:30 PM. He/ te acknowledged that the RAPs did not include ther assessments on the identified (triggered) eas. The record was reviewed May 16, 2006. A review of Resident #15's annual MDS vealed that the RN failed to indicate which RAP oblem areas were triggered and failed to date 32 and VB4 and sign at VB3. ne annual MDS dated March 28, 2006 at ection VAa (RAP problem area check if ggered) did not have any RAP problems ecked. extion VB2 (RAPS completion date) was not ted and Section VB3 and VB4 were not signed d dated. The record was reviewed on May 16,	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSCIDENTIFYING INFORMATION) ID PREVIDENTIFYING INFORMATION) PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION SP REFERENCED TO THE APPROPR TAG continued From page 16 F 272 esident #8. F 272 review of the significant change MDS mpleted October 6, 2005 revealed a "RAP arrative Report" containing the following: " gonitive Loss - Trigger continue to be addressed ider CP (care plan) #4; Urinary Incontinence/ dwelling Catheter - trigger is addressed under P #5; Falls - Trigger is addressed under CP #3." face-to-face interview with the charge nurse as conducted on May 16, 2006 at 3:30 PM. He/ te acknowledged that the RAPs did not include ther assessments on the identified (triggered) eas. The record was reviewed May 16, 2006. A review of Resident #15's annual MDS vealed that the RN failed to indicate which RAP oblem areas were triggered and failed to date 32 and VB4 and sign at VB3. me annual MDS dated March 28, 2006 at ection VB2 (RAPS completion date) was not ted and Section VB3 and VB4 were not signed d dated. The record was reviewed on May 16,	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) Intinued From page 16 esident #8. F 272 Intinued From page 16 esident #8. F 272 Intinued From page 16 esident #4. F 272 Intinued From page 16 esident #15's annual MDS vealed that the RAPs did not include ther assessments on the identified (triggered) eas. The record was reviewed May 16, 2006. A review of Resident #15's annual MDS vealed that the RN failed to indicate which RAP oblem areas were triggered and failed to date 32 and VB4 and sign at VB3. Inte annual MDS dated March 28, 2006 at ecked. F 2006 at coin VB3 and VB4 were not signed d dated. The record was reviewed on May 16,

		I AND HUMAN SERVICES				FORM	06/15/2006 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		IPLE CONSTRUCTION	(X3) DATE S COMPLE	URVEY
		095022	B. WI	NG		05/1	9/2006
	ROVIDER OR SUPPLIER			2	REET ADDRESS, CITY, STATE, ZIP CODE 425 25TH STREET SE VASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE [BE CROSS-	(X5) COMPLETION DATE
F 276 SS=D	A facility must asse quarterly review ins and approved by C once every 3 month This REQUIREMEN : Based on observat interview for one (1 was determined that complete a quarter due in February 20 The findings include A review of Reside he/she was admitte 2005. An admission August 4, 2005. A c on November 7, 20 in February 2006. A face-to-face inter Assistant Unit Mana AM. He/she acknow	NT is not met as evidenced by ion, record review, and staff) of 30 sampled residents, it at facility staff failed to ly Minimum Data Set that was 06. Resident #10. e: nt #10's record revealed that ed to the facility on July 21, n MDS was completed on quarterly MDS was completed 005. A quarterly MDS was due rview was conducted with the ager on May 15, 2006 at 8:50 wledged that a quarterly MDS done in February. The record	F	276	 483.20© QUARTERLY REVIEW ASSESSM Resident #10 1. The quarterly assessment not corr at the time of the survey was immediately upon discovery. 2. The timeliness of all quarterly was evaluated and adjustments in necessary. 3. The Clinical Managers will mon timeliness of the quarterly MDSs units. They will report their finding DON. Additionally, inservicing h done for all staff involved in corr the MDS in a timely fashion. 4. The Director of Nursing will the monitoring. The results monitoring, along with any actin for improvement, will be present 	npleted s done mDDSs nade as nitor the on their gs to the nas been npleting oversee of this on plans ed at the ovement	S 19 04 6 30 06 8 30 06
FORM CMS-25	67(02-99) Previous Versions	Obsolete Event ID: D95S11	F;	acility	IÐ: WASHNURS If contin		Page 18 of 96

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI	TIPLE CONSTRUCTION	(X3) DATE S COMPLI	
		095022	B. WING		05/1	9/2006
	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE 2425 25TH STREET SE WASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHOU REFERENCED TO THE APPROPRIAT	LD BE CROSS-	(X5) COMPLETIO DATE
F 278 SS=D	The assessment m resident's status. A registered nurse each assessment w participation of hea A registered nurse assessment is com Each individual who assessment is com Each individual who assessment must s that portion of the a Under Medicare an willfully and knowin false statement in a subject to a civil mo \$1,000 for each ass willfully and knowin to certify a material resident assessme penalty of not more assessment. Clinical disagreeme material and false s This REQUIREMENT: Based on observati review for five (5) o one (1) supplement that the Registered ate the Minimum D after the assessors	must sign and certify that the npleted. o completes a portion of the sign and certify the accuracy of assessment. Ind Medicaid, an individual who ngly certifies a material and a resident assessment is oney penalty of not more than sessment; or an individual who ngly causes another individual and false statement in a ent is subject to a civil money than \$5,000 for each	F 27	 RESIDENT ASSESSMENT RESIDENT ASSESSMENT Residents #5, 6, 12, 15, 21, W3 1. Errors in timing of the RN si and of inaccurate coding and omi- the MDS found at the time of the were all corrected upon discover 2. All current MDSs will be eval similar error and omission adjustments made as necessary. 3. The Clinical Managers will their unit's MDSs for accur completeness. They will report findings to the DON. Add inservicing was done for the staff in the completion of the MDS to their understanding of the err corrections. 4. The Director of Nursing will the monitoring. The results monitoring, along with any acti- for improvement, will be present 	ssions on e survey y. uated for ns and monitor acy and ort their itionally, involved o ensure rors and oversee of this on plans ed at the ovement	5/19/04 7/2/06 1/2/06 1/2/06

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		AND HUMAN SERVICES			·	FORM	06/15/2006 APPROVED 0938-0391
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	Rovider or Supplier GTON NURSING FAC	ILITY	·		TREET ADDRESS, CITY, STATE, ZIP CODE 2425 25TH STREET SE WASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	١X	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOUL REFERENCED TO THE APPROPRIATE	D BE CROSS-	(X5) COMPLETION DATE
F 278	Continued From pa	age 19	F	278	8		
	ostomy care, one (and one (1) resider	t loss, one (1) resident for 1) resident for resisting care nt for an antibiotic resistant s #5, 6, 12, 15, 21 and W3.				<u> </u>	
	The findings includ						
		urse failed to sign after the mpleted their portions of the #5.					
	quarterly MDS ass R, "Assessment In	nt #5's record revealed a essment was signed in Section formation" as completed by on September 24, 2006.					-
	completed a Portio Assessment or Tra practical nurse, soo	nature of Persons who n of the Accompanying icking Form," the licensed cial worker, dietician and signed on September 26, 2005					
	3-212, "The RN As not sign and attest	MDS 2.0 User's Manual," page sessment Coordinator must to completion of the Il other assessors have ns of the MDS."					
	clinical manager or /she acknowledged disciplines signed a	view was conducted with the n May 15, 2006 at 1:05 PM. He I that the above identified after the RN coordinator's ord was reviewed May 15,					
		dent #6's annual MDS () revealed that the RN (

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Event ID: D95S11 Facility ID: WASHNURS

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SI COMPLE		
		095022	B. WIN	IG		05/1	9/2006	
	ROVIDER OR SUPPLIER	ILITY		24	EET ADDRESS, CITY, STATE, ZIP CODE 25 25TH STREET SE ASHINGTON, DC 20020			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	x	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE	BE CROSS-	(X5) COMPLETION DATE	
F 278	Registered Nurse) Date RN assessme	failed to date the MDS at R2b (ent Coordinator signed as other assessors finished their	F 2	278				
	The most recent ar and dated (R2b)as At Section AA9 (Sig Completed a Portio Assessment or Tra disciplines signed a	nual MDS was signed (R2a) complete on April 25, 2006. gnatures of Persons who n of the Accompanying cking Form) four (4) and dated on May 3, 2006.						
	the assessment aft their portions of the reviewed on May 10 3. A review of Resid that facility staff ina	dent #12's record revealed ccurately coded the quarterly						
	Section K3a coded	s. DS dated March 21, 2006 at weight loss-5% or more in last more in last 180 days.						
	A review of the "V revealed the followi Date Weight 9/15/05 148 10/15/05 141 11/15/05 145 12/15/05 148	ital Sign Flow Sheet " ng:						
	1/14/06 152 2/06 no weight r 3/06 no weight r							
		view was conducted with the ay 16, 2006 at 2:38 PM. He/						

		AND HUMAN SERVICES				FORM	06/15/2006 APPROVED 0938 <u>-0</u> 391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	
		095022	B. WH	NG		05/19	9/2006
	ROVIDER OR SUPPLIER	עדו ווי			IREET ADDRESS, CITY, STATE, ZIP CODE 2425 25TH STREET SE		
WASHIN					WASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	ΞIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETION DATE
F 278	Continued From pa	age 21	F	278	8		
	She acknowledged February and Marc	the missing weights for h 2006.					
	loss of weight of 5% March 21, 2006 du February or March 10% from Septemb 2006. The record w 4. A review of Resi facility staff failed to most recent annua The annual MDS d Section K5b (Oral/I feeding tube. Sect and Procedures) fa The February and I Administration Rec the resident receive was reviewed on M 5. Facility staff inac for resisting care of April 17, 2006. A review of the qua 2006 coded Reside Behavioral Sympto type occurred 1 to 3	ated March 28, 2006 at Nutritional Status) included a ion P1f (Special treatments illed to indicate ostomy care. March 2006 TAR (Treatment ords) indicated [by initials] that ed ostomy care. The record lay 16, 2006. curately coded Resident #21 in the quarterly MDS dated interly MDS completed April 17, ent #21 in Section E4, " ms" as "1 - behaviors of this 3 days in the last 7 days."				·	
	page 3-66, " [The] identify (A) the freq of behavioral symp that cause distress	MDS 2.0 User 's Manual " Intent [of this section is] To uency and (B) the alterability toms in the last seven days to the resident, or are ptive to facility residents or					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	06/15/2006 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU	. ,	PLE CONSTRUCTION	(X3) DATE SI COMPLE	JRVEY
		095022	B. WI	\G	·,	05/1	9/2006
NAME OF P					REET ADDRESS, CITY, STATE, ZIP CODE		
WASHIN	GTON NURSING FAC	ILITY			425 25TH STREET SE VASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETION DATE
F 278	Continued From pa	ge 22	F	278			
	staff members."						
	common observation The nurses ' notes through 10, 2006.	ference date (end-point for a on period) was April 10, 2006. were reviewed from April 3 There was no evidence that ed care during the identified					
	which was a record conference, dated A Problem 17: Reside	Interdisciplinary Summary, " of the discussion at care April 11, 2006, under, " ent has not exhibited behaviors monitored for [them]. " The d May 17, 2006.					
		dent W3's record revealed ed to accurately code the MDS stance infection.					
		ated December 12, 2006 as) failed to code for antibiotic					
	included the following	rder Form" for May 2006 ng: "Contact isolation (eye discharge" [origination er 17, 2005].					
	2005 included the for Diagnosis) MRSA (I	ess note dated December 6, bllowing: Eye follow-up. Dx (Methicillin Resistant reus of conjunctiva OD (right	·				
	14, 2005 included th	v Summary dated December ne following: "Problem #22 condary to MRSA - eye	_				

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CENTE		H AND HUMAN SERVICES	(Y2) MILL 7		OMB NO.	APPROVE . 0938-039
	DF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	•	(X3) DATE SI COMPLE	
		095022	B. WING _		05/1	9/2006
NAME OF F	PROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE		
WASHIN	GTON NURSING FAC			2425 25TH STREET SE WASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHOU REFERENCED TO THE APPROPRIAT	LD BE CROSS-	(X5) COMPLETIC DATE
F 278	discharge - antibio 05, repeat culture discharge due 12/	age 23 tic eye drop completed 12/13/ and sensitivity of right eye 15/05. Maintained on contact ord was reviewed on May 18,	F 278	 483.20(d), 483.20(k)(1) COMPREHENSIVE CARE F Resident #6 1A. 1. The family member of received the facility's apologic oversight and assurances that sl personally contacted for future received for future receive	esident #6 es for the he will be neetings.	7 2 0k
F 279 SS=D	CARE PLANS A facility must use to develop, review comprehensive pla The facility must de plan for each resid objectives and time medical, nursing, a needs that are iden assessment. The care plan must to be furnished to a highest practicable psychosocial well-1 25; and any service required under §48 to the resident's ex- including the right 10(b)(4). This REQUIREME : Based on observati interview, for two (2 was determined th	k)(1) COMPREHENSIVE the results of the assessment and revise the resident's an of care. evelop a comprehensive care ent that includes measurable etables to meet a resident's and mental and psychosocial htified in the comprehensive at describe the services that are attain or maintain the resident's e physical, mental, and being as required under §483. es that would otherwise be 33.25 but are not provided due cercise of rights under §483. 10, to refuse treatment under §483. NT is not met as evidenced by tion, record review, and staff 2) of 30 sampled residents, it at facility staff failed to: invite rty (RP) to the care planning	F 279	 communication which invites the and/or responsible party to planning meetings. 3. The unit clerks have inclevidence of this communication monthly audits of the medical They will report their finding Clinical Managers. 4. The Director of Nursing will the monitoring. The results monitoring, along with any act for improvement, will be presen quarterly Quality Imp Committee, which is chaired Administrator. 1B. 1. The approaches implement the use of psychoactive medicatibeen added to this resident's care 2. The care plan for similar respective medications has checked to ensure that approache place 3. The Clinical Managers will their unit's care plans for accur completeness. They will report the set of the set	e resident the care luded the n in their records. s to the l oversee of this ion plans ted at the rovement by the ented for ions have e plan. idents on ve been ness are in monitor racy and ort their itionally, involved plans to	7 2 01 7 1 06 6 70 0 5 71 06 6 70 01

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SI COMPLE	URVEY
		095022	B. WIN	IG		05/1	9/2006
NAME OF P	ROVIDER OR SUPPLIER	<u> </u>			EET ADDRESS, CITY, STATE, ZIP CODE	•	
WASHIN	GTON NURSING FAC	CILITY	1		25 25TH STREET SE ASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETION DATE
F 279	conferences and in to be used on the p plan for one (1) resident 6, and 24. The findings includ 1. A review of Resid facility staff failed to the care planning of care plan for psych approaches were to A. Facility staff faile party to the care plan The facility policy "S Conferences" #170 following: "The of an interdisciplinary participation of the family, significant of The family will desid an invitation to fam two weeks prior to A telephone intervier responsible party of He/She stated, " I -day around 1:00 P [care planning confithat they hadn't had get a letter for the r one they invite me. The Interdisciplinar following:	dicate which approaches were by choactive medication care ident and develop a care plan ton hospice care. Residents # e: dent #6's record revealed that b invite the responsible party to conferences and indicate on the conferences and indicate on the conferences and indicate on the conferences and indicate on the conferences and indicate on the conferences. Social Work Care Planning 2020A.000 included the care plan must be prepared by teamand when practical the resident, the resident ' s ther or responsible party. #3. gnate a staff member to send ilies or legal representatives the scheduled conference " ew was conducted with the n May 19, 2006 at 10:00 AM. come to the facility every-other M. They [facility] just had one ference] last month. Before d one for over one year. I did ecent one and when they have " y Summaries included the		279	Committee, which is chaired Administrator.	of this a plans at the vement by the hitiated and blan by ents on that the n was blan. erviced updates Clinical t's care eteness. e DON. oversee of this n plans d at the by the	6 32 004 5 9 06 5 9 06 6 30 106 6 30 106 6 30 106
FORM CMS-25	67(02-99) Previous Versions	Obsolete Event ID: D95S11	Fa	cility IE	D: WASHNURS If continu	uation sheet	Page 25 of 96

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		AND HUMAN SERVICES				FORM	06/15/2006 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL			(X3) DATE SU COMPLE	JRVEY
	_	095022	B. WIN	G		05/1	9/2006
	ROVIDER OR SUPPLIER	ILITY		242	T ADDRESS, CITY, STATE, ZIP CODE 5 25TH STREET SE SHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETION DATE
F 279	" November 1, 2005, January 31, 2006, attendance" April 25, 2006, " The social service p following: April 5, 2006, " party for next IDT n April 26, 2006, " supportive and was There were care pl February 22, May 1 , 2005 and January was no evidence in notes that the RP w care planning confe The record was rev B. Facility staff faill for psychoactive m were to be implement The care plan "Or secondary to agitat and most recently u approaches. The to front of them. Appr facility would be inco box. There were no boxes. A face-to-face inter charge nurse on Ma	No family members present "RP not in attendance " "No family members in [RP] attending (friend). progress note included the nailed invitation to responsible neeting on April 25, 2006 " Family continues to be present at meeting " anning conferences held on 0, August 2 and November 11 31, 2006. However, there the social service progress vas notified of aforementioned erences. viewed on May 16, 2006. ed to indicate on the care plan edications which approaches ented. psychoactive medication ion" dated March 17, 2005 updated April 2006 listed ten en approaches had boxes in roaches to be used by the licated by a check mark in the p check marks in any of the view was conducted with the ay 16, 2006 at 10:16 AM. He/	F 2	79			
EORM CMS-25	She acknowledged 67(02-99) Previous Versions				WASHNURS If contin		Page 26 of 96

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		AND HUMAN SERVICES					FORM	06/15/2006 APPROVED 0938 <u>-</u> 0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		iultip Lding	PLE CONSTRUCTION		(X3) DATE SU COMPLE	
		095022	B. WI	1G		-	05/1	9/2006
Į	ROVIDER OR SUPPLIER	ILITY		24	EET ADDRESS, CITY, STATE, 2 25 25TH STREET SE	ZIP CODE	· · ·	
 				W	ASHINGTON, DC 20020		<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	id Pref Tag		PROVIDER'S PLAN ((EACH CORRECTIVE ACTIO REFERENCED TO THE APP	ON SHOULD	BE CROSS-	(X5) COMPLETION DATE
F 279	Continued From pa	ge 26	F	279	·			
		ed for this care plan. iewed on May 16, 2006.						
	2. Facility staff faile plan for Resident #	d to initiate a Hospice care 24.			·			×
	physician's order da	nt #24's record revealed a ated May 3, 2006, "[Hospice] t for hospice care secondary to condition. "						
	Subsequently, Hos 15, 2006. A review revealed that there	visit was May 5, 2006. pice staff visited May 8, 12 and of the resident's care plan was no problem with nd approaches for Hospice				·	,	-
	was conducted on t /she acknowledged problem with goals	view with the charge nurse May 17, 2006 at 10:30 AM. He that the care plan lacked a and approaches for Hospice vas reviewed May 17, 2006.						
						-		
								t.
FORM CMS-25	67(02-99) Previous Versions	Obsolete Event ID: D95S11	Fa	cility IE	D: WASHNURS		uation sheet l	Page 27 of 96

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STATEMENT	RS FOR MEDICARE	KANNER CALCULAR SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE S COMPLE	
		095022	B. WIN	IG		05/1	9/2006
	ROVIDER OR SUPPLIER	CILITY		24	REET ADDRESS, CITY, STATE, ZIP CODE 425 25TH STREET SE VASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETION DATE
F 280 SS=D	CARE PLANS	10(k)(2) COMPREHENSIVE	Fź	280	483.20 (d)(3), 483.10(k)(2) COMPREHENSIVE CARE PL Residents #1, 2, and 14.	ANS	· · · · · ·
	incompetent or oth incapacitated unde	r the laws of the State, to ing care and treatment or			1. The care plans of the residents the time of the survey have been u to reflect new approaches after a new interventions for agitated beh	updated fall and aviors.	5/30/06 5/30/06
	within 7 days after comprehensive as interdisciplinary tea	care plan must be developed the completion of the sessment; prepared by an am, that includes the attending ered nurse with responsibility			 The care plans of similar rewith falls and agitated behaviors hareviewed to ensure that update recorded as appropriate. The Clinical Managers will plane for each state. 	we been es were monitor	Spolo
	for the resident, an disciplines as deter and, to the extent p the resident, the re legal representative	d other appropriate staff in rmined by the resident's needs, practicable, the participation of sident's family or the resident's e; and periodically reviewed			their unit's care plans for app updates, accuracy and completener will report their findings to the Additionally, inservicing was done staff involved in the completion residents' care plans to ensur	ss. They e DON. e for the n of the re their	6 30 /04
	each assessment.	am of qualified persons after NT is not met as evidenced by			understanding of the error corrections. 4. The Director of Nursing will the monitoring. The results monitoring, along with any action	oversee of this on plans	10 200/04
	review for three (3) was determined the new approaches af and initiate new inte	ion, interview and record of 30 sampled residents, it at facility staff failed to: initiate iter a fall for two (2) residents erventions for one (1) resident <i>v</i> iors. Residents #1, 2, and 14.			for improvement, will be presente quarterly Quality Impro Committee, which is chaired Administrator.	ovement	
	The findings includ						
		d to initiate new approaches in a fall for Resident #1.			• •		
	February 4, 2006 a	nt #1's nurse's note dated t 10:00 PM documented, " the floor in [his/her] room in a					

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

Event ID: D95S11 Facility ID: WASHNURS

		AND HUMAN SERVICES			,	<u>.</u>	FORM	06/15/2006 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	```	ULTIPLI LDING	E CONSTRUCTION	_	(X3) DATE SU COMPLE	
		095022	B. WI	IG			05/19	9/2006
	ROVIDER OR SUPPLIER			242	ET ADDRESS, CITY, STATE, ZIP 5 25TH STREET SE SHINGTON, DC 20020	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTION S REFERENCED TO THE APPROI	SHOULD E	BE CROSS-	(X5) COMPLETION DATE
F 280	Continued From pa	age 28	Fź	280				
	the floor around [hi	A pool of blood was noted on m/her]. On assessment, [
	laceration measuring	d with a big hematoma and a ng 3 x 1 cm on the left side of ent] left the unit via 911 at 7:30						-
	2005," Need for sa and blindness" rev was documented u	an problem #3 on February 4, fety [due to] limited mobility realed that the above incident nder the "Problems" column. re no new approaches initiated all						
	was conducted on she acknowledged approaches initiate	view with the charge nurse May 17, 2006 at 9:30 AM. He/ that there were no new d after the above cited fall. viewed May 17, 2006.						
		dent #2's record revealed that o update the care plan after a						
	PM revealed the fo alert and oriented x stood up, close his	ated March 30, 2006 at 2:50 llowing: "Resident remains (3. Resident stated that he door to the room, stepped to assessed the resident no ted"	·					
	risk for falls related psychoactive meds	d December 8, 2005 for "At to decreased mobility, use of and use of antihypertensive dated on March 10, 2006.						
		ed to update the falls care approaches after the resident						
FORM CMS-25	67(02-99) Previous Versions	Obsolete Event ID: D95S11	Fa	cility ID:	WASHNURS	If continu	ation sheet I	Page 29 of 96

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		I AND HUMAN SERVICES & MEDICAID SERVICES				FORM	06/15/2006 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		IPLE CONSTRUCTION	(X3) DATE SI COMPLE	
. •		095022	B. WII	NG_		05/1	9/2006
	ROVIDER OR SUPPLIER	ILITY		2	REET ADDRESS, CITY, STATE, ZIP CODE 2425 25TH STREET SE WASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ΊX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE [BE CROSS-	(X5) COMPLETION DATE
F 280 F 281 SS=G	for Resident #14 for A review of Resider nurse's note dated Resident involved i altercation with and Care plan #12 date on November 14, 2 use of abusive lang a verbal altercation occurred November incident was not lis were no interventio 2006 episode. A face-to-face inter charge nurse on M she acknowledged reviewed after the a record was reviewed 483.20(k)(3)(i) CON The services provide must meet profession This REQUIREMENT Based on observation four (4) supplement	2006. d to initiate new interventions r agitation and verbal abuse. nt #14's record revealed a March 15, 2006 at 3:00 PM, " n an explosive verbal other resident" d April 21, 2004 and updated 005, "Period of agitation with juage" listed under "Problems" with another resident that r 14, 2005. The above cited ted under "Problems." There ns initiated after the March 15, view was conducted with the ay 16, 2006 at 3:15 PM. He/ that the care plan was not above cited incident. The ed May 16, 2006. MPREHENSIVE CARE PLANS ded or arranged by the facility onal standards of quality. NT is not met as evidenced by ions, staff interview and record of 30 sampled residents and		280	 COMPREHENSIVE CARE PLA Resident #29 1. This resident expired at the h with a cause of death unrelated results of the PT/INR. 2. Any resident on Coumadin an and symptoms of bleeding will be for according to the facility's eme policy. 3. The nursing staff was inserviced facility's Emergency Care and the contact the Medical Director, D Administrator should the PM respond in a very timely manne House Supervisors and Clinical M will monitor the residents needs che ensure compliance with the facility The results of this monitoring forwarded to the DON. 4. The Director of Nursing will the monitoring. The results monitoring, along with any action for improvement, will be presented quarterly Quality Improvement 	a signs e cared ergency d on the need to ON, or D not r. The anagers osely to y policy will be oversee of this n plans d at the Clinical and not was not self with cinating was sent this was iagnosis	4/18/06 5/20/06 6/20/06 8/20/06 3/15/06

Event ID: D95S11

Facility ID: WASHNURS

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		HAND HUMAN SERVICES E & MEDICAID SERVICES			FORM	: 06/15/2006 APPROVED : 0938-0391
TATEMEN	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI	LTIPLE CONSTRUCTION	(X3) DATE S COMPL	URVEY
		095022	B. WING	B	05/1	9/2006
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC		
WASHIN	GTON NURSING FAC	CILITY		2425 25TH STREET SE WASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION SH REFERENCED TO THE APPROPR	OULD BE CROSS-	(X5) COMPLETION DATE
F 281	facility's policy rega one (1) resident or	age 30 arding: the emergency care of Coumadin with a nosebleed; (1) suicidal resident; weighing	F 28	exacerbations will be prompti and the continued document reflect the results of the hospit	y cared for tation will tal visit.	5/30/06
	weighing two (2) re assessment for two laboratory tests for anticoagulation the	for four (4) residents; re- esidents; initial social worker to (2) residents; and monthly one (1) resident receiving erapy. Residents #29, S14, 1, , 25, S11, S12 and S13.		3. The nursing staff was ins assessment and proper docume Clinical Managers will monitor care plans for appropria accuracy and completeness. report their findings to Additionally, inservicing was	ntation. The r their unit's te updates, They will the DON.	6 70 00
	emergency care po taking Coumadin, a nosebleed. The re hospital on April 18 According to the fa Emergency Care-F	o follow the facility's resident blicy for Resident #29 who was an anticoagulant, and had a sident subsequently died at the		staff involved in the complete residents' care plans to e understanding of the corrections. 4. The Director of Nursing	etion of the ensure their errors and will oversee ults of this action plans sented at the	6/20/06
	Advanced directive emergency is due diagnosis. A. In case of signific condition: 2. Notify attend Medical Director. I Nursing Director or transfer of resident room. D. Epistaxis:	es will be followed when the to the residents condition or icant change in resident's ling physician, associate or f no doctor can be reached call Administrator regarding to the nearest emergency		Residents #1, 8, 9, 12, 15, 17 Weights 1. Residents who were cited the survey for the facility follow the weight policy w immediately. The Clinica corporate and facility dietic the charts and interventions when indicated. 2. A weight audit was con- cooperative effort of Managers and Dieticians to other residents whose weight	at the time of 's failure to vere weighed al Managers, tian reviewed implemented onducted in a the Clinical o address any	5 270 06 6 270 06
	2. Apply pressu apply ice over nose	ure on one or both nostrils		properly addressed. 3. Nursing staff and di	eticians were	6 20 06

		HAND HUMAN SERVICES			FORM	06/15/2006 APPROVED 0938-039	
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED 05/19/2006		
095022		B. WING_					
NAME OF PROVIDER OR SUPPLIER WASHINGTON NURSING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 2425 25TH STREET SE WASHINGTON, DC 20020				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE	BE CROSS-	(X5) COMPLETION DATE	
F 281	Continued From page 31 minutes, notify doctor for further orders. Every change in resident condition, will be written on the nursing 24 hour report, reported to physician and family and documented in detail on nurses notes. " A review of the "Physician's Discharge Summary " dated April 25, 2006, under "Course of Diseases and Treatment" indicated: "Patient had started bleeding from the nose on 4/17/06. Nose bleeding was treated unsuccessfully with ice pack on the nasal bridge. PT/INR =134.4/19.84. [He/ she] was transferred to the ER for treatment. Reason For Discharge (Including cause of death if applicable): Nose bleed and Cournadin toxicity." The resident was admitted to the facility on March 22, 2006. According to the admission Minimum Data Set (MDS) signed and dated April 14, 2006, the resident 's diagnoses included: Diabetes Mellitus (DM), Congestive Heart Failure, Hypertension, Cerebrovascular accident (stroke) Hemiparesis, and Depression (Section I). The admission orders dated March 22, 2006 included, "Warfarin Sodium 10mg (Coumadin) 1 tablet GT/PO daily blood thinning (3/21/06-3/28/ 06). Labs. (1) CBC every 6 months; (2) FBS every month DM." Physician Orders: March 22, 2006 at 10:00 PM, "Obtain PT/INR lab work in 3 days."		F 281	inserviced on weight collection and a weight collection team per unit was implemented per a new weight policy. The Clinical Managers were inserviced on the accuracy of documentation specific to weight variations as mandated by policy and the MDS. The Clinical Managers will oversee and monitor the weight teams and the documentation of the weights. 4. The Director of Nursing will oversee the monitoring. The results of this monitoring, along with any action plans for improvement, will be presented at the quarterly Quality Improvement Committee, which is chaired by the Administrator.		6 70 d	
				 Resident #S11 and S12 Monthly PT/INRs The residents cited at the time of the survey for not having monthly or bi- weekly PT/INRs were ordered that lab test. Results were forwarded to the attending physician for review and comment, if necessary. All residents on Coumadin (warfarin), Dicumarol have orders addressing their individual needs for PT/INRs ordered by the physician. The results were forwarded to the attending physician for review and comment, if necessary. An inservice was done with the licensed nursing staff regarding the monitoring and ordering of lab tests. A 100% lab audit was performed and 		5/30/06 5/30/06	
	urinalysis with cult O (rule out) UTI (u	ure and sensitivity) in AM, to R/ rinary tract infection)." plained of) burning sensation			ecessary.		

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Event ID: D95S11 Facility ID: WASHNURS

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 06/15/2006 FORM APPROVED OMB NO 0938-0391

							<u>ONID NO. 0936-0391</u>	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		095022	B. WING			05/19/2006		
NAME OF PROVIDER OR SUPPLIER WASHINGTON NURSING FACILITY				STREET ADDRESS, CITY, STATE, ZIP CODE 2425 25TH STREET SE WASHINGTON, DC 20020				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE	BE CROSS-	(X5) COMPLETION DATE	
F 281	tab po (by mouth) of Drug Interactions time in the setting of levofloxacin use ha episodes of bleedin International Norma suitable anticoagula monitored if levoflo concomitantly with Ortho-McNeil] press Levaquin (levofloxa March 28, 2006 at 2 Sodium 10mg, 1 tab thinning. Check PT April 17, 2006 at 7: compress over brid Complete Blood Co Time) and INR (Inte today; notify PMD of /06.'' April 17, 2006 at 1: for Coumadin Toxio Laboratory Studies: March 28, 2006: co 0620 (6:20 AM) PT 27.4 P (Patient) seconds	 2:00 PM, "Levaquin 500mg 1 (every) day for 7 days." [Elevations of the prothrombin of concurrent Warfarin and ve been associated with ng. Prothrombin time, alized Ration (INR), or other ation tests should be closely xacin is administered Warfarin Manufacturer's [cribing information for ncin), August 2005]. 2:00 PM, "Continue Warfarin b. Qd (daily) GT/PO - blood T/INR every month." 00 AM "Continue to apply ice log of nose. Do CBC (bunt) and PT (Prothrombin ernational Normalized Ratio) of results. Hold Coumadin 4/18 15 PM "Send resident to ER city." 	F :	281	 was asked to specifically address the in her monthly chart audits. The of Managers will monitor this throughout the month and report findings to the DON. 4. The Director of Nursing will the monitoring. The results monitoring, along with any action for improvement, will be presented. 	his issue Clinical issue rt their oversee of this n plans d at the ovement by the cited at updated episode esidents e been ventions monitor ropriate ss. They e DON. e for the n of the re their s and	6/30/06 5/20/06 5/20/06 80/06	

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Facility ID: WASHNURS

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		AND HUMAN SERVICES				FORM	06/15/2006 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY
		095022	B. WI	1G		05/19) /2006
NAME OF P		La de la desta de la desta			EET ADDRESS, CITY, STATE, ZIP CODE		
WASHIN	GTON NURSING FAC	CILITY		1	25 25TH STREET SE ASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETION DATE
F 281	(9:00 AM) PT 134.4 P Norma	ige 33 julation collected 4/17/06 0900 I Range 12.2-15.0 seconds Therapeutic range 2.0-3.0.	F	281	quarterly Quality Improvement Con which is chaired by the Administra		
	on Levaquin 500mg routine meds given bed), appetite good	3:00 PM, "Resident continue g, fluids encouraged and all and tolerated. OOB (out of l, all ADLs (Activities of Daily esting quietly, no obvious		-			
	by lab regarding PT aware, no new orde	3:30 PM, " Writer was called F/INR result, PMD made ers given but said to continue I was noted accordingly."					
	oriented times 3. C No S/S (signs/syr hyperglycemia was	1:00 PM, "Alert, verbal, Consumed 75% of meal served mptoms) of hypo/ noted. Able to verbalize provided. No c/o pain/].			
	bleed. Small amou bridge of nose. Pla medical doctor] and answering machine Vital signs (V/S) B/I	I:00 PM, "10:00 PM had nose int. Ice compress applied over ace a call to PMD [private d left message to the e not responded at this time. P (Blood Pressure) 150/86, T (, P (Pulse) 78, and R (· · · · · · · · · · · · · · · · · · ·		
	small amount of no apply ice compress	35 AM, "Continue to have se bleeding. Continue to over bridge of nose and nose PMD responded and made					
FORM CMS-2	67(02-99) Previous Versions	Obsolete Event ID: D95S11	Fa	cility IE	D: WASHNURS If contin	uation sheet I	Page 34 of 96

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-	F OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	IULTIP	LE CONSTRUCTION	(X3) DATE SU COMPLE	
		095022	B. WI	NG		05/1	9/2006
	ROVIDER OR SUPPLIER	CILITY		24	EET ADDRESS, CITY, STATE, ZIP COD 25 25TH STREET SE ASHINGTON, DC 20020	E	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SHO REFERENCED TO THE APPROPRIA	JLD BE CROSS-	(X5) COMPLETION DATE
F 281	continue to apply i PT/INR today and Warfarin until result endorse to oncom April 17, 2006 at 2 22 (R), 144/80(B/F nose bleed, PT/IN INR 19.89. Family send resident to E PM. No acute dist On May 19, 2006 a interview was cond Clinical Manager v receive anticoagul monitored for bruis are to be drawn m be called to report medication might k results if they are h the resident was tr because of a nose Facility staff failed emergency care p associate or Medic from the resident's hours. The record . Cross referenced 2. The facility staff Residents'' policy f A review of Reside nurse's note dated	cal problem. Ordered to ce compress and to do CBC, to report result to PMD. Hold lit of PT/INR arrives. Will ing nurse." :30 PM, "V/S 97.8 (T), 72 (P), P). Resident was noted with a R result received. Pt. 134.4, 7 and MD notified order given to R. Resident picked up at 2:00 tress on departure." at 9:45 AM a face-to-face ducted with the Assistant who indicated, "Residents who ant medications are to be sing and bleeding. Blood tests onthly. The physician was to the results. Adjustments to the be needed depending on the high or low. I remember that ansferred to the hospital bleed." to follow the facility's resident olicy by not contacting the cal Director after no response a primary physician for nine (9) was reviewed on May 17, 2006 I to CFR 483.25, F309. failed to follow the "Suicidal	F	281			

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		AND HUMAN SERVICES				FORM	06/15/2006 APPROVED 0938-0391
STATEMEN	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI			(X3) DATE SI COMPLE	JRVEY
		095022	B. WIN	IG		05/1	9/2006
NAME OF P	ROVIDER OR SUPPLIER				ET ADDRESS, CITY, STATE, ZIP		
WASHIN	GTON NURSING FAC	ILITY			5 25TH STREET SE SHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION S REFERENCED TO THE APPROF	SHOULD BE CROSS-	(X5) COMPLETION DATE
F 281	Continued From pa	ige 35	F 2	281			
		d "I did it, I pulled it. I don ' t					
	helped out/away fro	out of here." Resident was om fire alarm to [his/her] room.					
		erved. Then staff went back to dresident in the bath room					
		er head hose to wrap it around en asked resident why? Or					
	what [he/she] was o	doing with it, resident said, "I bks like a snake." Resident					
	was brought to the	nursing station for close					
	monitoring"						
		e's note dated March 15, 2006 dent on hourly watch. [-
		a] was phoned at 8:35 AM AM with resident. Telephone					
	order of Haldol 2 m	g po (orally) QID PRN (four ed) for agitation. Psyc (
	psychological) cons	sult with [psychiatrist] and					
	notified of the incide	RP (responsible party) was ent. At 9:45 AM [psychiatrist]					
		lephone order of Haldol 2 mg daily) routine for agitation.					
		onitoring. Psyc consult for 3/16 for] UA and C&S (urinalysis					
	and culture and ser	nsitivity). Resident received and 1 PM. Resident is now				· .	
	sleeping."			,	·		
		cility's policy, "Nursing Suicidal					
	September 1998, u	1404480A.000, dated nder, "Procedure - #3. Assign					
	stay within the dista	one to one observation and to ant of an arm length of the					
		nination of the course of made by a physician#7 (c)					
	Obtain physician or	der for transfer or if the n in the facility an order for an					
FORM CMS-24	567(02-99) Previous Versions		Fa	cility ID:	WASHNURS	If continuation about	Page 26 -6.00
				,		If continuation sheet	aye 300190

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CENTER		AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) ML			APPROVE 0938-039 URVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	COMPLE	
		095022	B. WING	5	05/19/2006	
NAME OF P	ROVIDER OR SUPPLIER		-	STREET ADDRESS, CITY, STATE, ZIP COI 2425 25TH STREET SE		
WASHIN	GTON NURSING FAC	ILITY		WASHINGTON, DC 20020		•
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SHO REFERENCED TO THE APPROPRIA	ULD BE CROSS-	(X5) COMPLETION DATE
F 281	Continued From pa	ge 36	F 28	B1		
		tric consult. The psychiatrist the frequency and length of				
	clinical manager an , 2006 at 10:55 AM "When we found (th hose around (his/he confused. The resi nurse ' s station and bed. Then we calle physician) to tell [hi The charge nurse s the fire alarm and w [attending physician the Director of Nurs	view was conducted with the ad the charge nurse on May 19 . The clinical manager stated, he resident) with the shower er) neck, [Resident S14] was dent was brought out to the d then a little later put back to ed the doctor (attending m/her] what happened." stated, " The resident pulled was very confused. We called h] and the psychiatrist. When sing found out what was going was sent out to the hospital."				
	one to one observa time he/she was no hose around the ne sounded until the p record was reviewe	•				
	3. Facility staff faile Resident #1 for Ma	d to obtain a weight for rch and April 2006.				
	Services - Weights 0504060A.00, date Procedure -3. Mont according to the fac	cility's policy, "Nutritional and Heights", Policy # d April 2004, under, " hly: (a) Weights will be done cility schedule which indicates d and the date the weight is to				

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Facility ID: WASHNURS

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TATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		095022	B. WING _	<u> </u>	05/1	9/2006	
	ROVIDER OR SUPPLIER GTON NURSING FAC	CILITY	2	REET ADDRESS, CITY, STATE, ZIP (2425 25TH STREET SE WASHINGTON, DC 20020	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION S REFERENCED TO THE APPROP	HOULD BE CROSS-	(X5) COMPLETIC DATE	
F 281	Resident #1, the an March and April 20 A face-to-face inte clinical manager of After reviewing the that the weights we April 2006. The re 2006. 4. Facility staff faile Resident #8 for Fe According to the, " Resident #8, the a February 2006 was A face-to-face inte charge nurse on IV After reviewing the that the weight was The record was res 5. A review of Res	Vital Sign Flow Sheet" for rea for recording the weight for 06 was blank. Twiew was conducted with the n May 15, 2006 at 3:35 PM. record, he/she acknowledged ere not done for March and cord was reviewed May 15, ed to obtain a weight for bruary 2006. Vital Sign Flow Sheet" for rea for recording the weight for s blank. Twiew was conducted with the lay 16, 2006 at 10:30 AM. record, he/she acknowledged s not done for February 2006. viewed May 16, 2006.	F 281				
	according to facility	ow Sheet" included the					
	2/14/06 123.5 3/13/06 131 4/6/06 121 4/14/06 117 5/9/06 113						

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PRINTED: 06/15/2006

CENTER		AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA				APPROVED 0938-0391 IRVEY
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN		COMPLETED	
		095022	B. WING		05/19	9/2006
	ROVIDER OR SUPPLIER		2	REET ADDRESS, CITY, STATE, ZIP CC 425 25TH STREET SE	DE	
				VASHINGTON, DC 20020	·	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION SH REFERENCED TO THE APPROPR	OULD BE CROSS-	(X5) COMPLETION DATE
F 281	Continued From pa	age 38	F 281			
	unit manager on M She acknowledged obtained in Februa	view was conducted with the ay 15, 2006 at 3:12 PM. He/ that a reweight was not ry, March and April 2006 . The unit manager was asked				
		nt. He/She later said that the				
	Services Weights a following: "Montl weights for change 5% in 30 days, 7.5	4060A.000, Nutritional and Heights included the hly: b. check the previous s. If there is a change of + or - % in 90 days, schedule				
	There was over a 5 January to Februar increase in weight and there was over March 13 to April 1	eighed within 24 hours" 5% weight decrease from y 2006, there was over a 5% from February to March 2006 r a 7% decrease in weight from 4, 2006. The facility failed to nt. The record was reviewed on				
		ident #12's record revealed led to weigh the resident to facility policy.				
	The "Vital Sign Flo following weights: Date Weights 12/15/05 148	w Sheet" included the				
	1/14/06 152 4/2006 148 There were no weig and March 2006.	ghts in the record for February				
		view was conducted with the ay 16, 2006 at 2:38 PM. He/				

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CENTE	RS FOR MEDICARE	AND HUMAN SERVICES				FORM OMB_NO.	06/15/2006 APPROVED 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
l		095022	B. WI	NG_	· · · · · · · · · · · · · · · · · · ·	05/1	9/2006
ł	ROVIDER OR SUPPLIER	CILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 2425 25TH STREET SE WASHINGTON, DC 20020				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETION DATE
F 281	and March 2006 we The record was rev 7. A review of Res that the facility staff on readmission to t Facility Policy #050 Services Weights a following: "All resid hours of admission week and then mor frequently 1. On member will measu height within 24 hou weights will be done When feasible 1- designated for all m The resident was re February 23, 2006. progress note inclu weight) 122 lbs " The "Vital Sign Flo included the followin Date V 12/11/05 1447 1/11/06 144 2/14/06 12 4/14/06 12	that the weights for February ere not in the record. viewed on May 16, 2006. ident #15's record revealed f failed to reweigh the resident the facility. 4060A.000, Nutritional and Heights included the dents will be weighed within 24 /readmission, again after one nthly, unless ordered more Admission: Weight team ure the resident 's weight and urs of admission 3. a. e according to facility schedule 2 days each month will be nonthly weights." eadmitted to the facility on The nurse 's readmission ded the following: "Wt (w Sheet [form SM-67)" ng weights: /eight 7.5 8 7	F	281			
	The record lacked e	evidence of a reweight one (1)					

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Event ID: D95S11

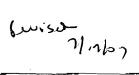
Facility ID: WASHNURS

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						FORM	: 06/15/2006 APPROVED
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M		E CONSTRUCTION	(X3) DATE S COMPL	
		095022	B. WIN	IG		- 05/1	9/2006
	PROVIDER OR SUPPLIER				ET ADDRESS, CITY, STATE, ZIP 25 25TH STREET SE		
WASHIN	GTON NURSING FAC			W/	ASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTION S REFERENCED TO THE APPROF	SHOULD BE CROSS-	(X5) COMPLETION DATE
F 281	Continued From pa	nge 40	F2	281			
	resident ' s weight v pounds on March 1	sion and a reweight when the was determined to be 147 6, 2006 [increase of 25 . The record was reviewed on					
	8. Facility staff faile Resident #17 for M	d to obtain a weight for arch 2006.					1, 25
		/ital Sign Flow Sheet" for area for recording the weight s blank.					Lender P
	charge nurse on Ma After reviewing the that the weight was	view was conducted with the ay 17, 2006 at 12:30 PM. record, he/she acknowledged not done for March 2006. riewed May 17, 2006.					no port
		ed to obtain a weight for anuary, February and March					
	Resident #21, the a	Vital Sign Flow Sheet" for area for recording the weight ary and March 2006 was blank.					
	charge nurse on Ma reviewing the record the weights were no	view was conducted with the ay 17, 2006 at 7:30 AM. After d, he/she acknowledged that of done for January, February he record was reviewed May				* .	
	10. The social work service assessmen	er failed to do an initial social t for Resident # 25.					
	A review of Resider	nt #25's record revealed that					
ORM CMS-25	67(02-99) Previous Versions	Obsolete Event ID: D95S1	1 Fac	ility ID:	WASHNURS	If continuation sheet	Page 41 of 96

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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PRINTED: 06/15/2006 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD		(X3) DATE S COMPLE		
		095022	B. WING		05/1	9/2006	
	PROVIDER OR SUPPLIER	ILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 2425 25TH STREET SE WASHINGTON, DC 20020			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION S REFERENCED TO THE APPROP	HOULD BE CROSS-	(X5) COMPLETION DATE	
F 281	Continued From pa	ge 40 sìon and a reweight when the	F 28	1			
	resident 's weight v pounds on March 1	vas determined to be 147 6, 2006 [increase of 25 The record was reviewed on			•	•	
	8. Facility staff faile Resident #17 for Ma	d to obtain a weight for arch 2006.					
		Vital Sign Flow Sheet" for rea for recording the weight blank.					
	charge nurse on Ma After reviewing the r that the weight was	view was conducted with the ay 17, 2006 at 12:30 PM. record, he/she acknowledged not done for March 2006. iewed May 17, 2006.	F 28	Social Work notes Resident # 25, 513 1. Social Work notes missir of the survey have been eval Director of Social Work and	luated by the	6/20 /01	
		d to obtain a weight for nuary, February and March		were made whenever possib 2. A 100% audit of all socia was done by the Director of Records and the results of th	le. al work notes Medical	6/20/04	
	Resident #21, the a	Vital Sign Flow Sheet" for rea for recording the weight ry and March 2006 was blank.		forwarded to the Director of for correction. 3. Aggressive recruitment to vacant social work positions	o fili 2		
	charge nurse on Ma reviewing the record the weights were no	iew was conducted with the y 17, 2006 at 7:30 AM. After , he/she acknowledged that t done for January, February he record was reviewed May	· .	The facility signed a contract T, an agency which supplies workers, and an LICSW has an LGSW to begin soon. The of Social Work will monitor	t with Delta- contract started with ne Director	6/20/06	
	17, 2006.	er failed to do an initial social	:	completion of evaluations at 4. The results of his monito action plans for improvement presented to the quarterly Q	nd notes. ring and any nt will be uality	6 2d06	
	A review of Residen	t #25's record revealed that		Improvement Committee wh chaired by the administrator			

DEPART	MENT OF HEALTH	AND HUMAN SERVICES					APPROVED	
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			······································	OMB NO.	0938-0391	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		IPLE CONSTRUCTION	(X3) DATE SU COMPLE		
		095022	B. WI	۷G		05/19/2006		
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE					
WASHIN	GTON NURSING FAC	ILITY			425 25TH STREET SE VASHINGTON, DC 20020			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD I REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETION DATE	
F 281	Continued From pa	ge 41	F	281				
	2006. At the time of initial social service	ed to the facility on April 27, f this review there was no assessment in the record. been in the facility for 21 days to May 17, 2006.						
	Initial History and A A.000, dated May 1 The Psychosocial E the resident's media	cility's policy, "Social Work ssessment," Policy #1702010 997, under "Procedure - #3. Evaluation will be entered into cal chart within 14 days of rm will be maintained as part edical record.						
	social worker on Ma she stated, "We ha complete the initial the intermediate un Resident # 25 was service assessmen	view was conducted with a ay 17, 2006 at 2:30 PM. He/ ave a 14 day window to social service assessment for its which include [unit where admitted]. The initial social t should have been completed eviewed May 17,2006.			·			
		ed to obtain a monthly INR (alized Ratio) to measure blood sident S11.		Ţ				
	initial physician's or re-ordered February	nt S11's record revealed an der dated January 5, 2006 and y 7 and April 4, 2006 directing, din) 7.5mg 1 tab by mouth						
	The most recent IN January 13, 2006.	R laboratory value was dated						
		ong Term Care Pharmacy re Manual," policy #7.1 "						
				-	<u> </u>			

Event ID: D95S11

Facility ID: WASHNURS

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PRINTED: 06/15/2006

ATEMENT	T OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		PLE CONSTRUCTION	(X3) DATE S COMPLE	
		095022	B. WI	₩G		05/1	9/2006
	ROVIDER OR SUPPLIER		1	24	EET ADDRESS, CITY, STATE, ZIP COD 125 25TH STREET SE VASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	id Pref Tag		PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SHO REFERENCED TO THE APPROPRIA	ULD BE CROSS-	(X5) COMPLETION DATE
F 281	effective date Augu assessment of clot Warfarin (Coumadi A face-to-face inter charge nurse on M she acknowledged after January 2006 May 19, 2006. 12. Facility staff fail ordered by the phys A review of Reside initial physician's or and re-ordered Mat Warfarin (Coumadi evening. " A physician's order directed, "PT/INR of vein thrombosis)." The most recent PT dated March 16, 20	ing of Drug Therapy ", ist 1, 2002, page 6, "11. INR or ting function monthly, if on n), Dicumarol." view was conducted with the ay 19, 2006 at 11:15 AM. He/ that the INR was not obtained The record was reviewed ed to obtain an INR as sician for Resident S12. Int S12's record revealed an order dated January 7, 2006 rch 14, 2006 directing, " n) 2.5mg 1 tab by mouth every dated March 14, 2006 every other week - DVT (deep I/INR laboratory value was 006.	F	281			
	charge nurse on M she acknowledged obtained after Marc reviewed May 19, 2 13. The social work	er failed to complete an initial				·	
	According to the fa	ation for Resident S13. cility's policy, "Social Work ssessment", policy #1702010				· · · ·	

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STATEMEN	T OF DEFICIENCIES DF CORRECTION	A MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		(X3) DATE S COMPLI	
		095022	B. WING		05/1	9/2006
	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE 2425 25TH STREET SE WASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOUL REFERENCED TO THE APPROPRIATE	D BE CROSS-	(X5) COMPLETIO DATE
F 281 F 309 SS=G	 A.00, dated May 19 The Psychosocial If the residents's mediadmission. This for of the residents's mediadmission. This for admission. This for of the resident s's mediadmission. This for facility on February review, there was mediadmission. The facility on February review, there was mediadmission. This facility on February review, there was mediadmission. The facility on February review, there was mediadmission. The facility on February review, there was mediadmission. This facility on February review, there was mediadmission. This facility on February review, there was mediadmission. This facility on February review, there was mediadmission. The facility on February review, the facility 89 day facility on February review, the facility 80 day facility on February review, the facility	297, under "Procedure - #3. Evaluation will be entered into dical chart within 14 days of rm will be maintained as part hedical. ical record for Resident S13 esident was admitted to the 16, 2006. At the time of this to social worker's initial hation. The resident had been ys. The record was reviewed OF CARE	F 28	 QUALITY OF CARE Resident #29 1. This resident expired at the H with a cause of death unrelated results of the PT/INR. 2. Any resident on Coumadin an and symptoms of bleeding will b for according to the facility's emo- policy. 3. The nursing staff was inserviced facility's Emergency Care and the contact the Medical Director, D Administrator should the PM respond in a very timely mannee House Supervisors and Clinical M will monitor the residents needs cl ensure compliance with the facility The results of this monitoring forwarded to the DON. 4. The Director of Nursing will the monitoring. The results monitoring, along with any action for improvement, will be presented quarterly Quality Improvement 	to the d signs e cared ergency d on the need to ON, or D not r. The anagers osely to y policy will be oversee of this on plans	4/18/01 5/19/04 6/30/04
	: Based on observati and resident intervis seven (7) of 30 sam supplemental reside provide emergency 1) resident on an ar assess one (1) resid emergency room vis Lorazapam (Ativan)	NT is not met as evidenced by ons, record review and staff ews, it was determined that for ppled residents and 12 ents that facility staff failed to: care per facility policy to one (aticoagulant with a nosebleed; dent for pain after an sit; clarify the use of for two (2) residents; monitor ulse prior to the administration		 Resident #19 1. Resident identified at the tim survey has had pain managem neurological checks comple required. 2. The charts of any resident inv an altercation resulting in an ER v reviewed to ensure that prope documentation was received hospital, pain assessments neurological status was documen 	and	5/19/06 5/20/06

Facility ID:

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MUL A. BUILD	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	· ·	095022	B. WING		05/1	9/2006	
	Rovider or Supplier	ILITY	S	TREET ADDRESS, CITY, STATE, ZIP CC 2425 25TH STREET SE WASHINGTON, DC 20020			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COL (EACH CORRECTIVE ACTION SHO REFERENCED TO THE APPROPRI	OULD BE CROSS-	(X5) COMPLETIO DATE	
F 309	of an antihypertens multiple medication coverage as ordere- blood drawn as ord repeat a HGB A1C protectors and Ted clarify sliding scale 600 for five (5) resi resident was prepa Residents #29, 19,	ive medication; administer is and sliding scale insulin ed for one (1) resident; have ered for six (6) residents; blood test and apply heel stockings for one (1) resident; insulin coverage orders above dents and ensure one (1) red for an appointment. 2, 4, 6, 10, 21, S5, S6, S7, S8, W1, W2, W4 and W5.	F 30	regarding the importance of thorough assessment with a changes in the residents Reviewed the need to use polic an excellent reference tool. The Managers on the units will me residents to ensure compliance 4. The Director of Nursing with the monitoring. The resu monitoring, along with any a for improvement, will be prese	of doing a ny and all condition. y manual as The Clinical onitor their e. vill oversee lts of this ction plans	6/30/24	
	emergency care po taking Coumadin, a nosebleed. The re hospital on April 18 The resident was a 22, 2006. Accordin	o follow the facility's resident licy for Resident #29 who was an anticoagulant, and had a sident subsequently died at the b, 2006. dmitted to the facility on March g to the admission Minimum aned and dated April 14, 2006,		Resident # 2 and 9 So 1 12 local 1. The orders for this resident the facility's psychiatrist. 2. The pharmacy is performing audit of all PRN medications that those with the same therap for any given resident have a corder documenting the order	ident were consultant ng a 100% s to ensure eutic effect larification	6 730 01 6 730 01	
	the resident's diagr Mellitus (DM), Cong Hypertension, Cere Hemiparesis, and I The admission orde included, "Warfarin tablet GT/PO daily	noses included: Diabetes gestive Heart Failure, brovascular accident (stroke) Depression (Section I). ers dated March 22, 2006 n Sodium 10mg (Coumadin) 1 blood thinning (3/21/06-3/28/ every 6 months; (2) FBS		these medications should be gi 3. The consultant pharmacist w the orders for the PRN med ensure compliance. She will we through the DON and physic clarification orders are needed. 4. She will report the findin monitoring at the quarterly Improvement Committee.	ven. ill monitor	6 00 00 00 6 000 00	
	Physician Orders:	PM, "Obtain PT/INR lab work		Resident #4 1. Resident identified as not pulse taken prior to the admini	having a stration of	5/19/05	

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		AND HUMAN SERVICES				FORM	06/15/2006 APPROVED
STATEMEN	RS FOR MEDICARE FOF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		IPLE CONSTRUCTION	(X3) DATE SI COMPLE	
		095022	B. Wil	NG		05/1	9/2006
l.	ROVIDER OR SUPPLIER	ILITY		2	REET ADDRESS, CITY, STATE, ZIP CODE 2425 25TH STREET SE WASHINGTON, DC 20020		
(X4) ID PREFIX TÀG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE [BE CROSS-	(X5) COMPLETION DATE
F 309	urinalysis with cultu O UTI (urinary tract complained of) burn March 24, 2006 2:0 po (by mouth) q (ev Interactions Eleva in the setting of cor levofloxacin use ha episodes of bleedir International Norma suitable anticoagula monitored if levoflo concomitantly with Ortho-McNeil] pres Levaquin (levofloxa March 28, 2006 2:0 Sodium 10mg, I tat thinning. Check PT April 17, 2006 7:00 compress over brid and INR today; noti Coumadin 4/18/06. April 17, 2006 1:15 Coumadin Toxicity. Laboratory Studies March 28, 2006: co :20 (6:20 AM) PT 27.4 P (Patient)	 30 AM, " Obtain U/A C&S (ire and sensitivity) in AM, to R/ infection)." Resident c/o (hing sensation when urinating. A0 PM, "Levaquin 500mg 1 tab very) day for 7 days." [Drug ations of the prothrombin time neurrent Warfarin and ve been associated with lig. Prothrombin time, alized Ration (INR), or other ation tests should be closely xacin is administered Warfarin Manufacturer's [cribing information for licin), August 2005]. A0 PM, "Continue Warfarin b. Qd (daily) GT/PO - blood f/INR every month." AM "Continue to apply ice ge of nose. Do CBC and PT fy PMD of results. Hold " PM "Send resident to ER for " 	F		Clonidine has had her medical reviewed and corrected immed There was no identified harm resident. 2. All other residents on medications requiring a pulse p administration have had their reviewed and corrections done necessary. 3. Staff were inserviced of requirements of some hyper medications to have the pulse MARs reviewed with the nursing The Clinical Managers on the un monitor those MARs for consiste taking and recording the pulse. 4. The Director of Nursing will of the monitoring. The results of monitoring, along with any action for improvement, will be presented quarterly Quality Improv Committee. Resident #6 A. 1. The nurse who did not sign of resident's 10 AM medication administered has been counseled MAR was reviewed with no correction needed. No harm identified to the resident. 2. All MARs are consistently review the units to ensure that medication documented as given. 3. Staff were inserviced of requirements of documenting administration of medications at the they are given to the resident. MAR	diately. to the similar rior to MARs when on the tensive taken. g staff. its will ncy of oversee of this n plans I at the vement	5 70 00 6 70 00 6 70 00 7 2 00 7 2 00 6 70 00 6 70 00 6 70 00

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Facility ID: WASHNURS

If continuation sheet Page 46 of 96

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DEPART	MENT OF HEALTH	AND HUMAN SERVICES					APPROVED
CENTER	S FOR MEDICARE	& MEDICAID SERVICES			· · · · · · · · · · · · · · · · · · ·		0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI		IPLE CONSTRUCTION	(X3) DATE S COMPLE	
		095022	B. WI	NG_		05/1	9/2006
NAME OF P				ST	REET ADDRESS, CITY, STATE, ZIP CODE		0.2000
WASHING	GTON NURSING FAC	ILITY		1	2425 25TH STREET SE		
				<u> </u>	WASHINGTON, DC 20020	<u>. </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETION DATE
F 309	(9:00 AM) PT 134.4 P Normal Protime INR 19.84 Nurses' Notes: March 28, 2006 3:0 Levaquin 500mg, fil routine meds given bed), appetite good Living) done and re changes noted. " March 28, 2006, 3:3 lab regarding PT/IN no new orders giver Coumadin and was April 16, 2006 11:00 times 3. Consumed (signs/symptoms) of noted. Able to verb provided. No c/o pa April 16, 2006 11:00 bleed. Small amou bridge of nose. Pla medical doctor]and machine not resp (V/S) B/P (Blood Pr Temperature) 98.3, Respiration) 20."	 Julation collected 4/17/06 0900 I Range 12.2-15.0 sec. Therapeutic range 2.0-3.0. IO PM, "Resident continue on uids encouraged and all and tolerated. OOB (out of 1, all ADLs (Activities of Daily sting quietly, no obvious 30 PM, " Writer was called by IR result, PMD made aware, n but said to continue with noted accordingly." D PM, "Alert, verbal, oriented d 75% of meal served. No S/S of hypo/hyperglycemia was valize needs. ADL care ain/discomfort." D PM, "10:00 PM had nose nt. Ice compress applied over ice a call to PMD[private left message to the answering ponded at this time. Vital signs 	F	309	 Clinical Managers on the unit monitor those MARs for consiste documentation. 4. The Director of Nursing will of the monitoring. The results of monitoring, along with any action for improvement, will be presented 	as will ency of oversee of this oplans l at the vement he time proper actual volved s were ge was n the insulin suring d with nagers Rs for sliding versee f this plans at the vement	0 20 06 5 19 06 5 20 06 6 20 06 6 20 06 5 22 06
FORM CMS-25	67(02-99) Previous Versions	Obsolete Event ID: D95S11	Fa	cility	ID: WASHNURS If continu		Page 47 of 96

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Res. 4 10 Remarcal by IDR 7/14/06

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		AND HUMAN SERVICES		·		FORM	06/15/2006 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA iDENTIFICATION NUMBER:	(X2) MU A. BUIL		PLE CONSTRUCTION	(X3) DATE SI COMPLE	JRVEY
		095022	B. WING	G	······	05/1	9/2006
NAME OF P	ROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE		
WASHIN	GTON NURSING FAC	ILITY			125 25TH STREET SE /ASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE [BE CROSS-	(X5) COMPLETION DATE
F 309	and to report result result of PT/INR an oncoming nurse." April 17, 2006 2:30 R), 144/80(B/P). Re bleed, PT/INR resu 89. Family and MD resident to ER. Re No acute distress of On May 19, 2006 a interview was cond Clinical Manager w receive anticoagula monitored for bruis are to be drawn mo be called to report f medication might b results if they are h the resident was tra because of a nose According to the fa Emergency Care-R provide emergency Advanced directive emergency is due t diagnosis. A. In case of signifi condition: 2. Notify attend Medical Director. I Nursing Director or	and to do CBC, PT/INR today to PMD. Hold Warfarin until rives. Will endorse to PM, "V/S 97.8 (T), 72 (P), 22 (esident was noted with a nose It received. Pt. 134.4, INR 19. 0 notified order given to send sident picked up at 2:00 PM. on departure. " t 9:45 AM a face-to-face ucted with the Assistant ho indicated, "Residents who int medications are to be ing and bleeding. Blood tests onthly. The physician was to the results. Adjustments to the e needed depending on the igh or low. I remember that ansferred to the hospital	F 34	09	due on 4/28/06. The resident went hospital on 4/17/06, readmitted on 4 with the order for the FBS discom Instead, an HgA9C every 3 month ordered on the 4/19/06 admission. 2. A lab audit was done on all ch ensure accuracy and completeness orders and results. 3. Staff were inserviced or requirements of laboratory ordering new procedure was developed. Clinical team met with the Director Southern Maryland Hospital lab to accuracy of communications. The C Managers on the units will monit residents' lab orders for consisten accuracy. 4. The Director of Nursing will of the monitoring. The results of monitoring, along with any action for improvement, will be presented quarterly Quality Improv Committee. Resident #7 4 24 3/356 A. 1. The resident identified of missing lab had the test repeated time of its discovery. There was no to the resident. 2. A lab audit was done on all ch ensure accuracy and completeness orders and results. 3. Staff were inserviced on requirements of laboratory ordering new procedure was developed. Clinical team met with the Director Southern Maryland Hospital lab to accuracy and completeness orders and results.	/19/06 tinued. is was arts to of the in the g and a The of the ensure linical or the cy and versee this p ans at the ement with a at the o harm arts to of the ensure	6/70/06 6/70/06 6/70/06 5/19/06 6/70/06 6/70/06

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

Event ID: D95S11 Facility ID: WASHNURS

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

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							0920-0291
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		IG	(X3) DATE S COMPLE	
		095022	B. WI	NG_		05/1	9/2006
NAME OF P	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE		
				2	425 25TH STREET SE		
WASHIN	GTON NURSING FAC	,)_() 1		v	VASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULI REFERENCED TO THE APPROPRIATE	BE CROSS-	(X5) COMPLETION DATE
F 309	breathe through his 2. Apply pressu apply ice over nose 3. If bleeding d minutes, notify doc Every change in re- on the nursing 24 h physician and famil nurses notes." A review of the "Pl " dated April 25, 20 and Treatment" ind bleeding from the r bleeding from the r bleeding was treated on the nasal bridge she] was transferre Reason For Discha if applicable): Nose Facility staff failed t Medical Director af from the resident's hours. The record w 2. Facility staff failed to According to the ar completed April 11 coded in Section B long or short-term in D, "Vision Patterns"	upright and instruct him to s mouth ure on one or both nostrils	F	309	 Managers on the units will morresidents' lab orders for consistent accuracy. 4. The Director of Nursing will the monitoring. The results monitoring, along with any action for improvement, will be presented quarterly Quality Improcommittee. B. 1. The resident identified at the of the survey had heel protectors a stockings applied when ordered at of the discovery. There was not the resident. 2. A 100% review of physician's for similar protective devices was with corrective actions made necessary. S. A lab addit was done on all the ensure accuracy and completeness orders and results. 3. Staff were inserviced on the improf wearing such protective device devices. 4. The Director of Nursing will on the monitoring. The results of the monitoring. The results monitoring, along with any action for improvement, will be presented for improvement. 	itor the ncy and oversee of this n plans d at the ovement he time harm to s orders as done when harts to ortance ces and Clinical tor the iracy. oversee of this n plans	6/20/00 6/20/06 5/19/04 6/20/06 6/20/06 6/20/06

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

Facility ID: WASHNURS

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

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	T of deficiencies of correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	r í	ULTIPLE CONSTRUCTION	(X3) DATE S COMPLE	
		095022	B. WIN	اھ	05/1	9/2006
	PROVIDER OR SUPPLIER	ILITY		STREET ADDRESS, CITY, STATE, ZIP C 2425 25TH STREET SE WASHINGTON, DC 20020	ODE	
	······		I		· · · · · · · · · · · · · · · · · · ·	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	id Prefi) Tag		IOULD BE CROSS-	(X5) COMPLETION DATE
F 309	March 24, 2006 12: urinalysis with cultu O UTI (urinary tract complained of) burr March 24, 2006 2:0 po (by mouth) q (ev Interactions Eleva in the setting of con levofloxacin use hav episodes of bleedin International Norma suitable anticoagula monitored if levoflox concomitantly with V Ortho-McNeil] presc Levaquin (levofloxad March 28, 2006 2:00 Sodium 10mg, I tab thinning. Check PT April 17, 2006 7:00 / compress over bridg and INR today; notif Cournadin 4/18/06." April 17, 2006 1:15 J Cournadin Toxicity." Laboratory Studies: March 28, 2006: co :20 (6:20 AM) PT 27.4 P (Patient) C/T [call to] [name] report read back)	30 AM, "Obtain U/A C&S (re and sensitivity) in AM, to R/ infection). "Resident c/o (ing sensation when urinating. 0 PM, "Levaquin 500mg 1 tab ery) day for 7 days." [Drug. tions of the prothrombin time current Warfarin and /e been associated with g. Prothrombin time, lized Ration (INR), or other tion tests should be closely racin is administered Varfarin Manufacturer's [ribing information for cin), August 2005]. 0 PM, "Continue Warfarin Qd (daily) GT/PO - blood /INR every month." AM "Continue to apply ice ge of nose. Do CBC and PT y PMD of results. Hold	F 3	reviewed and corrected i There was no identified h resident. 2. All other residents medications requiring a put administration have had to reviewed and corrections necessary. 3. Staff were inservice requirements of some h medications to have the p MARs reviewed with the m The Clinical Managers on th monitor those MARs for con- taking and recording the pulse 4. The Director of Nursing the monitoring. The resu- monitoring, along with any a for improvement, will be pres quarterly Quality In- Committee. Resident #6 A. 1. The nurse who did not resident's 10 AM media administered has been couns MAR was reviewed with	mmediately. arm to the on similar lse prior to heir MARs done when ed on the hypertensive bulse taken. mrsing staff, he units will insistency of e. will oversee buts of this action plans ented at the mprovement sign off this cations as eled. The no further harm was reviewed by l bud negects of the no the harm the at the time	5 70 00 6 70 00 6 70 00 7 2 06 1 2 06 6 70 00

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CENTE	RS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES				FORM OMB NO	: 06/15/2006 APPROVED . 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDEP/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		VIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		095022	B. WI	۷G _		05/1	9/2006
	ROVIDER OR SUPPLIER	ILITY		2	REET ADDRESS, CITY, STATE, ZIP CODE 2425 25TH STREET SE WASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX 🗌	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE	BE CROSS-	(X5) COMPLETION DATE
F 309	follow objects.) In S Diagnoses", the re Glaucoma. A review of Resider nurse 's note dated documented, "Res emergency room) fi being hit in the hear roommate) visitor. writer. Vital signs ta limit. Neurochecks normal limits)" According to a nurs at 10:30 AM, "Resi A via stretcher with A nurse's note dated documented, "Aler of pain [in] arm but refused" There was no evide causing the residen returning from the h The "General Eme Instructions" docur a head computerize ray and left wrist x-re the record that the filter studies performed i	bes; eyes do not appear to Section I, " Disease sident was coded for In #19's record revealed a I 12, 2006 at 9:15 PM, that ident transferred to ER (or evaluation secondary to d by another resident ' s (Resident assessed by the aken and were within normal initiated and WNL (within e's note dated May 13, 2006 dent returned from ER at 755 2 attendants" d May 13, 2006 at 11:00 PM t and responsive. Complaining when asked if want pain med ence in the record that the arm t pain was assessed after nospital. rgency Department Discharge nented studies done included ed topography (CT), right hip x- ray. There was no evidence in facility received information or ital regarding the results of the n the emergency department.	F	309	 Resident #S5, S6, S7, S8 and W5 Sliding Scale Insulin All residents identified at the the survey having sliding scale orders which required the nurse to the physician when the blood glucos was over 750 were clarified. glucometers used by the facility blood glucose levels up to 600. were changed to notify the physicia the levels reached 500. No harm of any resident. All sliding scale insulin order reviewed for similar issues adjustments made when necessary. Staff was inserviced on the uppe reading of the facility's glucometer need to clarify physician The O Managers on the units will moni residents' sliding scale insulin order consistency and accuracy. The Director of Nursing will of the monitoring. The results of monitoring, along with any action for improvement, will be presented quarterly Quality Improv Committee. Resident #S11, S12, W1, W2, W4 Lab tests The residents cited at the time survey for not having monthly weekly PT/INRs, PSA level, urin dilantin and albumin levels were of that lab test. Results were forwar- the attending physician for review comment, if necessary. 	time of insulin o notify se level The y reads Orders in when came to rs were and r limits and the Clinical tor the lers for oversee of this n plans l at the yement	5/19/06 5/30/06 6/30/06 6/30/06
		I the results of the emergency hey were requested by the					

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

Event ID: D95S11 Facility ID: WASHNURS

		I AND HUMAN SERVICES				FORM	06/15/2006 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		095022	B. WI	۹G	······································	05/1	9/2006
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
WASHIN	GTON NURSING FAC	ILITY			425 25TH STREET SE VASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE [BE CROSS-	(X5) COMPLETION DATE
F 309	surveyor on May 18 studies were perfor CT was, "No intrac- but there is questio frontal calvarial frac- showed no acute fr The result of the let is cortical irregulari- styloid on the latera- tiny chip fracture. acute if the patient region." A face-to-face inter conducted on May Resident #19. The date, time and plac- resident stated, " I was in the second is but shadows. I sav and pull the curtain hollered "[roomma answered. I got my stick (cane bed. I saw a lady s What do you want? stunk of alcohol. S hit me with her crut wrist. I started to ye I couldn ' t see wi see that far. My rig shadows in my left and told the lady to	 a) 2006, five (5) days after the med. The result of the head cranial trauma is appreciated n of a nondisplaced high left cture." The right hip x-ray acture or dislocation. ft wrist x-ray showed, "There ty of the dorsum of the radial liview that is suggestive of a This should be considered is symptomatic in the same view with the resident was 18, 2006 at 8:30 AM with resident was alert, oriented to e and spoke clearly. The was watching the ball game, it nning. I don't see anything v someone walk past my bed between the two beds. I tes name] you there?" No one e) and walked to the end of my tanding there and asked """ She had crutches and he started cussing me out and ch on my head, my hip and my ell and took my stick and hit her here I hit her because I can't ht eye is blind and I only see eye. The nurse came quick wait outside. The cops came, what happened after that. 	F	309	 Additionally, the consultant pha was asked to specifically address the in her monthly chart audits. The Managers will monitor this throughout the month and report findings to the DON. 4. The Director of Nursing will the monitoring. The results monitoring, along with any action for improvement, will be presented 	and lab e results hysician with the ing the tests. A ed and cessary. armacist his issue Clinical issue of this n plans d at the oversee of this n plans d at the vement by the nt was not side e their ng staff ntion to attents tool of ication.	6/30/06 10/70/06 10/70/06 5/19/06 5/19/06 15/19/06

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	06/15/2006 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI			(X3) DATE SI COMPLE	
		095022	B. WINC	3		05/1	9/2006
NAME OF P	ROVIDER OR SUPPLIER				ET ADDRESS, CITY, STATE, ZIP CODE		
WASHIN	GTON NURSING FAC	ILITY			25 25TH STREET SE ASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	-	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE	D BE CROSS-	(X5) COMPLETION DATE
F 309	My wrist hurt a lot. swollen since Frida hurts and they just and don't even look like this all week. Can ' t hardly make The resident demot that he/she could o the left hand and co Additionally, the res wrist up or down wi Facility staff initiate resident returned fr 2006 at 10:00 AM. an assessment of p strength and motion temperature, pulse, pressure). According to the, " resident was consis normal pupillary rea strength and motion no pulse charted. The charge nurse a wrist after the above of the surveyor. The emergency room fo Facility staff failed t of Resident #19 up room after being str left wrist and right h	eight o'clock the next morning. Still does. And it has been y. I tell them (the nurse) that it ask me if I want pain medicine a try wrist. Been swollen a fist. " Instrated during the interview nly partially close the fingers of ould not make a fist. ident could not bend the left thout complaining of pain. d neurological checks after the om the hospital on May 13, Neurological checks include oupillary reaction, extremity n, sensorium and vital signs (respiratory rate and blood Neurological Chart", the stently assessed as having a action in the left eye and strong n in all extremities. There was assessed the resident's left e cited interview at the request e resident was sent to the r follow-up care. o accurately assess the status on return from the emergency uck by a crutch on the head, ip. Additionally, facility staff	F 3(issue throughout the month and their findings to the DON. 4. The Director of Nursing will the monitoring. The results monitoring, along with any actio for improvement, will be presente quarterly Quality Impro Committee, which is chaired Administrator.	oversee of this on plans d at the ovement	(e)770 op
FORM CMS-25	failed to accurately 67(02-99) Previous Versions	Complete the neurological Obsolete Event ID: D95S11	Faci	lity ID	: WASHNURS If cont	inuation sheet	

STATEMEN	T OF DEFICIENCIES DF CORRECTION	<u>& MEDICAID SERVICES</u> (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	OMB NO. 0938- (X3) DATE SURVEY COMPLETED	
		095022	B. WIN	IG		05/1	9 <u>/200</u> 6
	ROVIDER OR SUPPLIER	CILITY		24	EET ADDRESS, CITY, STATE, ZIP CODE 425 25TH STREET SE /ASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES (MUST BE PRECEEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE	BE CROSS-	(X5) COMPLETI DATE
F 309	Continued From pa	age 52	— F 3	309			
	checks as evidenc	ed by failing to identify the	,			`	
	decreased strength	al vision in the left eye and n and motion in the left wrist. viewed May 19, 2006.			·		
		dent #2's record revealed that o clarify orders for Lorazepam.					
	the following order (1 mg) intramuscul	sician's Order Form included s: "12/18/05, Lorazepam ½ ml arly (IM) every 4 hours as n"; and " 12/18/05,		,			
	Lorazepam 1 mg 1 hours as needed for information include	tablet by mouth every four or agitation. " There was no ed with the orders that would oute, IM or po, would be used.					-
	15, 2006 at 1:02 P She stated, "He ge	rview was conducted on May M with the charge nurse. He/ ets po (by mouth)." viewed on May 15, 2006.					
		ed to assess the pulse rate for ling to physician orders.					
	2005 indicated, "C daily for hypertensi pressure less than blood pressure is n	an orders dated December 12, lonidine 0.2 mg by mouth twice on. Hold for systolic blood 100. Notify physician if systolic nore than 160 or less than 100. pulse rate less 50 or more					
	for March 2006 sho	dication Administration Record owed no evidence that the essed prior to administration of ordered.					

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	06/15/2006 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l`,	IULTIF	PLE CONSTRUCTION	(X3) DATE SI COMPLE	JRVEY
		095022	B. WI	NG		05/1	9/2006
NAME OF P	ROVIDER OR SUPPLIER		•		EET ADDRESS, CITY, STATE, ZIP CODE		
WASHIN	GTON NURSING FAC	ILITY			ASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE I	BE CROSS-	(X5) COMPLETION DATE
F 309	Continued From pa	ge 53	F :	309			
	Assistant Clinical M :00 AM. He/she said have assessed the administration of cle	view was conducted with the lanager on May 15, 2006 at 11 d, "The nursing staff should pulse rate prior to the onidine 0.2 mg as ordered. iewed May 15, 2006.					
	revealed that facility 5) medications as p	ecord for Resident #6 v staff failed to administer five (er physician's orders and ect sliding scale insulin dose ysician's order					
	A. Facility staff faile medications as per	d to administer five (5) physician's orders.					
· ·	Record) included th Docusate Sodium 1 twice daily for bowe tablet by mouth ever Megestrol Acetate every day for weigh mouth every day for	R (Medication Administration e following medications: 00 mg capsule by mouth I regimen; Lisinopril 10 mg my day for hypertension; 10 ml (400 mg) by mouth t loss; Senna 8.6 mg tablet by r bowel management; and on 30 ml by mouth once daily			· .	• .	
.*	the medication was	failed to initial [indicating that administered] for the 10 AM ited medications for April 30,					
	charge nurse on Ma She acknowledged were not initialed as	view was conducted with the ay 16, 2006 at 10:16 AM. He/ that the five (5) medications s being administered on the AM dose on April 30, 2006.					

Facility ID: WASHNURS

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		AND HUMAN SERVICES			· .	FORM	06/15/2006 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1. 1		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		095022	B. WI	NG	· 	05/1	9/2006
	ROVIDER OR SUPPLIER			24	EET ADDRESS, CITY, STATE, ZIP CO 425 25TH STREET SE VASHINGTON, DC 20020	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION SHO REFERENCED TO THE APPROPRIA	ULD BE CROSS-	(X5) COMPLETION DATE
F 309	Continued From pa	ge 54	F	309			
		ed to follow physician's orders on of sliding scale insulin.					
	the following order: , 2006, "Humalog blood sugar three t subcutaneously wit 200 = 4 units, 201-	sician's Order Form included Initial order date of January 3 vial - ins [insulin] Fingerstick imes daily before meals inject h sliding scale coverage: 140- 280 = 6 units, 281-340 = 8 units. Call MD if blood sugar ater than 400."					
	sliding scale covera	ealed the following insulin age: Nood Sugar Coverage 215 4 units 127 4 units					
	should have received and no insulin cover	ysician's order the resident ed 6 units of insulin on April 7 rage on April 9, 2006. riewed on May 16, 2006.					
		d to do laboratory studies for ding to the physician orders.					
	Fasting Blood Suga	sician orders indicated, " ar (FBS) every month; Basic MP) every six months: March					
	indicated that BMP	nt #10's laboratory reports was not done in March 2006 one in April 2006 as ordered					
		view was conducted with the lanager on May 19, 2006 at 10					
ORM CMS-25	67(02-99) Previous Versions	Obsolete Event ID: D95S1	1 Fi	acility I	D: WASHNURS	ontinuation sheet I	

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

PRINTED: 06/15/2006 FORM APPROVED _OMB_NO. 0938-0391_

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	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					(X3) DATE SURVEY COMPLETED	
	•	·	A. BU	LDIN	G		
		095022	B. Wil	₩G		05/1	9/2006
	Rovider or supplier			2	REET ADDRESS, CITY, STATE, ZIP CODE 425 25TH STREET SE VASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETION DATE
F 309	company and said that the BMP was of evidence that the F The record was rev 7. Facility staff faile value for a Hemogl physician's orders fa and Ted stockings A. A review Reside laboratory report fo April 13, 2006, "Ca for procedure." The record that the Hem repeated. A face-to-face inter was conducted on she acknowledged repeated. The reco 2006. B. Physician's orde 11, 2006 directed, ' bilaterally when in the right foot/ankle/leg The resident was on 2006 at 7:40 AM. A removed the bed co The resident was n Additionally, the CN wore socks daily ar CNA searched the	ecked with the laboratory that there was no evidence lone in March 2006 and no BS was done in April 2006. riewed May 15, 2006. d to follow-up on a laboratory obin A1C and follow for the use of heel protectors	F	309			

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CENTER	RS FOR MEDICARE	AND HUMAN SERVICES	- <u>1</u> -	<u> </u>		FORM OMB NO.	06/15/2006 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IULTIP	CONSTRUCTION	(X3) DATE SU COMPLE	
		095022					9/2006
	Rovider or supplier	CILITY		24	EET ADDRESS, CITY, STATE, ZIP CODE 25 25TH STREET SE ASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE [BE CROSS-	(X5) COMPLETION DATE
F 309	Continued From pa	age 56	F	309			
	:10 PM, May 16, 20 2006 at 1:15 PM si	observed on May 15, 2006 at 2 006 at 10:45 AM and May 17, tting in a wheel chair wearing was reviewed May 17, 2006.					
	8. Facility staff faile orders for Resident	d to clarify sliding scale insulin S5.					
	monitoring meter c	anufacturer's for the blood glucose urrently used by the facility, a " e meter indicates blood					- -
· ·	physician's order d	nt S5's record revealed a ated May 2, 2006, directing, "(-650 give 14 units (of insulin) call MD."	·				
	blood glucose over	cose meter registers "Hi" for 600, facility staff would be e if the blood glucose level was					
	charge nurse on M she stated, "I neve because [Resident	view was conducted with the ay 19, 2006 at 2:30 PM. He/ r really looked at the order S5's] blood glucose never was cord was reviewed May 19,					
	9. Facility staff faile orders for Resident	ed to clarify sliding scale insulin S6.					
	physician's order da	nt S6's record revealed a ated April 11, 2006, directing, 1-650 give 8 units (of insulin)					

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	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA PLAN OF CORRECTION IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION	(X3) DATE SI COMPLE	
			A. BUILDI	NG		
		095022	B. WING		05/1	9/2006
	ROVIDER OR SUPPLIER	CILITY		REET ADDRESS, CITY, STATE, ZIP COD 2425 25TH STREET SE	E	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	WASHINGTON, DC 20020 PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SHOI REFERENCED TO THE APPROPRIA	JLD BE CROSS-	(X5) COMPLETIO DATE
F 309	Continued From pa		F 309			
		give 10 unitsif greater than	1 30.			
	Since the blood glublood glublood glucose over	ucose meter registers "Hi" for r 600, facility staff would be re if the blood glucose level was				
	charge nurse on <i>N</i> Residents S6, S7 a The charge nurse of the sliding scale The [blood glucose 600. I would call th that. There is no w glucose is if it is ab	rview was conducted with the lay 19, 2006 at 2:45 PM. and S8 resided on this unit. was asked if he/she was aware insulin order. He/she stated, " e] meter registers " Hi " above he doctor if I got a reading like ay to tell how high the blood bove 600. 1' ve never had a ed " Hi. " The record was 2006				
,	10. Facility staff fai insulin orders for R	led to clarify sliding scale resident S7 .				
	physician's order d	nt S7's record revealed a ated April 11, 2006, directing, 51-650 give 10 units (of insulin MD."				
	blood glucose over unable to determin	acose meter registers "Hi" for 600, facility staff would be e if the blood glucose level was ord was reviewed May 19,				
	11. Facility staff fai insulin orders for R	led to clarify sliding scale				

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	06/15/2006 APPROVED
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU			(X3) DATE SI COMPLE	
		095022	B. WI	NG _	· · · · · · · · · · · · · · · · · · ·	05/1	9/2006
	ROVIDER OR SUPPLIER	ILITY		2	REET ADDRESS, CITY, STATE, ZIP CODE 2425 25TH STREET SE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	ТХ	VASHINGTON, DC 20020 PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETION DATE
F 309	Continued From par physician's order da " (blood glucose) 55)551 - 750 give 12 750. " Since the blood glu- blood glucose over unable to determine over 750. The record was rev 12. Facility staff fail injectable Ativan for A review of Resider physician's order da 1 mg po (orally) or I hrs PRN (as neede There was no evide attempted to clarify the injectable form A face-to-face inter charge nurse on Ma surveyor asked whe would be used. The resident is very agit we would give him 1 reviewed May 19, 2	ge 58 ated March 14, 2006, directing, 51-650 give 10 units (of insulin unitsCall MD if greater than cose meter registers "Hi" for 600, facility staff would be e if the blood glucose level was iewed May 19, 2006. ed to clarify the use of oral or r Resident S9. ht S9's record revealed a ated March 14, 2006, "Ativan M (intramuscularly) every 4 d) for anxiety." ence that facility staff when to use the oral form or of the Ativan. view was conducted with the ay 19, 2006 at 11:30 PM. The en each form of the Ativan e charge nurse stated, "If the ated and won ' t take the pill, the injection. "The record was 006. led to obtain a monthly INR (alized Ratio) to measure blood		309			
	A review of Resider initial physician 's c	nt S11's record revealed an order dated January 5, 2006 ruary 7 and April 4, 2006				·	

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		I AND HUMAN SERVICES				FORM	06/15/2006 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
:		095022	B. WI	۱Ġ	<u> </u>	05/1	9/2006
	ROVIDER OR SUPPLIER	ILITY	•	2	REET ADDRESS, CITY, STATE, ZIP CODE 2425 25TH STREET SE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IL	VASHINGTON, DC 20020 PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETION DATE
F 309	Continued From pa	-	F	309			
	mouth every evenir	in (Coumadin) 7.5mg 1 tab by ng. "					
	The most recent IN January 13, 2006.	R laboratory value was dated			· · · · · · · · · · · · · · · · · · ·		
	According to the, "Long Term Care Pharmacy Policy and Procedure Manual, "Policy #7.1 " Laboratory Monitoring of Drug Therapy", effective date august 1, 2002, page 6, "11. INR or assessment of clotting function monthly, if on Warfarin (Coumadin), Dicumarol."				•		
	charge nurse on Ma she acknowledged	view was conducted with the ay 19, 2006 at 11:15 AM. He/ that the INR was not obtained The record was reviewed					
		ed to obtain an INR as sician for Resident S12.					
	initial physician 's o and re-ordered Mar	nt S12's record revealed an order dated January 7, 2006 rch 14, 2006 directing, " n) 2.5mg 1 tab by mouth every			· ·		
		dated March 14, 2006 every other week - DVT (deep					
	The most recent PT dated March 16, 20	Γ/INR laboratory value was 06.					
	charge nurse on Ma	view was conducted with the ay 19, 2006 at 11:30 AM. He/ that the PT/INR was not					

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	MENT OF HEALTH									FORM	06/15/2006 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SI IDENTIFICATI	UPPLIER/CLIA		IULTIP	PLE CONSTRUC			_	(X3) DATE SURVEY COMPLETED	
		09	5022	B. WI	NG					05/1	9/2006
	ROVIDER OR SUPPLIER	ILITY			_ 24	EET ADDRESS	EET SE	·	CODE		
						ASHINGTON				<u> </u>	
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L	• · · · · ·	DED BY FULL	ID PREF TAG		(EACH COR REFERENCE	RECTIVE	E ACTION		BE CROSS-	(X5) COMPLETION DATE
F 309	Continued From pa	ge 60		F	309						
	obtained after Marc reviewed May 19, 2		ecord was								
	15. Facility staff fail 13 kept a follow-up										•
	According to the Re was diagnosed with the distal tibia on M sent to the emerger soft cast. A follow- orthopedic physicia 2006 at 8:30 AM.	a nondisplace ay 15, 2006. Th ncy room and roup appointment	d fracture of he resident was eturned with a t with the					·			-
	An observation was at 6:30 AM. A trans confirm Resident S The night charge nu answering the phon 9:00 AM or 10:00 A transportation comp picked-up two (2) h	sportation comp 13's pick-up tim urse told the en le that the appo M. The employ pany that the re	bany called to the of 8:00 AM. Inployee bintment was at yee told the sident could be							- - -	
	At 7:15 AM, the day documents from Re for the appointment The surveyor obser resident was in bed sleeping. The surve clinical manager (At to have breakfast a medications prior to ACC called the diet tray and the day cha physician for an ord medications, sched administered at 8:00	esident S13's is to the orthoped ved at 7:18 AM , dressed in nig eyor asked the CC) if the resid nd receive the leaving at 8:00 ary department arge nurse called ler to receive the uled for 10:00 A	record to copy dic physician. I that the ght clothes and assistant ent was going morning D AM. The for an early ed the ie morning								
EORM CMS-25	67(02-99) Previous Versions		Event ID: D95S11	E): WASHNURS			16		Page 61 of 96

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		AND HUMAN SERVICES				FORM	06/15/2006 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	iultip Lding	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		095022	B. WI	1G	· .	05/1	9/2006
	ROVIDER OR SUPPLIER			24	EET ADDRESS, CITY, STATE, ZIP CODE 125 25TH STREET SE 1ASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ıx	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE	BE CROSS-	(X5) COMPLETION DATE
F 309	Continued From para Posted on the count a listing of resident 2006. Resident S1 AM. At 8:00 AM the trans transport the reside bed clothes and ha transportation comp was cancelled. The taken off a day from The ACC called the tried to re-schedule day. The transport accommodate the re- another transport contacted. The unit transportation comp The appointment has following week. Facility staff failed to a scheduled appoint physician. The rec 2006.	age 61 there of the nurse's station was appointment times for May 19, 3's appointment time was 8:30 asportation company arrived to ent. The resident was still in d not eaten breakfast. The pany left and the appointment e resident's daughter had in work to be with the resident. e transportation company and e a pick-up time for later in the ation company was unable to request. The surveyor asked if ion company could be it secretary stated that panies require 24 hours notice. ad to be rescheduled for the to ensure that the resident kept intment with the orthopedic ord was reviewed May 19, sident W1's record revealed ed to ensure that a PSA level		309			
	May 9, 2006 at 3:40	Form included an order dated OPM which included: "(2) cific Antigen) (3) Repeat U/A (
		k included a laboratory slip for I May 11, 2006 with the tests					
FORM CMS-25	67(02-99) Previous Versions	Obsolete Event ID: D95S11	Fa	cility IE	D: WASHNURS If contin	nuation sheet I	Page 62 of 96

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	06/15/2006 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		095022	B. WING 05/19/20					
·	ROVIDER OR SUPPLIER GTON NURSING FAC	ILITY		24	EET ADDRESS, CITY, STATE, ZIP CODE 425 25TH STREET SE /ASHINGTON, DC 20020		· · ·	
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEEDED BY FULL		ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETION DATE	
F 309	not signed [indicatin drawn] by the labor no reason on the la blood was not draw A face-to-face inter Assistant Director of approximately 1:35	ked. The laboratory slip was ng that the blood was not atory technician. There was boratory slip as to why the n. view was conducted with the of Nursing on May 17, 2006 at PM. He/She acknowledged	F	309				
	The record was rev 17. A review of Res that facility staff fail Albumin levels were The Interim Order I	was not performed. iewed on May 17, 2006. sident W2's record revealed ed to ensure that Dilantin and e drawn. Form included an order dated 30 AM which included: "						
	Dilantin and Album 06)". The record di Dilantin and Album A face-to-face inter Assistant Director of approximately 1:35 called and indicated blood drawn for Re	in level in one week (Due 5/12/ d not include results for in levels for May 2006. view was conducted with the of Nursing on May 17, 2006 at PM. The laboratory was d that there was no record of sident W1 on May 12, 2006. iewed on May 17, 2006.						
	that facility staff fail and INR levels were order. The Physician Orde Care dated March 2	ident W4's record revealed ed to ensure that weekly PT e drawn as per physician's er Sheet and interim Plan of 2, 2006 included the following (every) week secondary to						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED 095022 B. WING 05/19/2006 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2425 25TH STREET SE WASHINGTON, DC 20020 05/19/2006 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)			AND HUMAN SERVICES				FORM	06/15/2006 APPROVED 0938-0391	
NAME OF PROVIDER OR SUPPLIER OS/19/2006 WASHINGTON NURSING FACILITY STREET ADDRESS, CITY, STATE, 2/P CODE 2425 237H STREET SE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL TAG DEPEND (EACH DEFICIENCY MUST BE PRECEEDED BY FULL TAG PREFIX (EACH DEFICIENCY (EACH DEFICIENCY MUST BE PRECEEDED BY FULL TAG PREFIX (EACH DEFICIENCY (EACH DEFICIENCY TAG (EACH DEFICIENCY TAG (EACH DEFICIENCY TAG (EACH DEFICIENCY TAG (EACH DEFICIENCY TAG (EACH DEFICIENCY MUST EACH DATE) (EACH DEFICIENCY TAG (EACH DEFICIENCED AT (EACH DEFICIENCY TAG (EACH DEFICIENCY TAG (EACH DEFICIENCY TAG (EACH DEFICIENCED (EACH DEFICIENCED (EACH DATE) (EACH DATE) (EACH DATE) (EACH DATE) (EAC	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE SURVEY		
NME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE: WASHINGTON NURSING FACILITY VASHINGTON, DC 20020 (PATP) (BAUMARY STATEMENT OF DEFICIENCIES (RECOLATORY ON USST BE PREVEEDED BY FULL RECOLATORY ON USST BE PREVEEDED BY FULL PREVE TAC PREVE			095022	B. WI	NG_		05/19/2006		
CALL Description Provement Status Environment Description Provement Status Environment Constraint Constatis and is a for			ILITY		:	2425 25TH STREET SE	<u> </u>		
The Interim Order Form dated May 15, 2006 at 10:00 PW included: "7/0 (telephone order) PT/ INR for resident." The record included results for the PT/INR on April 3, 2006 - PT-31.6 and INR-3.0 and May 3, 2006 - PT - 16.9 and INR 1.34. The physician's progress note dated April 3, 2006 included the following: "Attending-Blood draw was done on the anterior aspect of the left ankle for PT/PTT, INR, CBC, CMP. Patient is a hard stick and we could not get blood from any other site peripherally. " The physician also had progress notes dated April 17 and 18, 2006. There were laboratory slips in the laboratory book for Resident W4 for PT/INRs to be drawn dated March 3, April 12, May 10 and May 15, 2006. The resident 's blood was not drawn on any of the aforementioned dates. A face-to-face interview was conducted with the clinical manager on May 17, 2006 at approximately 9:00 AM. He/She acknowledged that there were only two PT/INR levels drawn since the order. He/She stated that the staff and the physician were aware of the technician having difficulties drawing the labs. The PT/INR levels were not drawn weekly as ordered. The record was reviewed on May 17, 2006. 19. A review of Resident W5's record revealed that facility staff failed to clarify an order for sliding	PREFIX	(EACH DEFICIENCY	MUST BE PRECEEDED BY FULL	PREF	ı ıx	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD	BE CROSS-	COMPLETION	
 10:00 PM included: "T/O (telephone order) PT/ INR for resident." The record included results for the PT/INR on April 3, 2006 - PT -31.6 and INR -3.0 and May 3, 2006 - PT -16.9 and INR 1.34. The physician's progress note dated April 3, 2006 included the following: "Attending-Blood draw, was done on the anterior aspect of the left ankle for PT/PTT, INR, CBC, CMP. Patient is a hard stick and we could not get blood from any other site peripherally." The physician also had progress notes dated April 17 and 18, 2006. There were laboratory slips in the laboratory book for Resident W4 for PT/INRs to be drawn dated March 3, April 12, May 10 and May 15, 2006. The resident's blood was not drawn on any of the aforementioned dates. A face-to-face interview was conducted with the clinical manager on May 17, 2006 at approximately 9:00 AM. He/She acknowledged that there were only two PT/INR levels drawn since the order. He/She stated that the staff and the physician were aware of the technician having difficulties drawing the labs. The PT/INR levels were not drawn weekly as ordered. The record was reviewed on May 17, 2006. 19. A review of Resident W5's record revealed that facility staff failed to clarify an order for sliding 	F 309	Continued From pa	ge 63	F	309	9			
 April 3, 2006 - PT-31.6 and INR-3.0 and May 3, 2006 - PT - 16.9 and INR 1.34. The physician's progress note dated April 3, 2006 included the following: "Attending-Blood draw was done on the anterior aspect of the left ankle for PT/PTT, INR, CBC, CMP. Patient is a hard stick and we could not get blood from any other site peripherally." The physician also had progress notes dated April 17 and 18, 2006. There were laboratory slips in the laboratory book for Resident W4 for PT/INRs to be drawn dated March 3, April 12, May 10 and May 15, 2006. There were laboratory slips in the laboratory book for Resident W4 for PT/INRs to be drawn dated March 3, April 12, May 10 and May 15, 2006. The resident 's blood was not drawn on any of the aforementioned dates. A face-to-face interview was conducted with the clinical manager on May 17, 2006 at approximately 9:00 AM. He/She acknowledged that there were only two PT/INR levels drawn since the order. He/She stated that the staff and the physician were aware of the technician having difficulties drawing the labs. The PT/INR levels were not drawn weekly as ordered. The record was reviewed on May 17, 2006. 19. A review of Resident W5's record revealed that facility staff failed to clarify an order for sliding 		10:00 PM included:							
 included the following: "Attending-Blood draw, was done on the anterior aspect of the left ankle for PT/PTT, INR, CBC, CMP. Patient is a hard stick and we could not get blood from any other site peripherally." The physician also had progress notes dated April 17 and 18, 2006. There were laboratory slips in the laboratory book for Resident W4 for PT/INRs to be drawn dated March 3, April 12, May 10 and May 15, 2006. The resident 's blood was not drawn on any of the aforementioned dates. A face-to-face interview was conducted with the clinical manager on May 17, 2006 at approximately 9:00 AM. He/She acknowledged that there were only two PT/INR levels drawn since the order. He/She stated that the staff and the physician were aware of the technician having difficulties drawing the labs. The PT/INR levels were not drawn weekly as ordered. The record was reviewed on May 17, 2006. 19. A review of Resident W5's record revealed that facility staff failed to clarify an order for sliding 		April 3, 2006 - PT-3	1.6 and INR-3.0 and May 3,						
for Resident W4 for PT/INRs to be drawn dated March 3, April 12, May 10 and May 15, 2006. The resident ' s blood was not drawn on any of the aforementioned dates. A face-to-face interview was conducted with the clinical manager on May 17, 2006 at approximately 9:00 AM. He/She acknowledged that there were only two PT/INR levels drawn since the order. He/She stated that the staff and the physician were aware of the technician having difficulties drawing the labs. The PT/INR levels were not drawn weekly as ordered. The record was reviewed on May 17, 2006. 19. A review of Resident W5's record revealed that facility staff failed to clarify an order for sliding		included the followi was done on the ar for PT/PTT, INR, C stick and we could site peripherally. "	ng: "Attending-Blood draw Interior aspect of the left ankle BC, CMP. Patient is a hard not get blood from any other The physician also had						
clinical manager on May 17, 2006 at approximately 9:00 AM. He/She acknowledged that there were only two PT/INR levels drawn since the order. He/She stated that the staff and the physician were aware of the technician having difficulties drawing the labs. The PT/INR levels were not drawn weekly as ordered. The record was reviewed on May 17, 2006. 19. A review of Resident W5's record revealed that facility staff failed to clarify an order for sliding		for Resident W4 for March 3, April 12, M The resident 's blo	r PT/INRs to be drawn dated May 10 and May 15, 2006. od was not drawn on any of						
ordered. The record was reviewed on May 17, 2006. 19. A review of Resident W5's record revealed that facility staff failed to clarify an order for sliding		clinical manager on approximately 9:00 that there were only since the order. He the physician were	May 17, 2006 at AM. He/She acknowledged two PT/INR levels drawn e/She stated that the staff and aware of the technician having						
that facility staff failed to clarify an order for sliding		ordered.	-						
		that facility staff fail	ed to clarify an order for sliding				•		

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		AND HUMAN SERVICES	×			FORM	06/15/2006 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		095022	B. WI	1G		05/1	9/2006
	ROVIDER OR SUPPLIER	CILITY		2	REET ADDRESS, CITY, STATE, ZIP CODE 425 25TH STREET SE VASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETION DATE
F 309	The Physician Orde Care dated May 11 order: "Fingerstic times a day) with sl Regular Insulin - <6 o; 250-350-2 units; units; 551-650-8 un A face-to-face inter charge nurse on M She stated, "The g gives a reading of MD if it reads high." The May TAR (Tread did not include any higher.	er Sheet and Interim Plan of , 2006 included the following k blood sugar (BS) TID (three liding scale coverage with 50 - Facility protocol; 200-249- 351-450-4 units; 451-550-6 hits; If BS >651 Notify MD." view was conducted with the ay 18, 2006 at 7:00 AM. He/ lucometer goes up to 600 and "high" after that. We call the	F	309	 PRESSURE SORES # 24 1. The nurse who did the wound did but failed to sign the Transation Record (TAR counseled and educated. 2. An audit of the TARs was densure proper documentation. 3. Inservicing was done with the listaff to ensure their full understam signing each TAR upon completion order. The Clinical Managers will a their findings to the DON. 4. The Director of Nursing will a the monitoring. The results monitoring, along with any action for improvement, will be presented. 	done to icensed iding of n of the monitor d report oversee of this n plans d at the vement	7 2 06 7 2 06 1 2 06 6 70 06
F 314 SS=D	resident, the facility who enters the facility does not develop p individual's clinical they were unavoida pressure sores reco services to promote prevent new sores This REQUIREMEN Based on observati	prehensive assessment of a must ensure that a resident lity without pressure sores ressure sores unless the condition demonstrates that ible; and a resident having eives necessary treatment and a healing, prevent infection and	F	314			

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Facility ID: WASHNURS

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

PRINTED: 06/15/2006 FORM APPROVED OMB NO. 0938-0391

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		(X2) M A. BU		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		095022	B. WI	NG		05/1	9/2006
	Rovider or Supplier Gton Nursing Fac	ILITY		2	REET ADDRESS, CITY, STATE, ZIP CODE 425 25TH STREET SE VASHINGTON, DC 20020		
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEEDED BY FULL			IX G	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOUL REFERENCED TO THE APPROPRIATI	D BE CROSS-	(X5) COMPLETION DATE
F 314		ige 65 sility staff failed to administer according to physician orders.	F	314			
	The findings includ A review of Resider physician's orders t elbow wound, and shin every three (3) Treatment Adminis March 10, 13, 16, 1 identified as days t	e: nt #24's record revealed to treat the left hip wound, left two (2) wounds on the right days. According to the tration Record for March 2006, 9, 22, 25, 28 and 31 were ne wound treatments were to above cited dates had boxes					
	the wound treatment The boxes for the r the left elbow and to 2006 and all the wo	or the nurse to initial, indicating ints had been administered. nurse's initials were blank for both shin wounds for March 10, bunds for March 16, 2006 d treatments had not been					
	through March 17, resident was sent to March 13, 2006 at facility the same da	ses' notes from March 10 2006 revealed that the 5 the emergency room on 3:50 AM and returned to the 9 at 11:00 AM. On March 17, he resident was sent to the ed March 22, 2006.					
	wound treatments v 10 or 16, 2006. A face-to-face inter charge nurse on Ma	ence in the nurses' notes that were administered on March view was conducted with the ay 17, 2006 at 10:30 AM. The owledged that the above cited				<i>,</i> .	

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Event ID: D95S11 Facility ID: WASHNURS

ND PLAN OF		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU	LTIPLE CONSTRUCTION			
				(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		095022	B. WING		05/19/2006		
	OVIDER OR SUPPLIER	ILITY	s	STREET ADDRESS, CITY, STATE, ZIP CO 2425 25TH STREET SE		0.2000	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	WASHINGTON, DC 20020 PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION SHO REFERENCED TO THE APPROPRIA	ULD BE CROSS-	(X5) COMPLETION DATE	
t r v	treatments were no no explanation as to	ge 66 dicating that wound t administered. He/she had o why the wound treatments red. The record was reviewed	F 31	483.25 URINARY INCONTINENCE # 21 $\frac{2}{3}$			
SS=D I I I I I I I I I I I I I I I I I I I	483.25(d) URINARY INCONTINENCE Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.		F 315	 A review of the other catheters in the facility was done to ensure the proper positioning of the tubing. Inservicing was done with the nursing staff to ensure their understanding of the importance of the positioning of the catheter tubing. The Clinical Managers will monitor this issue throughout the month and report their findings to the DON. The Director of Nursing will oversee the monitoring. The results of this 		5/19/06 5/19/06 6/20/06	
F F F F F	Based on observati review for one (1) o determined that fac Foley catheter tubin urinary flow for Res The findings include Resident #21 was c 10 PM with the catl	· · · (monitoring, along with any action plans for improvement, will be presented at the quarterly Quality Improvement Committee, which is chaired by the Administrator.			

and a second and a second for the second particular and a second second second second particular second as

CENTER	RS FOR MEDICARE	AND HUMAN SERVICES			OMB NO.	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD		(X3) DATE SI COMPLE	
		095022	B. WING		05/19/2006	
	ROVIDER OR SUPPLIER	ILITY	s	TREET ADDRESS, CITY, STATE, ZIP CC 2425 25TH STREET SE WASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE ['] PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION SH REFERENCED TO THE APPROPRI	OULD BE CROSS-	(X5) COMPLET DATE
F 315	published by the Co Prevention, Februa	ige 67 enters for Disease Control and ry, 1981, under,"8. Urinary bags should always be kept	F 31	5		
F 240	clinical manager at He/she stated that positioned incorrec assigned Certified I tubing so the urine	view was conducted with the the time of the observation. the catheter tubing was tly and called the resident's Nursing Aide to re-position the would flow downward.	F 31	483.25 RANGE OF MOTION #8 1. The record of this resident we for contracture manager adjustments made as needed. 2. All residents are screened of the rehab department as a wa	as reviewed nent and quarterly by	1 2 0 1 2 0 1 2 0
F 318 SS=D	483.25(e)(2) RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.		F 31	 that their rehabilitative needs 3. The Clinical Managers will r issue throughout the month their findings to the DON. 4. The Director of Nursing with monitoring, along with any a for improvement, will be prese quarterly Quality In Committee, which is chain 	monitor this and report will oversee lts of this action plans ented at the approvement	6/30/
	: Based on observati review for one (1) o determined that fac	NT is not met as evidenced by on, interview and record if 30 sampled residents, it was illity staff failed to follow up on f a contracture. Resident #8.		Administrator.	,	
	A review of Resider physical therapist ir management for th on January 20, 200	e. ht #8's record revealed that the hitiated joint contracture e bilateral knee contractures 6. The resident was issued es and prescribed range of				

	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO. (X3) DATE SL	
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	•	COMPLE	
		095022	B. WING	·	05/19/2006	
NAME OF P	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
WASHIN	GTON NURSING FAC	CILITY		2425 25TH STREET SE NASHINGTON, DC 20020		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	ION	(X5
PRÉFIX TAG		MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD E REFERENCED TO THE APPROPRIATE DE		COMPLE DAT
F 318	Continued From pa	ige 68	F 318			
	discharged the resi					
	rehabilitation (rehal 2006.	b) program on February 3,				
		nerapist treated the resident hrough March 20, 2006 for ers and contracture				
	According to the "	Nursing Rehab Treatment ent received range of motion		483.25(h)(1)	٢	
		e splints applied from February		ACCIDENTS 1. The issues found at the time o survey (light covers, OTC meds		5/19/
	rehabilitation/restor May 16, 2006 at 1:	view with the nursing rative aide was conducted on 15 PM. He/she stated that the tinued because the resident hem.		inappropriate storage of detergent bleach, running water, damaged floor long phone cord) were all corrected discovery.	tiles, upon	
	There was no evide	ence in the record that either		2. The Maintenance Aides reviewe the rooms through use of their PM p list to ensure that accident prevention	unch	6/20
	therapist re-evalua	ist or the occupational ted the resident for additional ontracture management. The ed May 16, 2006.		given the utmost priority. 3. The Maintenance Supervisor monitor this issue throughout the m and report their findings to the Direct	will Nonth	10000 1 6. [3]
F 323 SS=E		DENTS	F 323	Maintenance. 4. The Director of Maintenance oversee the monitoring. The results o	will f this	
	environment remai as is possible.	nsure that the resident ns as free of accident hazards		monitoring, along with any action p for improvement, will be presented a quarterly Quality Improve Committee, which is chaired by Administrator.	ment	6/30
	:	NT is not met as evidenced by				
	Based on observat	ions during the survey period,				

If continuation sheet Page 69 of 96

TATEMEN	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MULTIPLE CONSTRUCTION			FORM APPROVE OMB NO. 0938-039 (X3) DATE SURVEY	
ND PLAN C	of correction	IDENTIFICATION NUMBER:	A. BUI	ildin	IG	COMPLI	ETED
		095022	B, WI	NG_		05/1	9/2006
AME OF P	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE		
VASHIN	GTON NURSING FAC	ILITY			425 25TH STREET SE VASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE	BE CROSS-	(X5) COMPLETIO DATE
F 318	Continued From pa	ge 68	FЗ	318			
	discharged the resid	The physical therapist dent to the nursing a) program on February 3,					·
-		erapist treated the resident rough March 20, 2006 for s and contracture				•	
· .	Record " the reside	Nursing Rehab Treatment ent received range of motion splints applied from February 22, 2006.			483.25(h)(1) ACCIDENTS 1. The issues found at the time survey (light covers, OTC meds		5/19/06
	rehabilitation/restora May 16, 2006 at 1:1	view with the nursing ative aide was conducted on 5 PM. He/she stated that the inued because the resident em.			inappropriate storage of deterger bleach, running water, damaged floo long phone cord) were all corrected discovery.	r tiles, I upon	5/19/14
	the physical therapis therapist re-evaluate	nce in the record that either st or the occupational ed the resident for additional stracture management. The May 16, 2006.	-		 The Maintenance Aides review the rooms through use of their PM list to ensure that accident prevention given the utmost priority. The Maintenance Supervisor monitor this issue throughout the and report their findings to the Direct 	punch on was will	6 m0/06
F 323	483.25(h)(1) ACCID	ENTS	F 3	23	Maintenance. 4. The Director of Maintenance	M Punch , will 1.45	6 90 / 01
SS=E	The facility must ensure that the resident environment remains as free of accident hazards as is possible.				oversee the monitoring. The results monitoring, along with any action for improvement, will be presented quarterly Quality Improv Committee, which is chaired by	plans 7 70 at the ement	
	This REQUIREMEN	T is not met as evidenced by			Administrator.		

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		AND HUMAN SERVICES				FORM	: 06/15/2006 APPROVED . 0938-0391	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		PLE CONSTRUCTION G	(X3) DATE S COMPLI		
		095022	B. WI	B. WING 05				
	ROVIDER OR SUPPLIER	ILITY		24	REET ADDRESS, CITY, STATE, ZIP 425 25TH STREET SE VASHINGTON, DC 20020			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	ix i	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTION REFERENCED TO THE APPRO	SHOULD BE CROSS-	(X5) COMPLETION DATE	
F 323	Continued From partial was determined to provide safety from evidenced by: a broch alcohol and antibiolowindowsill, toilets in detergent and blead water running in the damaged floor tiles cord in ambulatory unsecured frontal construction of the partial of the p	inge 69 hat facility staff failed to environmental hazards as oken night light cover, isopropyl tic ointment located on a ot secured to the floor, ch stored in an open area, e shower room unattended, in the bathroom, a long phone areas, and overbed lamps with covers. These observations resence of the Directors of lousekeeping and/or nursing		323				
	was observed in the 1006 at 2:10 PM.	the shower room unattended e 3 South tub room on May 18,						
		les in the 1 South dining room			·			
FORM CMS-25	567(02-99) Previous Versions	Obsolete Event ID: D95S11	Fa	acility I	D: WASHNURS	If continuation sheet	Page 70 of 96	

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		AND HUMAN SERVICES				FORM	06/15/2006 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. Bui			(X3) DATE S COMPLE	URVEY
		095022	B. WING			05/19/2006	
NAME OF P	ROVIDER OR SUPPLIER	·			REET ADDRESS, CITY, STATE, ZIP CODE		
WASHIN	GTON NURSING FAC	ILITY			425 25TH STREET SE VASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ı tx	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETION DATE
F 324	 observed during the 7. A long phone constructed across are on May 17, 2006 at 8. Overbed lamps wave in the following 1 North rooms: 125 10 observations on to 1:30 PM. 1 South room 160 is observations on Mage 2 North rooms: 209 observations on Mage 2:30 PM. 3 North room 313 is 	lorth pantry area were e survey period. In a residents's room mbulating areas in room 146 10:12 AM: with unsecured frontal covers g areas: (139 and 154 in three (3) of May 15, 2006 from 11:20 AM in one (1) of six (6) ay 17, 2006 at 2:00 PM. (231, 253 in three (3) of 10 ay 17, 2006 from 11:33 AM to in one (1) of five (5) ay 18, 2006 at 1:20 AM.		323	ACCIDENTS Residents S1, S2 and S3 1. The safety devices (mats and alarm) found not in use at the time survey were immediately implem upon discovery. 2. Other residents with similar devices were checked to ensure everything was in use and in place. 3. Inservicing was done with the n staff to ensure their con understanding of the use of safety d such as fall mats and chair alarms Clinical Managers will monitor this throughout the month and report findings to the DON. 4. The Director of Nursing will of the monitoring. The results of monitoring, along with any action for improvement, will be presented quarterly Quality Improv Committee, which is chaired to Administrator.	of the nented safety that ursing nplete evices The s issue t their versee of this n plans a the verset	5 19 06 5 19 06 6 30 04 6 30 04
SS=D	The facility must en	sure that each resident supervision and assistance					
	: Based on observati it was determined the adequately supervise	NT is not met as evidenced by ons during the survey period, hat facility staff failed to se residents as evidenced by: th bedside mats not in place					
FORM CMS-25	67(02-99) Previous Versions	Obsolete Event ID: D95S11	Fa		ID: WASHNURS If contin	uation sheet	 Page 71 of 96

If continuation sheet Page 71 of 96

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

PRINTED: 06/15/2006 FORM APPROVED OMB NO. 0938-0391

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ;	(X2) MULT A. BUILDII	IPLE CONSTRUCTION	(X3) DATE S COMPLE	
		095022	B. WING _		05/1	9/2006
	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CC 2425 25TH STREET SE WASHINGTON, DC 20020	DDE	· ·
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION SHO REFERENCED TO THE APPROPR	OULD BE CROSS-	(X5) COMPLETION DATE
F 324	resident with the ch observations were nursing staff. Resi The findings includ 1. On May 15, 200 observed lying his/ position with the be against the wall. T the bedside mat or stated that the resi without assistance assistance. The be	were in bed and one (1) nair alarm unconnected. These made in the presence of the dents S1, S2 and S3.	F 324			
	Resident S2's room After knocking, the the room. Resident the high position. and at the head of immediately lowere bedside mat on the nurse stated that R on the bedside mat bed without assista 3. On May 19, 2000 observed in a whee towards the nurse's present on the bac was not connected immediately conne and stated that the	ed the bed and placed the floor next to the bed. The lesident S2 is frequently found t after attempting to get out of				

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

Event ID: D95S11 Facility ID: WASHNURS

If continuation sheet Page 72 of 96

		AND HUMAN SERVICES				FORM	06/15/200 APPROVEI 0938-039
TATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE S COMPLE	URVEY
		095022	B. WING			05/19/2006	
NAME OF F			STREET ADDRESS, CITY, STATE, ZIP CODE				
WASHIN	GTON NURSING FAC		2425 25TH STREET SE WASHINGTON, DC 20020				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOULI REFERENCED TO THE APPROPRIATE	D BE CROSS-	(X5) COMPLETION DATE
F 325 SS=D	 483.25(i)(1) NUTRITION Based on a resident's comprehensive assessment, the facility must ensure that a resident maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible. This REQUIREMENT is not met as evidenced by : Based on record review and staff interviews for three (3) of 30 sampled residents, the dietician/ nutritionist failed to follow up on residents with weight loss. Residents #8, 9 and 16. 			325	 483.25(I)(1) NUTRITION Residents #8, 9, and 16 Residents found at the time of the survey to have issues with weight loss were reviewed by the dietician and changes to the diet orders made as necessary. The dieticians, in cooperation with the Clinical Managers, are performing a 100% audit of all residents' weights to ensure that their needs are being addressed. The dieticians and Clinical Managers will monitor this issue throughout the month and report their findings to the DON and the Director of Nutritional Services. 		
	1. A review of Residuation the dietitian failed to continued weight lo	The findings include: I. A review of Resident #8's record revealed that he dietitian failed to follow up on the resident's continued weight loss.			monitoring. The results of monitoring, along with any actio for improvement, will be presente quarterly Quality Impro Committee, which is chaired Administrator.	n plans d at the ovement	6/20/04
	residents's weights	ital Sign Flow Sheet" the were as follows: (pounds)			· · ·		
	March 8, 2006, "Re % weight loss since is significant and ur totally dependent of hydration' received 200 ml H2O (water)	etary progress notes dated sident has experienced a 9.22 e 1/06 (103#). This weight loss precommendedResident is n G-tube for nutrition and Jevity 1.5, 1 can 5 x daily with o flush after each can. This eWill continue to monitor and			· · · · ·		

		I AND HUMAN SERVICES				FORM	06/15/2006 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SU COMPLE	
	· . ·	095022	B WING			05/19/2006	
	ROVIDER OR SUPPLIER			2	REET ADDRESS, CITY, STATE, ZIP CODE 425 25TH STREET SE VASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IL	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE I	BE CROSS-	(X5) COMPLETION DATE
F 325		as needed)." gress notes by the dietician	F	325			
	after March 8, 2006. There was no evidence that the dietician monitored the resident's weight for March or April 2006. A face-to-face interview was conducted with the dietician on May 16, 2006 at 1:00 PM. The dietician stated, "I don't review every resident's weight every month. I only review the weights if nursing notifies me that there is a problem. I						
	don't have a list of r weight loss." The r 2006. 2. A review of Resid	residents that have continued ecord was reviewed May 16, dent #9's record revealed that follow up on the resident with					
	following weights: Date Weight 1/11/06 131 2/14/06 123.5 3/13/06 131 4/6/06 4/14/06 117	w Sheet included the t 121 13				•	
	13, 2006 included t Weight History: Th decrease in 1 year Comments/Action I 240 cc BID (two tim	nal assessment dated March he following: "Weight: 123. here has been a 7# (pound) not significant. Additional Plan: Suggest Ensure Plus hes a day) secondary to There were no other nutritional					

Facility ID: WASHNURS

If continuation sheet Page 74 of 96

STATEMENT	CENTERS FOR MEDICARE & MEDICAID SERVICES ratement of deficiencies ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			FORM APPROV OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED		
		095022	B. WIN		·	05/19/2006		
	ROVIDER OR SUPPLIER	ILITY		2	REET ADDRESS, CITY, STATE, ZIP CODE 425 25TH STREET SE VASHINGTON, DC 20020			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE	DBE CROSS-	(X5) COMPLETION DATE	
F 325	clinical manager or	record. view was conducted with the May 15, 2006 at 3:12 PM. He	F	325	· · ·			
• •	the recommendation the Director of Nurse and give it back to a was no evidence in followed up on the	ietician puts it [action plan] on on sheet and gives a copy to sing and to us. We follow up dietician/nutritionist]." There the record that facility staff suggestion from the dietician was no order for Ensure in the						
	nutritionist on May stated, "He/She w December 2005. T significant. I didn '	view was conducted with the 15, 2006 at 4:45 PM. He/She as getting ½ sandwich since he weight, 7 pounds is not t know anything [continuing he annual assessment. I don't ody's weights."	:					
	weight loss and foll	r Ensure. The record was						
	maintained an acce	d to ensure that Resident #16 ptable body weight.						
	he/she was admitte , 2004. He/she weig	ent #16's record indicated that ed to the facility on December 3 ghed 188.5 pounds according cord for December 2004.						
		ual nutritional assessment per 29, 2005 indicated that 87.5 pounds.				·		

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

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Event ID: D95S11 Facility ID: WASHNURS

If continuation sheet Page 75 of 96

	PRINTED: 06/15/2006 FORM APPROVED OMB NO. 0938-0391
(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED
B WING	

05/19/2006

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER

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- - ----

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

095022

 B. WIN	NG
	STREET ADDRESS, CITY, STATE, ZIP CODE 2425 25TH STREET SE
	WASHINGTON, DC 20020

.....

WASHIN	GTON NURSING FACILITY		WASHINGTON, DC 20020					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS- REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE				
F 325	Continued From page 75	F 325	5					
F 323	A review of the vital signs flow sheet indicated the following weights: Date Weight (pounds) 5/05 192 6/05 195 7/05 190 8/05 192 9/05 188.2 10/05 190 11/05 187.5 12/05 189 1/06 168.2 2/06 168 3/06 190 4/06 186 5/06 192 A review of a dietary progress note dated February 21, 2006 indicated, "Weight: 168.2, this weight for January is questionable, secondary to weight history of in the 180 's. If this weight is correct a 12.39 % weight loss occurred in 180 days review. This weight change is significant and unrecommended in its severity. No new labs available for nutritional assessment. Diet remains mechanical soft, no added salt, appropriate and well tolerated mouth in take of 100%." The resident had a significant weight loss in January. There was no evidence in the record that a reweight was done. There were no dietary interventions initiated to address the weight loss A face-to-face interview was conducted with the dietician on May 16, 2006 at 12:50 PM. He/she acknowledged that Resident #16 lost a							

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

Facility ID: WASHNURS

If continuation sheet Page 76 of 96

	F OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLE C LDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		095022	B. WIN	IG		05/1	9/2006
AME OF P	ROVIDER OR SUPPLIER	<u> </u>		STREET	ADDRESS, CITY, STATE, ZIP CODI		5/2000
WASHIN	GTON NURSING FAC	ILITY			5TH STREET SE HINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORR ACH CORRECTIVE ACTION SHOU FERENCED TO THE APPROPRIAT	LD BE CROSS-	(X5) COMPLETIO DATE
F 325		ge 76 e record was reviewed May 16,	F 3	UN 1. writ adju	.25(I)(1) NECESSARY DRUGS A request for a psych con iten at the time of the sur istments made as recommend	sult was vey and ed.	6/19/06
F 329 SS=D	unnecessary drugs drug when used in duplicate therapy); without adequate m indications for its us adverse consequer should be reduced combinations of the This REQUIREMEN Based on observati interview for one (1 was determined that psychiatric consult of	g regimen must be free from An unnecessary drug is any excessive dose (including or for excessive duration; or nonitoring; or without adequate se; or in the presence of neces which indicate the dose or discontinued; or any	F 3	wer psyd doe 3. Phy Mai moi and Me 4. the moi for qua Cor	Medication reviews by the psy e audited to ensure all resis ch-active drugs are receiving the s necessary. This issue will be discussed visician Services Meeting. The magers and Consultant Pharmanitor this issue throughout the report their findings to the I dical Director. The Director of Nursing will monitoring. The results nitoring, along with any action improvement, will be present interly Quality Import numittee, which is chaired ministrator.	dents on he lowest clinical acist will he month DON and loversee of this on plans ed at the rovement	6 19/06 9 2/06 6/30/06 1119/06
	he/she was admitte 2005. Physician ord indicated, "Risperd bed-time for psycho consult in the record the chart to indicate attempted between	e: ht #13's record revealed that d to the facility on April 21, lers dated October 25, 2005 al 0.5 mg 1 tablet by mouth at osis." There was no psychiatry d. There was no evidence in that a dose reduction was October 2005 and May 2006. view was conducted with the					

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		AND HUMAN SERVICES				FORM	06/15/2006 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUII		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		095022	B. WIN	G		05/19/2006	
	ROVIDER OR SUPPLIER	ILITY		24	EET ADDRESS, CITY, STATE, ZIP CODE 125 25TH STREET SE /ASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETION DATE
F 329	Charge Nurse on M she stated that he/s	ige 77 lay 19, 2006 at 10:00 AM. He/ she was not sure that it [dose e. The record was reviewed	F 3	:29	483.35(I)(2) SANITARY CONDITIONS - F PREP & SERVICE Floor Surfaces, Ceiling tiles, Ice Ma Meat Slicer, Garbage Disposal, Par Muffin pans 1. All issues found at the time	chine, ns and of the	6/30/000
F 371 SS=E	PREP & SÉRVICE	ARY CONDITIONS - FOOD ore, prepare, distribute, and anitary conditions.	F 3	571	 survey have been addressed and corn 2. Sanitation surveys of the entire k are done on a routine basis b Nutritional Services Staff to ensu going compliance. 3. The Nutritional Services Super will monitor the kitchen sanitation throughout the month and report findings to the Director of Nutr 	itchen y the re on- visors issues t their	6 30 06 6 30 06
	: Based on observati it was determined t maintain dietary ser manner as evidenc surfaces; soiled cei ice machine and m disposal unit failed muffin pans were s	NT is not met as evidenced by ions during the survey period, hat facility staff failed to rvices in a safe and sanitary ed by: damaged floor ling tiles, inner surfaces of the eat slicer; water to the to shut off; and hotel and tored wet. These observations resence of the Director of	·		Services. 4. The Director of Nutritional Se will oversee the monitoring. The res this monitoring, along with any plans for improvement, will be pre at the quarterly Quality Improv Committee, which is chaired be Administrator.	sults of action sented gement	6/30/06
	The findings include: 1. Floor surfaces were damaged and in disrepair in the cart wash room, nourishment room, walk in freezer and refrigerator, chemical room, tilt skillet area, and under the steam table in seven (7) of seven (7) observations between 8:45 AM and 4: 30 PM on May 15, 2006. 2. Ceiling tiles over the food preparation area and						
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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		LE CONSTRUCTION	(X3) DATE SI COMPLE	
·		095022	B. WIN	IG	· · .	05/1	9/2006
	ROVIDER OR SUPPLIER	ILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 2425 25TH STREET SE WASHINGTON, DC 20020				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION SH REFERENCED TO THE APPROPR	IOULD BE CROSS-	(X5) COMPLETIO DATE
F 371		soiled with food spillage and vo (2) observations between 8:	F 3	371	·		
	soiled with accumu other products in or	aces of the ice machine were lated mineral deposits and ne (1) of one (1) observations nd 4:30 PM on May 15, 2006.					
	was not thoroughly evidenced by partic machine in one (1)	tting areas of the meat slicer cleaned after being used as les of leftover meats on the of one (1) observation nd 4:30 PM on May 15, 2006.					
	and pan wash area had been turned of	to the disposal unit in the pot failed to shut off after the unit f in one (1) of one (1) n 8:45 AM and 4:30 PM on					
	wet and not allowed racks for reuse in fi	otel pans (12"x10"x6") were I to dry before placing pans on ve (5) of five (5) observations nd 4:30 PM on May 15, 2006.					
	preparation area we placing pans on rac	ed on a rack in the cook's ere not allowed to dry before ks for reuse in 12 of 12 en 8:45 AM and 4:30 PM on					
		· .			·		

		AND HUMAN SERVICES			·	FORM	06/15/2006 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		095022	B. WIN	IG		05/1	9/2006
NAME OF P	ROVIDER OR SUPPLIER	<u> </u>		STR	EET ADDRESS, CITY, STATE, ZIP CODE		
WASHIN	GTON NURSING FAC	LITY			425 25TH STREET SE		
	· ·			N	VASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETION DATE
F 386 SS=D	program of care, in treatments, at each of this section; write notes at each visit; with the exception of polysaccharide vac administered per pl policy after an asse This REQUIREMEN Based on observati 4) of 30 sampled re monitor anticoagula telephone call from bleed for one (1) re plan of care as evic in the progress note experienced weight 17, and 21. The findings include 1. The physician fai Resident #29 who with an elevated PT respond to a teleph report that the reside A. Resident #29 wa March 22, 2006. Th " Warfarin Sodium" PO daily blood thin Labs: CBC every 6 blood sugar month	t review the resident's total cluding medications and visit required by paragraph (c) e, sign, and date progress and sign and date all orders of influenza and pneumococcal cines, which may be hysician-approved facility essment for contraindications. NT is not met as evidenced by ion and record review, for four (ecords, the physician failed to: ant therapy and respond to a facility staff reporting a nose sident and review the total lenced by failing to document es for three (3) residents who t changes. Residents #29, 8,	F3	386	 483.40(b) PHYSICIAN VISITS Residents #29, 8, 17, 21 Physicians involved in de practices at the time of the survey been counseled regarding their error Physician response time documentation for residents significant weight changes wi addressed to all physicians a scheduled Physician Services M which is chaired by the Medical Di The Clinical Mangers will n the physicians for response time appropriate documentation on sign weight change and report their find the Director of Nurses and M Director. The Medical Director will of this monitoring and report on his f with any action plans for improve the quarterly Quality Impro Committee which is chaired administrator. 	y have prs. and with ill be at the leeting rector. nonitor he and hificant ings to Medical oversee indings ment at vement	7 2 06 7 2 06 7 2 06 (6 30 06
FORM CMS-25	67(02-99) Previous Versions		Fac	cility li	D: WASHNURS If contin	uation sheet	Page 80 of 96

		AND HUMAN SERVICES	•			FORM	06/15/2006 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		095022	8. WING			05/19/2006	
	ROVIDER OR SUPPLIER GTON NURSING FAC	ILITY			IREET ADDRESS, CITY, STATE, ZIP CODE 2425 25TH STREET SE WASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	1 1X	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE I	BE CROSS-	(X5) COMPLETION DATE
F 386	Continued From pa	ge 80	F	386	6		
	at 10:00 PM a telep Obtain PT/INR lab	work in 3 days. "					
		12:30 AM a physician ' s btain U/A C&S in AM to R/O					、
	March 24, 2006 2:0	0 PM a physician ' s order n 500mg 1 tab po everyday for					
	on the resident 's r however, there was that the physician a results requested for resident was received	a progress note was entered ecord by the physician is no documentation to indicate icknowledged the laboratory or March 22, 2006 or that ring Levoquin (Severity 11 tor the use of Coumadin/					· · · ·
	directed, " Continu tab daily GT/PO blo March 29, 2006 2:4	2:00 PM a physician ' s order e on Warfarin Sodium 10mg 1 ood thinning. 0 PM a physician ' s telephone heck PT/INR every month. "					
	indicated, "writer wa INR result, PMD m	at 3:30 PM a nurse's note as called by lab regarding-PT/ ade aware, no new orders ontinue with Coumadin and					, ,
	Normal range 12.2 the laboratory result	n March 28, 2006 was 27.4, 15.0. The physician signed t form on April 4, 2006. There totes in the record dated for					
	On May 19, 2006 a	t approximately 9:45 AM, the					

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		AND HUMAN SERVICES	-			FORM	06/15/2006 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		095022	B. WI	NG_		- 05/19/2006		
	ROVIDER OR SUPPLIER	ILITY			REET ADDRESS, CITY, STATE, ZIP CODE 2425 25TH STREET SE WASHINGTON, DC 20020			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	L	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETION DATE	
F 386	call comes from the level, it is usually in level that needs to The elevated PT re physician, however made of the residen The physician failed resident's PT level range. The record v B. The physician fa call from facility sta 29 had a nose blee On April 16, 2006 a indicated, "10:00 f amount. Ice pack a Place a call to PMD answering machine time."	nterviewed and indicated if a e laboratory to report a specific dicative of an abnormal value/ be addressed by the physician. port was communicated to the there were no adjustments of s Coumadin dosage. It to adequately monitor the after a reported elevated was reviewed May 19, 2006. iled to respond to a telephone ff to report that the Resident #	F					
	over bridge of nose aware of medical p apply ice and to do report result to PMI According to a nurs	PMD responded made roblem. Orders to continue to CBC and PT/INR today and to D. e's note on April 17, 2006 at 2: ry results were received and	·					
	PT 134.4 Norma	I range 12.2-15.0 I range 2.0-3.0. The resident						

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		AND HUMAN SERVICES				FORM	06/15/2006 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ultipl Lding	E CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY
		095022	B. WING			05/19/2006	
1	Rovider or Supplier GTON NURSING FAC	ILITY		242	ET ADDRESS, CITY, STATE, ZIP C 25 25TH STREET SE ASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION SI REFERENCED TO THE APPROP	HOULD BE CROSS-	(X5) COMPLETION DATE
F 386	Continued From pa	ge 82	F	386			
	the physician's res regarding the reside	oximately nine(9) hour delay of ponse of an emergency call ent with a nose bleed. The ed no May 17, 2006.					
		dent #8's record revealed that pounds in nine (9) months t by the physician.				. *	
	resident's weights v Date Weight 8/8/05 119.3 9/13/05 98 10/6.05 100 11/11/05 94.5 12/4/05 106.4 1/06 103 2/06 (blank)	(pounds)					
	3/6/06 93.5 4/06 93/5 5/8/06 90						
	record for August 1 22, December 20, 2 February 14, March There was no ass	notes were present in the 6, September 14, November 2005 and January 17, 13, April 13, and May 2, 2006 sessment or reference to the ss. The record was reviewed				· .	
	the resident gained	dent #17's record revealed that 7½ pounds in less than two (2 sessment by the physician.					
	According to the "V resident's weights v	ital Sign Flow Sheet" the vere as follows:					
FORM CMS-25		Obsolete Event ID: D95S11		ility ID:	WASHNURS	continuation sheet F	2000 82 of 06

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		AND HUMAN SERVICES		:	·	FORM	: 06/15/2006 APPROVED . 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED 05/19/2006	
		095022	B. Wil	1G	· · · · · · · · · · · · · · · · · · ·		
	ROVIDER OR SUPPLIER			2	REET ADDRESS, CITY, STATE, ZIP CODE 425 25TH STREET SE VASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	L IX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOUL REFERENCED TO THE APPROPRIATI	D BE CROSS-	(X5) COMPLETION DATE
F 386	Continued From pa Date Weight 1/12/06 130	ige 83 t (pounds)	F	386			
	2/23/06 134 3/2/06 137.5 4/06 (blank) 5/4/6 142						
	record for January 29, April 11, and Ma assessment of or re	notes were present in the 24, February 6 and 15, March ay 2, 2006. There was no eference to the resident's ecord was reviewed May 16,					
1	the resident lost 14 no assessment by						
	resident's weights v	t (pounds)		-			
· · · · · · · · · · · · · · · · · · ·	record for February 11, 2006. There wa	notes were present in the 6 and 23, March 19, and April is no assessment or reference ight loss. The record was 006.					
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		AND HUMAN SERVICES				FORM	06/15/2006 APPROVED _0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU			(X3) DATE SI COMPLE	JRVEY .
		095022	B. WI	B. WING		05/19/2006	
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
WASHIN	GTON NURSING FAC	ILITY			2425 25TH STREET SE WASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	TX -	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETION DATE
F 425 SS=D	drugs and biologica them under an agree) of this part. The f personnel to admin permits, but only ur a licensed nurse. This REQUIREMEN Based on observati interview for one (1 boxes, it was deter failed to ensure tha available for facility The findings include According to the fac 3.4, "Emergency Dr purpose of this poli- access to emergen an emergency situal standardize proced charging of emerge On Monday, May 19 were inspected for an isolated incident located on 2 South injection. According slip, on May 3, 2006 the emergency box A face-to-face inter	ovide routine and emergency ils to its residents, or obtain eement described in §483.75(h acility may permit unlicensed ister drugs if State law inder the general supervision of NT is not met as evidenced by on, record review and staff) of six (6) six emergency mined that pharmacy services t emergency drugs were residents. e: cility's Policy and Procedure, # rug Box" stipulates the cy is (1) to provide ready cy drugs that can be utilized in ation. (2) to ensure a ure for the replacing and ency drugs." 5, 2006, the nursing stations the storage of medication. In an emergency box (Box #5) did not contain Glucagon g to the emergency box receipt 5, Glucagon was taken from and used for a resident.	F	425	 483.60 PHARMACY SERVICES The emergency supply was reupon discovery. It is the responsibility of the mstaff to notify the pharmacy wmedication is used from the emerbox. The meds are replaced and the re-locked. The box is only exchanit approaches its date of expiration. Inservicing was done with all lidits staff to ensure their understanding emergency drug policy and their n contact the pharmacy whenever a dused. The Clinical Managers: Consultant Pharmacist will monitor issue throughout the month and their findings to the DON. The Director of Nursing will or the monitoring. The results of monitoring, along with any action for improvement, will be presented quarterly Quality Improv Committee, which is chaired b Administrator. 	pursing hen a rgency box is ged as censed of the eed to drug is and or this report versee f this plans at the ement	5/1×/06 7/2/06 Nevergen 7/2/06 6/70/06
EORM CMS-25	Charge nurse on Ma 67(02-99) Previous Versions	Obsolete Event ID: D95S11		oilitu	ID: WASHNURS If contin		Page 85 of 96

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DEPARTMENT OF H	IEALTH A	ND HUMAN	I SERVICES
CENTERS FOR MEL	DICARE &	MEDICAID	SERVICES

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PRINTED: 06/15/2006 FORM APPROVED OMB NO. 0938-0391

	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION PLAN OF CORRECTION IDENTIFICATION NUMBER: (A, BUILDING			(X3) DATE SURVEY COMPLETED		
		095022	B. WING	<u> </u>	— 05/	19/2006
	PROVIDER OR SUPPLIER	ILITY	·	IREET ADDRESS, CITY, STATE, ZI 2425 25TH STREET SE WASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTION REFERENCED TO THE APPRO	SHOULD BE CROSS-	(X5) COMPLETION DATE
F 425 SS=D	drugs and biologica them under an agree) of this part. The fa personnel to admini	Y SERVICES ovide routine and emergency is to its residents, or obtain ement described in §483.75(h acility may permit unlicensed ister drugs if State law der the general supervision of	F 425	 483.60 PHARMACY SERVICE I. The emergency supply upon discovery. 2. All emergency box checked to ensure that was both complete and date. 	was replaced ces were t their stock	5/1×/06 7/2/06
	: Based on observation interview for one (1) boxes, it was detern failed to ensure that available for facility The findings include According to the fact 3.4, "Emergency Dr purpose of this polic access to emergency an emergency situal standardize procedu charging of emergent	ility's Policy and Procedure, # ug Box" stipulates the ey is (1) to provide ready by drugs that can be utilized in tion. (2) to ensure a ure for the replacing and ncy drugs."		 Inservicing was done wastaff to ensure their underse emergency drug policy and contact the pharmacy where used. The Clinical M Consultant Pharmacist will issue throughout the montheir findings to the DON. The Director of Nursing the monitoring. The remonitoring, along with any for improvement, will be prequarterly Quality Committee, which is character. 	tanding of the d their need to never a drug is Managers and l monitor this th and report s will oversee esults of this y action plans resented at the Improvement	7/0/06
	were inspected for t an isolated incident located on 2 South o injection. According slip, on May 3, 2006 the emergency box A face-to-face interv	5, 2006, the nursing stations he storage of medication. In an emergency box (Box #5) did not contain Glucagon to the emergency box receipt Glucagon was taken from and used for a resident. view was conducted with the y 15, 2006 [Monday] at				

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		I AND HUMAN SERVICES				FORM	06/15/2006 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		095022	B. WIN	IG		05/1	9/2006
	ROVIDER OR SUPPLIER			24	REET ADDRESS, CITY, STATE, ZIP CODE 425 25TH STREET SE VASHINGTON, DC 20020	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETION DATE
	 F 425 Continued From page 85 approximately 10:00 AM. He/She stated that the emergency box is replaced every Tuesday. The emergency box was not replaced until May 18, 2006 [Thursday]. Glucagon injection was in the emergency box. F 428 483.60(c)(1) DRUG REGIMEN REVIEW 			125	 DRUG REGIME REVIEW 1. The drug regime review was do this resident for May and June 200 no particular issues arising. 2. The pharmacy did an audit medical records and found no other with a missing monthly audit. 3. The Consultant Pharmacist was a statement of the statement of	one for 06 with of the record vill be	5 31 06 5 31 06 7 2 06
F 428 SS=D	The drug regimen	B REGIMEN REVIEW	F 2	128	given an accurate census prior to e her visits so that she can be assured current residents and their room nu Business Office coordinator to wor the pharmacist to ensure this is comp The Clinical Managers will monito issue throughout the month and	mbers. k with pleted. or this	7 2 06
	Based on observat interview, it was de pharmacist failed to				their findings to the DON. 4. The Director of Nursing will o the monitoring. The results o monitoring, along with any action for improvement, will be presented quarterly Quality Improv Committee, which is chaired b Administrator.	f this plans at the rement	6/36/66
	monthly drug regim April 2006.	nt #4's record revealed that a nen review was not done for			· · ·		
	Assistant Unit Man AM. He/she acknow	view was conducted with the ager on May 15, 2006 at 11:00 wledged that the drug regimen 06 was not done. The record 15, 2006.					

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Facility ID: WASHNURS

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TATEMENT	OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			0938-0391 URVEY TED
		095022	B. WI	۹G		05/1	9/2006
	ROVIDER OR SUPPLIER	CILITY		24	EET ADDRESS, CITY, STATE, ZIP CODE 125 25TH STREET SE IASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE [BE CROSS-	(X5) COMPLETION DATE
F 429 SS≃D	The pharmacist mu the attending physic This REQUIREME Based on observat 2) of 30 sampled re that the facility's co report to the physic that orders for Lora by mouth), had the	B REGIMEN REVIEW ust report any irregularities to ician and the director of nursing NT is not met as evidenced by ion and record review for two (esidents, it was determined ontract pharmacist failed to cian and Director of Nursing azapam (Ativan), IM and PO (same indication for use for	F 429		 483.60(c)(2) DRUG REGIME REVIEW Residents #2 and S9 1. The orders for these resident clarified with the residents' att physicians. 2. The pharmacy is performing a audit of all PRN medications to that those with the same therapeutic for any given resident have a clarifier order documenting the order in these medications should be given. 3. The consultant pharmacist will medications for the PRN medications work does not be a solution. 	ending 100% ensure effect ication which onitor ons to irectly	5 1910b 7 210b 6 2010b
	regimen. The findings includ 1. A review of Res the pharmacist faile and Director of Nur	idents. Residents #2 and S9's drug			 through the DON and physicians clarification orders are needed. 4. She will report the findings of monitoring at the quarterly Q Improvement Committee. 	of her	6430/06
	the following order (1 mg) intramuscul needed for agitatio 1 mg 1 tablet by m needed for agitatio	sician's Order Form included s: "12/18/05, Lorazepam ½ ml larly (IM) every 4 hours as n"; and "12/18/05, Lorazepam outh every four hours as n. " There was no information rders that would determine po, would be used.					
	December 2005 th	review was done monthly, rough March 2006. There es for the aforementioned					

Event ID: D95S11 Facility ID: WASHNURS

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		AND HUMAN SERVICES				FORM	: 06/15/2006 APPROVED
STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SI COMPLE	
		095022	B. WIN	IG		05/1	9/2006
NAME OF P					REET ADDRESS, CITY, STATE, ZIP CODE		
WASHIN	GTON NURSING FAC	ILITY			425 25TH STREET SE VASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETION DATE
F 429 F 441 SS=D	report to the physic that the order for Lo specify when to use A review of Resided physician's order da 1 mg po (orally) or hrs PRN (as neede There was no evide pharmacist notified when to use the ora the Ativan. The facility's contra record April 10 and irregularities" was of The record was rev 483.65(a) INFECTI The facility must es infection control pro safe, sanitary, and to prevent the deve disease and infection an infection control investigates, control the facility; decides isolation should be resident; and maint corrective actions r	htract pharmacist failed to ian and Director of Nursing prazapam (Ativan) failed to e IM or PO. Int S9's record revealed a ated March 14, 2006, "Ativan IM (intramuscularly) every 4 d) for anxiety. " ence that the contract the physician of that to clarify al form or the injectable form of et pharmacist reviewed the May 11, 2006. "NI" (no sircled for both review dates. riewed May 19, 2006. ON CONTROL etablish and maintain an ogram designed to provide a comfortable environment and elopment and transmission of on. The facility must establish program under which it ols, and prevents infections in what procedures, such as applied to an individual rains a record of incidents and		429	 483.65(a) INFECTION CONTROL 1. Improper infection control washing technique was corrected it time of the survey. 2. Inservicing was done with all ne staff to ensure their knowledge technique of proper hand was procedures. 3. The ADON and Clinical Manager monitor this issue throughout the rand report their findings to the DON 4. The Director of Nursing will over the monitoring. The results of monitoring, along with any action for improvement, will be presented quarterly Quality Improved Committee, which is chaired by Administrator. Soiled bedside mats, soiled shower or shower stall with mildew, storal plungers, linen chute 1. All issues found at the time of survey were corrected immediately. 2. A review of the other similar equit was done and corrections made necessary. 3. Inservicing was done Environmental Services staff to environmental Services staff to environmental Services when dwith resident equipment. Housekeeping Supervisors will m this issue throughout the month and their findings to the Director Environmental Services. 	at the ursing ashing rs will month N. versee f this plans at the ement y the chairs, ge of of the pment de as with ensure g and ealing The onitor report	E/19/06 6/20/06 6/20/06 6/20/06 6/20/06 7/206 7/206 7/206
FORM CMS-25	67(02-99) Previous Versions	Obsolete Event ID: D95S11	Fa	cility I	ID: WASHNURS If continu	uation sheet	Page 88 of 96

		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMEN	F OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU			(X3) DATE SU COMPLE	JRVEY
	<u></u>	095022	B. WI	۹G		05/1	9/2006
	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE 425 25TH STREET SE		
				V	VASHINGTON, DC 20020		<u></u>
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETION DATE
F 441	facility staff failed to transmission of dise drying washed hand resident; soiled and with foot prints on th shower mats and shower mats and show with mildew; plunge bathrooms and soil These findings were	ons during the survey period, prevent the development and ease as evidenced by: a nurse ds on a towel used by a uncovered bedside floor mats he mat; soiled shower chairs, hower stretcher; a shower stall ers stored uncovered in ed and stained linen shoots. e observed in the presence of ekeeping and nursing staff.	F -	441	4. The Director of Environmental S will oversee the monitoring. The re- this monitoring, along with any plans for improvement, will be pr- at the quarterly Quality Impro Committee, which is chaired Administrator.	sults of action esented vement	6 70 06
	 The clinical mana resident who had a because of excessi his/her hands and to resident, dried his/he towel in the soiled li observation on May Soiled and /or un observed in the follo and 237 during the 	ager (CM) repositioned a towel on his/her chest ve drooling. The CM washed ook the towel from the her hands and disposed of the nen bin in one (1) of one (1) v 15, 2006 at 9:27 AM. covered bedside mats were bwing areas:106, 144, 225, survey period.					
	North shower room in one (1) of one (1) 5. A shower stall wit 2 South shower roo observation on May 6. Plungers were ste in room 204 and the	th mildew was observed in the m in one (1) of one (1) 17, 2006 at 4:00 PM. ored uncovered in bathrooms 1 South staff bathroom.					
		d linen shoots were observed					
ORM CMS-25	67(02-99) Previous Versions	Obsolete Event ID: D95S11	Fa	cility I	D: WASHNURS If contin	uation sheet F	Page 89 of 96

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	OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED	
			A. BUILDING			
		095022	B. WING _		05/1	9/2006
NAME OF P	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP COD 2425 25TH STREET SE	Ξ.	
WASHIN	GTON NURSING FAC	ILITY		WASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION SHOU REFERENCED TO THE APPROPRIA	LD BE CROSS-	(X5) COMPLETIO DATE
F 441	Continued From pa	ge 89	F 441	483.70(c)(2)		
	on 1 North, 2 North	and 3 North in three (3) of six		SPACE AND EQUIPMENT		
		ring the survey period.		Oxygen concentrators 1. Any oxygen concentrator	with an	
F 450			E 450	odometer reading over 10,000	hours has	6/20/01
F 456 SS=D	483.70(c)(2) SPAC	E AND EQUIPMENT	F 456	been pulled from the unit and with another one.	replaced	6 30/06
00 2	The facility must ma			2. NeighborCare is assisting the		now and
	mechanical, electric equipment in safe of	cal, and patient care		developing an aggressive and preventative maintenance progr		7/2/01
	equipment in cale e	pordanig contaition.		oxygen concentrators. Logs h		
		NT is not met as evidenced by		developed for tracking.3. Inservicing was done by Neig	hharCara	
	:			of the Central Supply and Ma		
		ons during the survey period,		staff regarding the measuring of output to ensure therapeutic level		7/2/06
		o maintain all essential cal, and patient care		residents. Additionally, Neig	hborCare	12/00
	equipment in safe of	operating condition as		will provide preventative mainte		
		of service tags for oxygen functional amplifiers on		the oxygen concentrators wh reached certain odometer readin		
	telephones; failure	of elevator indicator lamps to		4. The Director of Maintena	ince will	
		ogs to track preventive uipment. These observations		report on the progress of the PM for the facility's oxygen concern		della
	were made in the p	resence of nursing staff and/or		the quarterly Quality Imp	rovement	6/20/0
	the Directors of Ma	intenance and Housekeeping.	`	Committee which is chaired administrator.	by the	
ĺ	The findings include	9:				
	1. Oxygen concentr	ators were observed without		Amplifiers and indicator lamps 1. Amplifiers on the public ph	ones and	
		lometer readings in rooms 308		indicator lamps on the elevators	missing	1/2/06
		in four (4) of four (4) y 15, 2006 between 9:15 AM		at the time of the survey hat repaired and/or replaced.	ve been	
	and 9:45 AM.			2. All public telephones and		1/2/04
		public telephones were not		were checked to ensure ampli indicator lamps were present.	fiers and	' ~!*0
	functioning on 3 No AM in one (1) of fou	rth on May 18, 2006 at 10:15		3. Maintenance aides will mo		1 2/06 7 2/06 7 2/06
				amplifiers and lamps on a monthl	y basis to	י יון-וי
1		r lamps failed to illuminate on				

Facility ID: WASHNURS

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

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		& MEDICAID SERVICES				<u>OMD NO</u>	. 0938-0391
STATEMENT AND PLAN C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A, BU		IPLE CONSTRUCTION	(X3) DATE S COMPLE	
		095022	B. WI	NG		05/1	9/2006
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
WASHIN	GTON NURSING FAC	ILITY		1	425 25TH STREET SE VASHINGTON, DC 20020		
04010	CI DALADY STA	TEMENT OF DEFICIENCIES	ID	<u> </u>	PROVIDER'S PLAN OF CORRECT		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETION DATE
F 441	Continued From page	ge 89	F 4	441	483.70(c)(2)		
	on 1 North 2 North	and 3 North in three (3) of six			SPACE AND EQUIPMENT		
		ring the survey period.			Oxygen concentrators		
		ing the ourvey period.			I. Any oxygen concentrator wi		
F 450	400 30(.)(0) 00400		F 4	156	odometer reading over 10,000 hou		6/70/06
	483.70(C)(2) SPACE	E AND EQUIPMENT	F 4	100	been pulled from the unit and rep with another one.	blaced	6 20 06
SS=D	The facility must ma	intain all assential					
	mechanical, electric				2. With the assistance of Neighbor all oxygen concentrators were anal		
		perating condition			for their efficacy and efficent produced		7/2/06
				1	of oxygen. Logs have been develo		
					for tracking odometer readings.	· · · · ·	
•	This REQUIREMEN	T is not met as evidenced by			3. Inservicing was done by Neighbo		
	•				of the Central Supply and Mainter		
		ons during the survey period,			staff regarding the measuring of or		7/2/06
		maintain all essential			output to ensure therapeutic levels for residents. Additionally, Neighbor		././.
	mechanical, electric	ar, and patient care			will provide preventative maintenan		
		of service tags for oxygen			the oxygen concentrators which		
		unctional amplifiers on			reached certain odometer readings.		
		of elevator indicator lamps to			4. The Director of Maintenance	will	
•	illuminate; and no lo	gs to track preventive			report on the progress of the PM pro		
	maintenance for equ	ipment. These observations			for the facility's oxygen concentrate		6/20/06
	were made in the pr	esence of nursing staff and/or			the quarterly Quality Improve		•/•-/•
	the Directors of Mair	ntenance and Housekeeping.		~	Committee which is chaired by	the	
	The findings include	:			administrator.		
	1 Oxygen concentra	ators were observed without			Amplifiers and indicator lamps	and	
		ometer readings in rooms 308			1. Amplifiers on the public phones indicator lamps on the elevators mi	s and	1/2/06
	, 316, 337 and 349 in				at the time of the survey have	been	
	observations on May	/ 15, 2006 between 9:15 AM			repaired and/or replaced.		1/2/06 7/2/06 7/2/06
	and 9:45 AM.	·)			2. All public telephones and elev	ators	7/2/04
	· · · · · · · ·				were checked to ensure amplifiers	and	1~100
		public telephones were not			indicator lamps were present.		
	functioning on 3 Nor AM in one (1) of four	th on May 18, 2006 at 10:15			3. Maintenance aides will monitor	r the	7/2/06
					amplifiers and lamps on a monthly ba	sis to	·1 ·
	3. Elevator indicator	lamps failed to illuminate on					

FORM CMS-2567 (02-89) Previous Versions Obsolete

Facility ID: WASHNURS

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PRINTED: 06/15/2006

FORM APPROVED

	· .	AND HUMAN SERVICES & MEDICAID SERVICES			FOR	D: 06/15/2006 MAPPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		PLE CONSTRUCTION (X3) DATE	SURVEY
1		095022	B. WII	4G		19/2006
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE	
WASHIN	GTON NURSING FAC			(425 25TH STREET SE VASHINGTON, DC 20020	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS- REFERENCED TO THE APPROPRIATE DEFICIENCY	(X5) COMPLETION DATE
F 456	the main elevator o 4. Documentation w temperatures/press cleaning and filter o HVAC units, hot wa	n May 15, 2006 at 8:30 AM. vas not available to show that ure checks, lubrication, coil hanges were performed on ter boilers, laundry washers, on pumps, air handlers and	F	456	 ensure compliance. They will report their findings to the Director of Maintenance. 4. The Director of Maintenance will report any action plans for the amplifiers and indicator lights at the quarterly Quality Improvement Committee which is chaired by the administrator. Logs Logs have been developed as evidence 	6 /20 /06
F 490 SS=G	enables it to use its efficiently to attain o	dministered in a manner that resources effectively and or maintain the highest , mental, and psychosocial	F	490	that the temperatures pressure checks call	7/2/010
	Based on observati interviews, it was de Administrator failed	to integrate, coordinate and practice related to residents'			 facility's preventative maintenance program. 3. The Maintenance Aides and Director will ensure the documentation of these logs on a routine and consistent basis. 4. The Director of Maintenance will report on the progress of the PM program af the quarterly Quality Improvement Committee which is chaired by the 	7/2/06 7/2/06 6/30/06
	 The Administrato housekeeping and i maintained in a safe reference 483.15(h) The Administrato were provided or an professional standa 	r failed to ensure that maintenance services were and sanitary manner. Cross (2), F253, Quality of Life. r failed to ensure that services ranged by the facility to meet rds of quality. Cross (3)(i), F281, Resident			administrator. 483.75 ADMINISTRATION 1. See response to 483.15 (h)(2) 2. See response to 483.20 (k)(3)(I) 3. See response to 483.25	7/2/06 7/2/06 7/2/06

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Event ID: D95S11 Facility ID: WASHNURS

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		& MEDICAID SERVICES	- <u>_</u>		OMB NO	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED 05/19/2006	
		095022	B. WING			
	Rovider or Supplier	ILITY	2	REET ADDRESS, CITY, STATE, ZIP COD 425 25TH STREET SE VASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION SHOU REFERENCED TO THE APPROPRIAT	LD BE CROSS-	(X5) COMPLET DATE
F 490 F 492 SS=D	Assessment. 3. The Administrator residents received services to attain of practicable physical well-being in accord assessment and pl 483.25, F309, Qual 483.75(b) ADMINIS The facility must op compliance with all local laws, regulation accepted profession that apply to profess such a facility. This REQUIREMENT: Based on observation and review of staffind days of the survey of maintain staffing at per day to comply vo four (4) of 30 samp determined that the quarterly progress of 3229.5. Residents The findings included 1. The facility failed	or failed to ensure that the necessary care and r maintain the highest I, mental and psychosocial dance with the comprehensive an of care. Cross reference lity of Care. STRATION werate and provide services in applicable Federal, State, and ons, and codes, and with nal standards and principles sionals providing services in NT is not met as evidenced by on, interview, record review ng sheets for four (4) of five (5) period, the facility failed to 3.5 nursing hours per resident with 22 DCMR 3211.3 and for led residents, it was e social worker failed to write notes to comply with 22 DCMR #1, 12, 18 and 21. e: d to comply with 22 DCMR maintain 3.5 nursing hours	F 490	 ADMINISTRATION 1. The facility strives to attain 3. hours per patient day. 2. Each day the staffing is evaluadjusted to ensure proper staff residents of the facility. 3. The staffing coordinator, AI DON will ensure proper staff and certified nursing assistants ar on the units to attain and mai residents' highest level of function 4. The Director of Nursing with the monitoring. The result monitoring, along with any act for improvement, will be presented attain and the staff. 	the time addit were ial Work 2 vacant ng. The by the converse by the converse conve	5 19 1 5 19 1 5 19 1 5 19 1 5 19 1 6 30 1 6 30 1 1 2 1 7 2 1

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Event ID: D95S11 Facility ID: WASHNURS

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		H AND HUMAN SERVICES				FORM	06/15/2006 APPROVED
STATEMENT	T OF DEFICIENCIES	<u>AMEDICAID SERVICES</u> (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		PLE CONSTRUCTION	(X3) DATE SI COMPLE	
		095022	B. WI	۹G		05/1	9/2006
1	ROVIDER OR SUPPLIER	CILITY	- <u>I</u>	2	REET ADDRESS, CITY, STATE, ZIP COD 425 25TH STREET SE VASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRI PREFIX (EACH CORRECTIVE ACTION SHOU TAG REFERENCED TO THE APPROPRIAT			ULD BE CROSS-	(X5) COMPLETION DATE
F 492	According to 22 Do January 1, 2005, "I sufficient nursing s	age 92 CMR, Beginning no later that Each facility shall employ staff to provide a minimum daily sing hours per resident per day	F	492	of evaluations and notes. 4. The results of his monitoring action plans for improvement presented to the quarterly Improvement Committee which by the administrator.	will be Quality	6/30/06
	requested for May actual staffing sche DON for May 14, 1 four (4) days review staffing was less th resident per day. again by the DON	Staffing Sheets were 14 through 21, 2006. The edules were reviewed with the 5, 16, and 17. Three (3) of the wed, revealed that the actual han 3.5 nursing hours per The same days were reviewed (Director of Nurses) and ADON of Nurses) and the result of ule indicated:					
		3.09 3.09 3.6 3.16. ur (4) days staffing reviewed by N remained below the required					
	3.5 nursing hours 2. The social work	per resident per day. ser failed to write a quarterly ded a social assessment and					
	last social worker's	ent #1's record revealed the s progress note was written on A progress note was due April					
		rview was conducted with the Services on May 16, 2006 at 9:					
FORM CMS-28	567(02-99) Previous Version	s Obsolete Event ID: D95S11	Fa	cility i	ID: WASHNURS If co	ontinuation sheet	Page 93 of 97

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		095022	B. WIN	IG	·	05/1	9/2006
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2425 25TH STREET SE				
			<u> </u>	W	ASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SHO REFERENCED TO THE APPROPRIA	ULD BE CROSS-	(X5) COMPLETIC DATE
F 492	Continued From p	age 93	F 4	192			
	in the progress no turn over in staff a	ated, "We know we are behind tes on all the units. We had a nd are trying to catch up. We ass residents with immediate					
		viewed May 15, 2006.					
ı		er failed to write a quarterly ided a social assessment and ident #12.			·		
	worker progress n 2005 and Decemb	ent #12's record revealed social otes were written on July 5, per 27, 2005. A quarterly s due October 2005. The ed May 16, 2006.					
		er failed to write a quarterly ided a social assessment and ident #18.					
	worker progress n 1, 2005 and April	ent #18's record revealed social otes were written on November 5, 2006. A quarterly progress February 2006. The record was 2006.	1				
		er failed to write a quarterly ided a social assessment and ident #21.					
	last social worker's January 17, 2006.	ent #21's record revealed the s progress note was written on A progress note was due April was reviewed May 17, 2006.					

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		AND HUMAN SERVICES				FORM	06/15/2006 APPROVED 0938-0391		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
095022			B. WING			05/19/2006			
}	NAME OF PROVIDER OR SUPPLIER WASHINGTON NURSING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 2425 25TH STREET SE WASHINGTON, DC 20020					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	¢	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETION DATE		
F 493 SS=G	The facility must had designated persons body, that is legally and implementing p management and of governing body app licensed by the Stat and responsible for facility This REQUIREMEN Based on the obser record review, it was Governing Body fai	OVERNING BODY ave a governing body, or s functioning as a governing responsible for establishing policies regarding the operation of the facility; and the points the administrator who is te where licensing is required; the management of the NT is not met as evidenced by rvations, staff interview and as determined that the led to ensure that policies	F 4	93	483.75(d)(1)-(2) GOVERNING BODY 1. See response to 483.15(h)(2) 2. See response to 483.20(k)(3)(I) 3. See response to 483.25		7/2/06 1/2/06 1/2/06		
	facility were implem The findings includ 1. The Governing E housekeeping and maintained in a saf reference 483.15(h 2. The Governing E services were provi to meet professiona								
FORM CMS-25	residents received services to attain an practicable physica well-being in accord	Body failed to ensure that the necessary care and nd maintain the highest I, mental and psychosocial dance with the comprehensive an of care. Cross reference	Fari	lity II	D: WASHNURS If continu		Page 95 of 97		

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TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER: 095022		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 05/19/2006		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE	BE CROSS-	(X5) COMPLETIO DATE
	483.25, F309, Qua	lity of Care.	F 4		483.75(1)(1) CLINICAL RECORDS # 18 1. The admission MDS was con	npleted	alai
F 514 SS=D	 483.75(I)(1) CLINICAL RECORDS The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. 		F 5	514	 and included in the discharged records The Director of Medical Harvewed similar discharged records found no other missing MDSs. The Clinical Managers will monocompletion of the MDSs to ensure are done in a timely manner. That report the results of their monitoring DON. The Director of Nursing will return the timely completion of the MD any action plans for improvement quarterly Quality Improvement Communications. 	ord. ecords ds and tor the that all ey will to the oort on Ss and at the mittee	1 2 04 7 2 0 7 2 06 7 2 06
	Based on the revie records, it was dete to maintain a clinica	NT is not met as evidenced by w of one (1) of three (3) closed ermined that facility staff failed al record in accordance with ional standards and practice. e:					
	Resident #18 who	of the clinical record for was discharged home, it was e record was incomplete.					
	January 25, 2006 a February 16, 2006. Data Set assessme	dmitted to the facility on ind was discharged home on The admission Minimum ent was not included in the of the record review. The					-

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391								
STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED		
						-		
	095022			B. WING 05/19/200				
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE				
WASHINGTON NURSING FACILITY			2425 25TH STREET SE WASHINGTON, DC 20020					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS- REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 514	Continued From page 96		F	514				
	record was reviewed on May 17, 2006.							
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}								
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FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: D95S11

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Facility ID: WASHNURS

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