STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095005	A. BUILDING _____ B. WING _____	R 03/11/2010

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS A follow up certification survey was conducted to the annual recertification survey (January 5 through 8, 2010). The following deficiencies are based on observation, record review, staff and resident interviews. The sample included 16 residents (60% of a standard survey sample) based on a census of 168 residents on the first day of survey.	{F 000}	The Washington Home makes its best effort to operate in substantial compliance with both Federal and State law. Submission of this Plan of Correction (POC) does not constitute an admission or agreement by any party, its board, officers, directors, employees or agents as to the truth of the facts alleged or the validity of the conditions set forth on the Statement of Deficiencies. The following Plan of Correction constitutes the facility's written credible allegation of compliance. It is prepared and/or executed solely because it is required by Federal and State law.	
{F 309} SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview for one (1) of 16 sampled records, it was determined that facility staff failed to follow the physician's treatment orders for a PICC dressing for Resident #11. The findings include: Resident #11's upper right arm was observed on March 11, 2010 at 2:18 PM. The PICC line was covered with a transparent dressing dated February 26, 2010 (indicating the last date the dressing was changed). A review of the Physician's Order Sheet written and signed by the physician on March 3, 2010 at	{F 309}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Denise D Allen Williamson — TITLE: LNHA — (X6) DATE: 3/21/2010

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

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{F 309}	Continued From page 1 10:00AM directed, "Change catheter site dressing every week and as needed with transparent dressing". A review of the "Central Line Catheter" treatment record and "Medication Administration Record" was conducted on March 11, 2010, at 2:15 PM. The review revealed that the PICC line catheter dressing was scheduled to be changed on March 9, 2010 on the night shift. The treatment record was not signed indicating that the treatment was completed. A face-to-face interview was conducted with Resident #11 on March 11, 2010 at 2:18 PM. He/she stated that since he/she returned from the hospital on March 2, 2010 no one had changed the dressing. A face-to-face interview was also conducted with Employee #2 on March 11, 2010 at 4:10PM. He/She acknowledged that the resident went to an area hospital on February 25, 2010 and returned on March 2, 2010 and that the dressing was scheduled to be done on March 9, 2010. A face-to-face interview was conducted with Employee #1 on March 11, 2010 at 4:50 PM. He/She acknowledged that the resident's dressing was dated February 26, 2010 and that the dressing was not changed. The record was reviewed on March 11, 2010.	{F 309}	**1. Corrective Action(s)** The resident's PICC site dressing was changed on 3/11/2010 immediately after the observation. There was no sign/symptom of infection at the site. **2. Identification of Deficient Practices & Corrective Actions** Other resident in the facility with this dressing change or a PICC line. At the time of the discovery, was assessed and found to be in compliance. **3. Systemic Changes** a. The licensed nurses on the specific unit were re-educated on the protocol/process for dressing changes by the clinical manager on 3/18/2010 and will be ongoing. b. A PICC line checklist was developed to address the dating of dressing changes, signs/symptoms at the site, length of the PICC line and the frequency of checks by the licensed nurse and will montored daily by the nurse manager, and weekly by Staff Development department for 4 months. **4. Monitoring** Complianc with systemic change for PICC Line dressing will be reviewed on a weekly basis for 4 weeks and outcomes will be reported to the monthly QI committee. **5. Compliance Date** 3/25/2010	
{F 468}	483.70(h)(3) CORRIDORS HAVE FIRMLY SECURED HANDRAILS The facility must equip corridors with firmly secured handrails on each side.	{F 468}		

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{F 468}	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on observations on Unit 2A, it was determined that nine (9) of 57 handrails were identified to be loose and not firmly affixed to the walls. The findings include: At approximately 10:00 AM on March 11, 2010 during the unit tour with Employee #3, the following handrails were observed to be loose: outside of rooms 202, 207, 215, 223, 226, 238, 242, 254 and 281. A face-to-face interview was conducted with Employees #3 and 4 at the time of the observations and the employees acknowledged the aforementioned findings.	{F 468}	**1. Corrective Action** An independent contractor was hired to initiate immediate repairs of the identified and listed handrails. All rails were re-anchored into studded walls. Liquid nails were then used to seal all joints. **2. Identification of Deficient Practices & Corrective Actions** All other handrails throughout the facility were inspected and repaired/remounted as indicated. **3. Systemic Changes** Maintenance rounds were revisited. Maintenance staff was retrained on the importance of having securely affixed handrails throughout the facility. Independent Contractor will inspect all hand-rails (including elevators) in addition to the identified deficient handrails. Contractor will provide detailed reports of work completed. Maintenance staff will accompany independent contractor during inspections. Identified deficiencies will be repaired during these inspections. **4. Monitoring** Maintenance handrail inspection rounds/ repairs to be conducted on a daily basis. Independent contractor rounds/repairs to be conducted monthly. **5. Compliance Date** 3/25/2010	03/18/10 03/19/10 03/19/10 03/11/10